How Have We Silenced the *Everydayness* of our Mental Dis-ease, in Mainstream Aotearoa New Zealand?

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A dissertation submitted to Auckland University of Technology in partial fulfilment of the requirements for the degree Master of Psychotherapy and Counselling

2018

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Abstract

This study originated with a wondering about my childhood understanding of 'normal' and the 'crazies' in the mental hospitals down the road. I wondered about the silence between these apparent extremes. Between these two opposites there seemed to be an abyss, a silence that was the 'normal'. This normal was everywhere but there were no words describing it and no-one appearing to notice it.

To understand this silence, this study began with an exploration of the literature on the history of madness in Europe and Aotearoa New Zealand. This created a base for an interpretive hermeneutic analysis. Through this analysis I arrived at three findings: the need for connection; stigma and the process of othering; and the Force. The Force is an intertwining braid that links our past and our traditions to the way we view mental health today. This final finding was key and led to an unexpected turn and personal insight. From this, implications for practice, training and policy were discussed along with strengths and limitations of the study. Gaps and future directions were considered. The conclusion was a reflection that tried to make sense of the findings that were pivotal to this study and especially, the unexpected turn.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgments), nor material which, to a substantial extent, has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Louise Player-Bishop

25 November 2018

Acknowledgements

This research project was one of the most challenging endeavours I have ever undertaken and would not have come to fruition without the support of many.

Foremost, I wish to thank Dr. Brian Rodgers as my supervisor without whose support, belief and wise counsel, this endeavour would have floundered. Your guidance, encouragement and belief in this topic was empowering and helped me find my way in searching for something that was silent.

To my running friends, thank you listening to me (for a long time). To my friends and peers who gave freely words of support and encouragement and who were tolerant of my ongoing focus and distraction, thank you.

To Kaye, whose understanding and time given when needed, a heart-felt thank you.

Finally, to my family and especially my daughter Lucy, thank you. Your belief in me and this project along with the words of encouragement kept me going and this I will forever hold dear.

Chapter 1. Introduction

This research is a hermeneutic enquiry into the everdayness of mental dis-ease in Aotearoa, New Zealand. My intention was to articulate the 'how' we have silenced the 'everydayness' of mental dis-ease, using hermeneutic methodology, the hermeneutic circle and hermeneutic spirals. These processes were used to create a platform for exploration and interpretation, to peel back layers of meaning and perspective, while acknowledging my part in their creation.

Background

Last year, in preparation for the dissertation, we were encouraged to think about a topic that kindled our interest and our passion. I took time to ponder and to wonder about all the possible topics to explore. I felt both privileged and daunted. I have a full life, and responsibilities that come with age, family, friends, interests and hobbies. Thus, to embrace this writing opportunity, and to enrich my understanding of myself, the people around me, and especially my clients, I wondered how my past and present life experiences could be embraced or utilised to become part of my dissertation.

I had started psychotherapy sessions as part of the compulsory requirement for the Graduate Diploma in Psychotherapy. On reflection, I have often asked myself why I had been so reluctant to take this initial step into psychotherapy. There was the invisibility of psychotherapy in New Zealand as a therapeutic option, but this was not really what had kept me constrained, stuck in a felt-sense of dis-ease. This *dis-ease,* to me, reflects a feeling of tension, a felt discomfort; from slight to intense, chronic to acute entwined with how I view 'normal'.

Within this tension, I felt the hints or shadows of shame, the invisible and silent blocks that, in asking for help, I felt were real and present in friends, family, and wider groups. I wondered about the invisible, the silent, the hints and shadows, about my own 'normal' or my own dis-ease. What were these hints and shadows, where were they, and where had they come from? In this journey, could I articulate this hesitancy, my and others' inhibitions, this *stuckness* in dis-ease in preferring not to seek help? I reflected on my own 'normal' upbringing to look for some indications, some pointers to make visible what I had both perceived and felt as the silence, the abyss between the normal and the 'other', in order to understand the normal and from where the mental dis-ease originates.

Two phrases sparked my interest confirming this direction. The first, while reading about stigma resonated with me, "… they internalised the beliefs and myths surrounding mental illness that they had grown up experiencing, realising that all of these now applied to them" (Peterson, Barnes & Duncan, 2008, p. 57).

This statement landed in me and spoke of my upbringing. I too had grown up with the invisible but tangible myth of mental illness. This myth, unspoken, unseen was and still is all around me. Wondering about my own journey through childhood, I grew up with a *get over it*, *pull your socks up*, *it's just a stage*, and *she'll be right* view of happiness, unhappiness, and dis-ease. In my family, these terms were used to avoid confronting emotions and entanglement, defining what was mentally or emotionally acceptable and allowed, consequently defining what was *normal* and what was *other*, with the *other* being mostly ignored or dismissed. Cementing these understandings were the Auckland 'mental' hospitals, Oakley and Kingseat, where craziness was contained and hidden from those on the outside. This containment seemed to be more than just keeping the *crazies* locked up, it was as if there was a fear of exposure or contamination, such that *they* had to be kept away from *us*. Within this fear, there seemed to be a 'turning away', an active 'not seeing' of something too threatening to acknowledge, that in the eyes of the mad and insane, perhaps we recognized our own reflection. In Yalom's *When Nietzsche Wept*, the protagonist asks "who am I afraid of?, not the other, but what the other represents in me, what I align within myself…" (Yalom, 2015). To me, this was the myth of mental illness, there were the *crazies* in the hospitals and then there was everybody else and everybody else embraced the myth of normality.

The second phrase that jumped out at me mirrors what I currently feel. David Seymour, in early May 2018, wrote to his Epsom constituents raising concerns regarding a proposed Housing New Zealand development in his electorate stating, "There is also a chance that some of the future residents will have social and mental health issues who will need to have special support measures in place" (as cited in Cooke, 2018). This comment fuelled much controversy when it was shared via local media. What was his concern about mental health and that 'they' may need special support measures? Who were 'they'? Was he articulating a felt fear, a public fear about the 'they', something unseen but known or were these the myths and beliefs that still were hidden but so very alive. In Seymour's statement I felt the 'currentness' of a fear that was centuries old.

I began to brainstorm, putting ideas, words, thoughts to paper in an attempt to give shape and substance to these myths and beliefs as depicted in Figure 1.

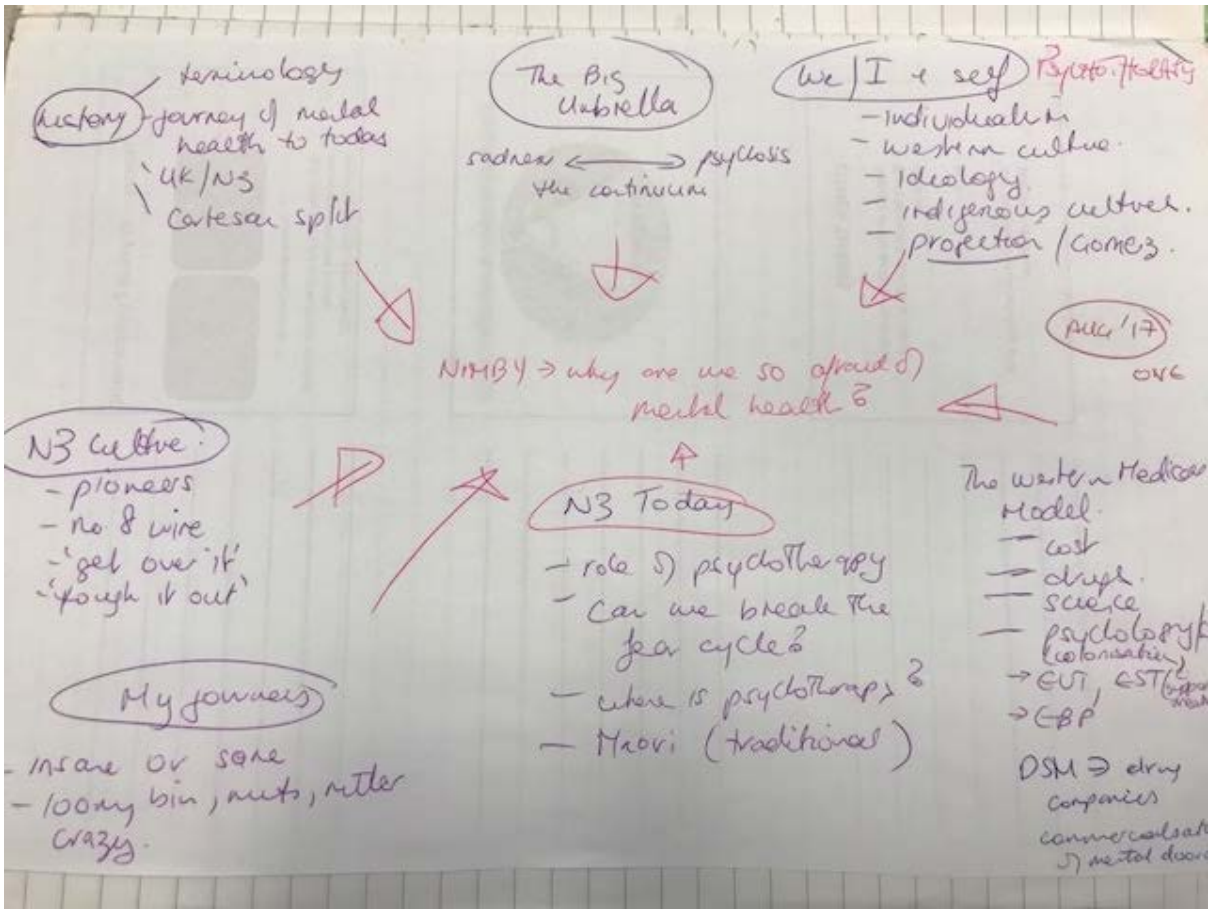

Figure 1 My first brainstorm and mind map

This first mind map covered ideas such as the history of madness in Europe (observing my own connection as a descendent from Scotland and England); the history of madness in New Zealand as a colony; how the colonisers were influenced by the indigenous population; stigma; and trying to understand how normal was conceptualised. Is 'normal' a growing, living organism, culturally defined, or is there a rule-book with a definitive answer? Furthermore, is the myth constructed from the western perspective of medicine, pharmaceuticals and their companies; bio-medicine and the history of diagnosis; the collective versus the individual, or is the individual controlled by the collective? What or where did Seymour's fear come from?

As I embarked on this exploration, I was cognisant of my female, Pakeha perceptions that reflect the dominant discourse of a western bio-medical model of health with an emphasis on diagnosis (Germov, 2009; Horwitz, 2002). Additionally, I have been brought up to embrace individualism and my colonial history with an attitude of 'number eight wire' (Bardsley, 2008). Using number eight wire is New Zealand jargon for making a clever repair with available material (Cryer, 2006) and

reflects the perceived ‘can-do’ attitude of New Zealanders. ‘Making do’ and similarly ‘get over it’ are part of my history, perhaps my colonial history and I wondered if these historic influences had kept me shackled (and us) to only embrace the normal ‘normal’?

Words and ideas streamed and I felt overwhelmed by the possible directions and the potential pathways to explore. As I continued with these ideas I became aware of the need to find a direction reflecting my own need for a predictable pathway, that was structured and followed guidelines. I mused at my own teaching and disciplined academic background, and how these influences were biting at my heels, undermining me and yet paradoxically, highlighting the opportunity to release me from their shackles. Finally, I wondered at the permission, inhibited or prohibited, in having a relationship with myself in this exploration.

Using this first brainstorm, I began an initial investigation into the literature, realising quickly that the topic was too big, and I had to rein it in and focus on a couple of carefully chosen key elements. The literature was still overwhelming in researching these elements, but interestingly, there was little when investigating the silence or myths around mental dis-ease. Thus, I chose first to explore the history of madness to create a base or a springboard from which to move forward into investigating this silence.

History of Madness

In beginning the journey into madness, it was important to locate this in relation to contemporary definitions of ‘health’, ‘mental health’, and related terms. ‘Health’ is defined positively by the World Health Organisation (WHO) as “… a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2014, Mental Health, para 2). Further, mental health is described as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO, 2014, Key Facts, para 2). However, Pilgrim (2005) reminds us that the term ‘mental health’ can be used “positively to indicate a state of psychological well-being, negatively to indicate its opposite (as in ‘mental health problems’) or euphemistically to indicate facilities used by, or imposed upon, people with mental health problems (as in ‘mental health services’)” (p. 3). It is interesting to observe in New Zealand, that the term ‘mental health’ is commonly used to comment negatively on one’s state of mind, for instance, ‘he has/had mental health issues’.

The WHO further defines mental illness or mental ill health as “a brain disease manifested when the individual experiences alteration in thinking, mood or behaviour often accompanied by distress and/or impairment in functioning, disability or morality” (as cited in Yearwood & Case, 2017, p. 5). Yearwood and Case add that “mental health disorders are a set of symptoms associated with a DSM (Diagnostic and Statistical Manual of Mental Disorders) or ICD-10 (International Statistical Classification of Diseases – 10th Revision) diagnosis in which there is significant disturbance in an individual’s cognition, emotion regulation, or behaviour that impacts functioning” and importantly, mental disorders are caused by environmental, social or genetic factors (2017, p. 8).

Neurological disorders, different from mental dis-ease, are diseases of the central and peripheral nervous systems, namely; the brain, cranial nerves, spinal cord, peripheral nerves, nerve roots, neuromuscular junction, autonomic nervous system, and muscles (WHO, 2016). Examples of neurological disorders include epilepsy, dementias including Alzheimer’s, cerebrovascular diseases (migraine and headache disorders and stroke), multiple sclerosis, Parkinson's disease, brain tumours, neuro-infections, outcomes of head trauma and malnutrition affected neurological disorders (WHO, 2016).

In comparison, an example of a contemporary definition of madness is given by Scull (2015) who describes the mad as those who have lost control of their emotions, those who do not and are unable to share reality, and those who are “profoundly at variance with the conventions and expectations of their culture” (p. 1066). Pilgrim (2005) adds that “since antiquity records of various societies indicate that those who transgress social expectations, in some ways which others cannot fathom, provoke some clear description of difference” (p. 19). These definitions capture an important sociological aspect of mental dis-ease and its historical equivalent ‘madness’ that positions it in relation to the perceived ‘normal’ and a perceived normal of the time.

Within this context of time, Vartejanu-Joubert (2017) states that “madness is one of the topics inextricably related to an etic approach since its meaning depends on the criteria used by its observers and the definition the latter give to it” (p. 19). Thus, in this brief journey into the history of madness through the ages, I am aware that what was written by Caelius Aurelianus in fifth century AD ‘On Acute Diseases and Chronic Diseases’ was as an interpretation of his time. Similarly, authors of the Hippocratic Corpus were reflecting and interpreting the work of Hippocrates, from several centuries before (Thumiger, 2017). As Eghigian (2017) so aptly states, madness has histories and “as societies and their institutions and values have changed, so too have the ways in which

madness has been experienced, understood and treated" (p. 2). As I write in 2018, I am interpreting the work of these learned scholars to present to the reader both my understandings of these readings and more importantly, what I choose to highlight and interpret, relevant to my questions and the principles of hermeneutic methodology. As this history of madness is explored, intertwining themes emerge, including societal perceptions of the mad, origins of diagnosis and treatment and the cultural and philosophical influences in relation to the mad, and when combined, lead to *an arrival* discussed in the Results and Discussion sections. Therefore, this journey begins with the ancient times.

Ancient times

Ancient medical ideas of the Greeks and Romans reflected the holistic and materialistic approach to their understanding of the mind and body as a unit (Thumiger, 2017; Wright, 2010). The main influences on health were natural phenomena, the humours, and the organs. The belief that madness was a bodily ailment continued through to the texts of the Hippocratic Corpus in the early 4th and 5th centuries and included an emphasis on the visible signs of ill-health and madness (Scull, 2011). Madness was viewed as both pathological and endogenous, reflecting a mind-body unit in origin and cure, which was not influenced by anything meta-physical (Thumiger, 2017). Moreover, disease was accounted for by the interaction of the four humours, and effects of the environment or psychosocial influences, along with organ operation (for instance breathing and nutrition) (Scull, 2011; Thumiger, 2017). The Greeks believed that diet, exercise, sleeping and breathing were all important components of health with the psyche, or soul, being identified as one's spirit, vitality and life-force. The three components of the materialistic framework (a philosophy current at the time explaining the nature of reality and the world), which are also relevant to mental health, were: theories of mind, importantly highlighting the brain as the source of judgment, character and perception; the importance of air and blood; and the 'pathological portrait' (what was the visible, which, in the 18th and 19th centuries, had a significant influence over the diagnosis of madness; Thumiger, 2017; Scull, 2011). Fifth century AD saw the first texts describing diseases such as melancholia, mania, phrenitis (inflammation of the brain leading to death), and epilepsy which were described systematically by symptomology, etiology and therapy, leading to the initial classifications of disease (Thumiger, 2017). Philosophy also had a significant influence on medical discourse (Scull, 2011; Thumiger, 2017).

The four humours

Polybus first described the four humours around 400 BC. Some 550 years later, the scholar Galen further linked the notion of the four humours to overall health, specifically temperament and mental health, with these perceptions continuing until the 17 th century (Trenery & Horden, 2017; Wright, 2010). The humours, as described by Thumiger (2017) and Scull (2011) were: black bile (cold and dry, developing in the spleen darkening stools and blood alike); yellow bile (hot and dry); phlegm (making the body cold and wet, using secretions such as tears and sweat); and blood (making the body hot and wet). It is interesting to note that words reflective of the four humours are still used today such as: phlegmatic (calm and unemotional); choleric (angry and irritable); sanguine (optimistic and hopeful); and melancholic (Wright, 2010). In literature and common lexicon, bodily parts and the associated humours are used to reflect the personality of the person. For example, in Shakespeare's Hamlet, 'I am pigeon-livered and lack gall….' (Craig, 1913, p. 1023) and, currently, in common parlance 'he was livid'; his 'blood was boiling' and so on. It is important to highlight these threads of language that are still used today, a reminder that history is not just in the past. Each humour reflected mental and physical health conditions and the specific humour was used for diagnosis by medical practitioners over many centuries. Critically, equilibrium of the physical and mental body was realised with a balance between all four humours. Purging, especially bloodletting, was the favoured therapy to remove excess or corrupted humours to achieve equilibrium (Wright, 2010). The Ancients' legacy was, as described by Thumiger (2017), a developing knowledge and awareness of the "normative ideal of mental soundness" (p. 56) to which, the next epoch, religion would be a significant influence.

The middle and the dark

The Middle Ages is considered to have started with the fall of the Roman Empire, around 476 AD, and with the beginning of the Renaissance around the 14th century (Trenery & Horden, 2017). As a period of 1000 or so years, it is difficult to highlight the multiple and long-term influences. However, there are some significant themes to note. Historical texts highlight that the representation of madness was most visible in theatre as there were no printed books available to the public (Gilman, 1982). The rise of Islam and influence of Arabic scholars saw previously lost Greek and Roman texts translated, which renewed European interest in historical medical theories; especially the four humours (Scull, 2011). Persian physician Avicenna suggested that mental illness was caused by an imbalance in at least three of the humours. Frenzy for example, was caused by a hot brain abscess, where cooling of the brain was the advised treatment. Similarly, mania, was caused by excess in

one's diet and was treated by purging to restore humoral balance (Trenery & Horden, 2017). Further, the 11th century medical school of Salerno helped circulate the humoral model of health among the European universities (Trenery & Horden, 2017). Importantly, the humours were now seen visibly with phlegm, yellow bile, and blood as the humours colouring the body. Black bile, not visible to the naked eye, became associated with madness as a 'fall into the soul of blackness' and a symbol able to generate other symbols (Gilman, 1982). The symbol and colour of black describing depression or melancholy is still common today, for instance, 'black dog'.

The influence of the Church

Along with the growing influence of the humoral model, the Middle Ages saw the rise of the influence of the Church, with the emerging medical and diagnostic connection between the mind, body, soul and religion. From about the 12th century, the influence of the demon and moral failings was seen to be in competition with God (Scull, 2011). Demons entered the physically disordered and then God used the body and soul to correct and chastise (Trenery & Horden, 2017; Scull, 2011). This was a time of witch-burning and the devil reflecting the fear of the supernatural. These beliefs lasted hundreds of years into the 19 th century. Historical texts, from about 1000 to 1250 AD, indicate that 'appropriate' or 'normal behaviour' was now being formally described and recorded. For example, a person's emotional reaction could be judged in a court of law as appropriate or inappropriate, indicating that societal norms were emerging (Trenery & Horden, 2017).

During the Middle Ages, the mad were looked after by their families and, to a lesser extent by the Church. Hospitals, traditionally for pilgrims and the needy, began to take in the sick but not the insane (or interestingly pregnant women) as they risked corrupting the religious nature of these institutions (Trenery & Horden, 2017). Historical texts indicate that changes were evidenced in the 13th century with the notorious and formerly monastic Bethlem Hospital beginning to take a few mad 'patients' (six in 1403 rising to 44 in 1642; Scull, 2017). However, there is little known in terms of treatment until much later when the humoral based treatment of purging became common (Scull, 2011; Trenery & Horden, 2017; Wright, 2010). Generally, during this period, the 'mad', if not looked after by their families, relied on alms. This was alongside the poor, the orphaned and infirm, and famine, with disease and early death common occurrences.

The Renaissance

The Renaissance, from about the 14th to 17th centuries, reflected a period of great change in culture, art, literature, and health care concurrent with a rejection of medieval rituals. Importantly, Mellyn (2017) notes that as historical texts give little information about how ordinary men and women looked after the insane, aside from the sensational or the extreme events, understandings can only be surmised. There are, however, several key examples. First, in the 16th century, was the very fashionable ailment of melancholia commonly diagnosed as a way of understanding the significant changes happening at this time (Mellyn, 2017). Second, casebooks of Richard Napier, an English astrological physician of the late 1500s and early 1600s provides some insight. These casebooks indicate that causes of mental illness were considered both natural and supernatural. For instance, causes included the influence of demons, witches, planets and the moon along with the impact of emotions, diet, and the environment. Napier said "people during this period struggled, as we all do, to cope with the wear and tear of daily life. Sometimes they are not equal to the task; sadness turned to suicidal despair and anger to blind rage" (Mellyn, 2017, p. 88). This remains relevant today.

The rise and rise of reason

In the Renaissance period physical and the mental health ailments were still intertwined. Thus, treatment was primarily based on the traditions of the humoral system and management of temperament based on home care (Mellyn, 2017). Factors outside the corporeal such as diet, sleep, exercise, environment and climate, and "retention and evacuation of bodily substances" (Mellyn, 2017, p. 86) were comparable to religious confession, and were considered critical in maintaining the fragile balance between illness and health. At this time, care of the body was not separated from care of the mind. This changed toward the latter part of the Renaissance as the mind/body interconnection for overall health gave way to a monistic view where the body dominated the mind and soul articulating the rule of reason (Gilman, 1982; Scull, 2011). At this point, the mad were locked up and seen as objects of scientific enquiry and importantly, to keep society safe. Significantly, the mad were now considered treatable (Foucault, 2006). This reflected Cartesian discourse and popular Newtonian scientific reasoning, and as Foucault (2006) said, "… the fear of madness grew at the same rate as the dread of unreason" (p. x). Therefore, moving into the 18th century the rise of science and secularisation altered the concept of madness (Berrios & Markova, 2017) and gave rise to the birth of the human sciences (Foucault, 2006). It is important to highlight the influence of Descartes and Cartesian discourse, as these are still felt today.

The Cartesian split

Cartesian philosophy has permeated and guided our understanding of the mind and the body and, critically, the connections between the two. Cartesian theory posits that mathematical measurement of the physical world is more objective than measurement achieved by the senses (Sorrell, 1987). Inclusive to Descartes' philosophy and, as stated by Urban (2018), was the "existential separation of the mind and body" (p. 232), with the often quoted phrase 'I think, therefore I am'. This empowered and created a discourse for the individual to understand knowledge in terms of themselves. According to Thomson (2000), Descartes promoted "the need to evaluate methodically and systematically all claims to knowledge, to think about how knowledge is possible, and to reconcile the conflict between the new science and the old religion" (p. 9). This philosophy, developed in the early 1600's, was radical as the Catholic Church had, and was continuing to dominate, all knowledge and acquisition of knowledge (Urban, 2018). However, and likely adhering to both his religious faith and the times, Descartes maintained that the corporeal body (a physical entity or space, therefore, measurable) was separate or independent from the thinking body (not measurable). Further, that both conformed to the power and influence of the Catholic Church, and were unified by God (Bracken & Thomas, 2002; Thomson, 2000; Urban, 2018). Understanding Descartes and Cartesian philosophy is, unfortunately beyond the scope of this study but the legacy of these philosophies and how they how have impacted our view of medicine, madness and diagnosis in the 20th and 21st centuries is significant.

The Modern Period

The Modern period (around 1500 to 1800) saw a growing fascination with madness reflected by and within the arts, literature, architecture and politics. Popular images of 'unreason' were illustrated by pictures of madman, highlighted by chains of confinement, violence, and despair (Gilman, 1982). Bethlem Hospital, or more commonly called Bedlam, the notorious London asylum, reflected a fascination with those hidden behind walls, highlighting the freedom of the sane and protection from the perils that the insane represented (Foucault, 2006). This dichotomy, the sane and insane represented by freedom and confinement, is an important premise that exists today.

The popular image of the 17th madman, according to Gilman (1982), was a seated figure, with eyes downcast, hands not visible, or the face seeing inwardly, and possessed by the devil. This developing visual image evolved over time and attempted to define the concept of madness, the "etiology of insanity" (Gilman, 1982, p, 42). These images led to developing the concepts of

deviancy and the 'other'. A rise in popular literature further compounded this notion of difference and 'other', and a desire to keep the sane safe by confining the 'other' (Gilman, 1982; Trenery & Horden, 2017). Mellyn (2017) highlights that these representations of the mad as seen in Bedlam, were intended to not only entertain, caution, and instruct, but, importantly, were "highly moral reminders of the wretchedness of the human condition, the vanity of earthly life and the glory of the Kingdom of God" (p. 83). Foucault (2006) further expanded this concept by stating that the mad were locked up because they had "freely chosen the path of mistake, against truth and reason" (p. xvii) along with the blasphemous, the unemployed, the prostitutes and the deviants. Thus, the discourse of sane and insane is becoming more tangible, and more visible.

Physiognomy

Images that diverged from the perceived 'norms' of society inferred boundaries of what was considered normal and, consequently, what was not normal. Moreover, Gilman (1982) states that, from the 15 th century, the madman was increasingly depicted in confinement; both a physical and metaphorical state and, as Foucault so aptly defines, "a psychological alienation of the self from the self" (2006, p. xviii). By the beginning of the 19th century, the theory of physiognomy, being outer appearance reflecting character, was used to illustrate the mad, with such illustrations appearing in medical texts to aid diagnosis. Gilman (1982) highlights that lithographs made by Pinel and others which illustrate the physiognomy of madness ensured diagnostic ubiquity. Lithographs, depicted in Figures 2 and 3, were used in the Dictionary of Medical Sciences to illustrate the physical appearance of the insane; diagnosed, for instance with demonomania (possession by demons) and mania or blackness of the skin, and melancholia (Gilman, 1982; Trenery & Horden, 2017).

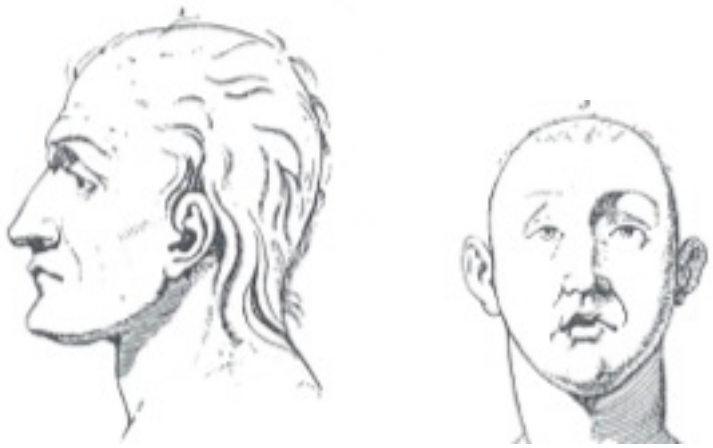

Figure 2 Illustrations of the physiognomy of madness (Gilman, 1982, p. 75).

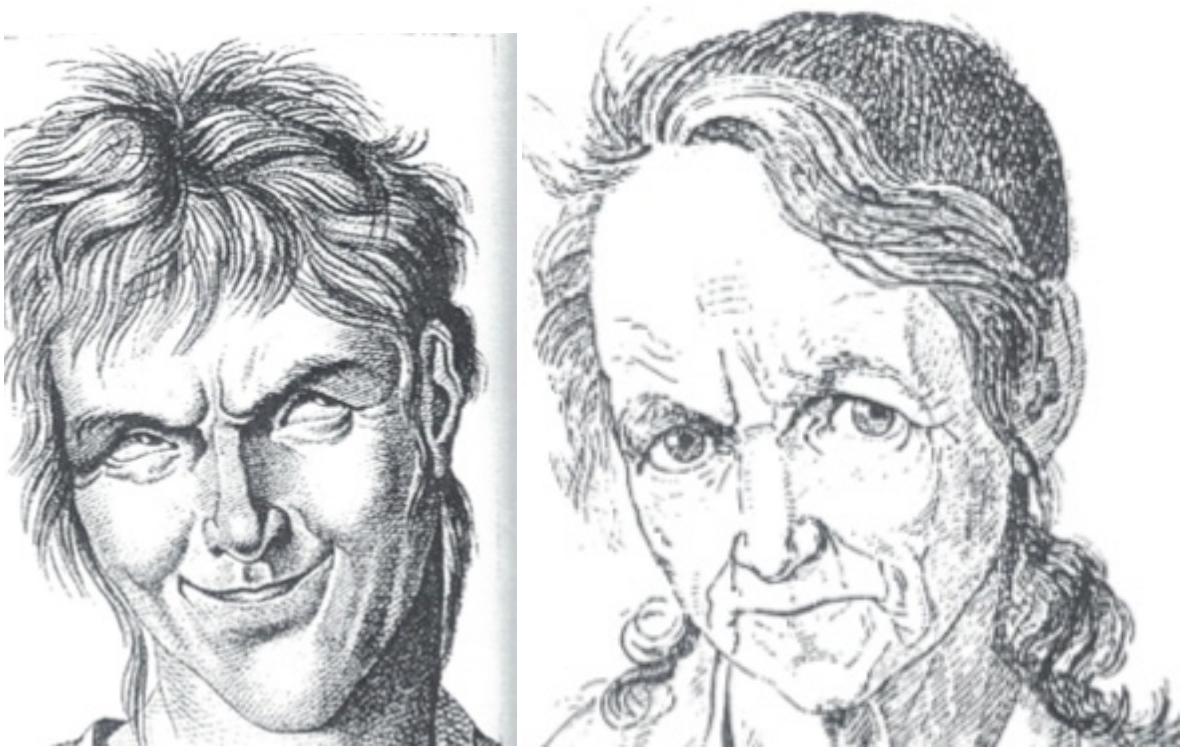

Figure 3 Illustrations of mania (left) and demonomania (Gilman, 1982, p. 76).

The photograph, invented in the early 1800s, had, by the mid-1850's, superseded the traditional lithograph and was used in medical texts. This subsequently verified the visual criteria to diagnose the insane. Photography was now the new medium that distinguished between normal passions (and persons) and those who were seen to be wandering from reason. Photography emerged as "the ultimate means of creating an objective representation of reality" (Gilman, 1982, p. 164). Physician, H. W. Diamond, reflecting the legitimacy and pervasiveness of this diagnostic tool, informed the British Royal Society that photography could be used to 'see' the insane via four functions (Gilman, 1982).

A. It was a record of the 'phenomena of each passion' and the connection between the diseased brain and the organs;
B. It could track physical or visual changes in the treatment outcomes;
C. It acted as a reminder of the case in readmission;
D. It could take a picture of the criminally insane to give to police if they escaped

Thus, the new science of physiognomy was legitimised using the photograph. Gilman (1982) proposes that in seeing the visual depictions of the mentally disturbed, distance was created for the viewer, who were the righteous sane, and kept the anxiety of being close to or the same as the insane at bay. She goes onto say that the pictures of the insane provide the viewer access to a "perpetuation of a fantasy of 'beauty and health' and 'ugliness and illness'. This dichotomy is the basic, underlying pattern that represents the healthy through the beautiful and the ill through the ugly" (p. 225). Furthermore, Gilman (1982) states that these images provide a way of dealing with the anxieties of illness, with the images giving us the space to control our anxieties and highlighting the abyss between the healthy and the other. In wondering what is different today, I refer to De Rosa's research, of 1987, where participants were asked to draw madmen. De Rosa found common elements of deviancy and otherness between the participant's drawings and the drawings from the Middle Ages, indicating the tenacity of these themes that are still current today (as cited in Foster, 2007).

Madhouses and Asylums

By the 18th and 19th centuries, and along with growing economic prosperity, charity asylums and 'madhouses' were being constructed across Europe (Scull, 2017). Madhouses were increasingly popular for the rich to get rid of their mad and unwanted relatives and, although only a small number were confined, madhouses became notorious out of all proportion to their numbers (Scull, 2011). Mad-doctors and alienists, terms used in the 18th century, became the entrepreneurs of the day with the 'lunacy trade' becoming commercially lucrative (Scull, 2015). The public perception of the mad was reinforced by those visiting the restrained in Bedlam, where chains and nakedness for a fee, titillated the viewing public. Open viewing finally ended in 1770, however, this potentially allowed for even greater abuse behind closed doors reflecting economic expedience (Scull, 2011).

Public policy also influenced the development of asylums. The English 1845 'Lunacy Act' required counties to build asylums to house the mentally ill and pauper lunatics (Scull, 2011; Wright, 2010). Scull (2017) adds that the 19th century saw massive incarceration of the mad throughout Europe and North America with confinement, becoming an unintended treatment. Public perception of asylums was poor with Scull stating that "it was the hordes of the hopeless, the legions of chronic patients who constituted the public image of the asylum" (2017, p. 105). Long-term incarceration became commonplace and numbers increased significantly. From the 1860's, some asylums housed more than 1000 patients, increasing in the early 20th century to tens of thousands on a single site (Scull, 2017). Predictably this led to welfare focussed institutions with treatment goals falling prey to

economic realities. Henry Maudsley, a famous 19th century English alienist, observed "I cannot help feeling, from my experience, that one effect of asylums is to make permanent lunatics" reflecting cure rates of less than one third of people treated (Scull, 2017, p. 107). It wasn't until deinstitutionalisation between the late 1950s and 1970s, when asylums were no longer economically viable and parallel with the rise of the psychopharmacological revolution, that confinement as an unintended treatment ceased (Scull, 2017).

Moral treatment and the emergence of psychiatry

Concurrent with the rise of asylums was the development of the 'moral treatment' based on the theory that if one garnered the last vestiges of reason that the mad possessed, this *reasoned* and benevolent treatment could restore the insane to normal (Scull, 2017). Additionally, this reflected an emerging belief that the insane could be treated, a significant development. Moral treatment moved away from the controlled and isolating therapy of chains and humoral motivated purging to buildings designed as 'therapeutic instruments'. Treatments developed aiming to restore the lunatic's internal moral standards (Scull, 2011, 2017).

Moreover, from the earlier non-medical 'asylum superintendent' there was an emergence of the medical specialist, who claimed authority in caring for the mad. Called alienists in France, mad doctors in England, and psychiatrists in Germany with 'psychiatrist' emerging as the dominant description across Europe by the 20th century (Scull, 2015). For this emerging profession, training was generally via an apprenticeship except in Germany, where from the mid 19th century, training was linked to clinical practice along with academic and laboratory research. The asylum provided a ready pool of people to study with this practice common across the UK, Europe and the United States (Scull, 2017; Wright, 2010). Therapy included experimentation such as deep sleep therapy, lobotomies, electroshock therapy, and surgical excisions (Scull, 2017). At this time, the insane were considered a burden on society with the growing sentiment that they were "degenerates, evolutionary throwbacks whose biological defects were engraved upon their bodies and brains visible in their physiognomy and incapable of being cured" (Scull, 2017, p.106).

It is important to highlight that these views on biological degeneration and inferiority were common less than a century ago. This widely pervasive discourse eventually led to an acceptance of the 20th century Nazi regime which initially sterilised the insane, and by citing the theory of eugenics justified the murdering of these "useless eaters" (Scull, 2017, p. 106). However, it was not only Germany who managed the insane in this way. The Great Depression and the World War II (WW2) saw soft

extermination in France where around 45,000 patients died of starvation and disease, and in America, mental hospitals were called 'American Death Camps' (Scull, 2017, p. 110). New Zealand was not innocent of these beliefs and kept the mentally defective separate to avoid breeding (Reed, 2001).

The rise of new diagnoses

Berrios and Markova (2017) posit that madness in the 18th century occupied a bodily space reflecting an "imperfection of the rational faculties" (p. 118). By the 19th century, however, understandings of madness reflected contemporary scientific thinking and growing secularism. At this time, there was a drive to classify madness across borders and an impetus to understand mental symptoms as a unit of analysis and mental disease as a cluster of symptoms (Berrios & Markova, 2017). Berrios and Markova (2017) add that a new language was developed called 'descriptive psychopathology' (p. 120). Alienism was now professionalised and critically, mental symptoms could be common to more than one disease, a system of classification still used today. As there were few bio-markers of madness compared to physical diseases, social deviance signified mental abnormality and was based on what was considered acceptable, ethical, and proper (Berrios & Markova, 2017). In the 21st century this is known as the medicalisation of disease where a disease category is developed to define and label certain social problems (Iley & Nazroo, 2007).

The 20th century saw the categorisation of many new diagnoses. For instance, the epidemic of nervous disorders attributed to the horrors of the World Wars gave legitimacy to the term 'shell shock', viewed as the result of extreme psychological stress (Scull, 2011). Initially, soldiers were treated as malingering cowards, with treatment consisting of electric shocks given to their tongues and genitals to force them back to fighting (Scull, 2011). Other diagnoses of the time reinforce the significance of the 'social deviant' construction of madness. For instance, drapetomania was the diagnosis given to black slaves who ran away from their masters. Masturbation and homosexuality were believed to be root causes of madness (Scull, 2011). By 1973, however, homosexuality was subsequently defined as a 'sexual orientation' disturbance, and finally removed from the DSM II as a diagnosis in 1987 (Burton, 2015, para. 4). I wonder in years to come, what diagnoses will we reflect upon with amusement or horror?

Wartime medicine and psychiatric practice contributed to current global health practices with the development of psychotropic drugs helping cement the medical model of illness and treatment

(Coleborne, 2009; Corrigan, Roe & Tsang, 2011). This is currently viewed as the bio-medical model of medicine and health and frames the current dominant discourse on health, citing dysfunction as residing in the individual (Bennett & Liu, 2017). Furthermore, the bio-medical model explicates that the cause of disease affects the body in a predictable manner, and if extrapolated, supports that a cure is theoretically possible for all, while ignoring the possible social or psychological origins of the disease (Germov, 2009). Germov goes onto say that this perspective supports a 'reductionist' discourse and advantages medical scientism, with both viewpoints ignoring the psychological and social aspects of disease. To expand this understanding, the biomedical model includes the physical and excludes the less measurable, including the personality of the individual, his or her upbringing, family, his or her social environment, living standards, and cultural environment, thus, all the psychosocial factors (Miley, 1999)

Madness in Aotearoa, New Zealand

The asylum model was exported to the colonies to deal with the "mad white colonists" (Scull, 2017, p. 110). Bearing witness to this statement a brief history of New Zealand mental health and mental health care will be explored to highlight some of the imported conventions. These conventions additionally reflect larger world patterns and processes, "illuminated by the complex histories of empire and imperialism, colonialism and race" (Coleborne, 2009, p. 487). Included in this brief history are the ideals of social norms that maintained safety and control reflecting the importance of imperial strategy in creating this British Empire outpost (Bell, 1996; Bryder, 1991).

The second imports

Immigration to New Zealand began in the late 18 th century with whalers and sealers (New Zealand History, n.d.). Later arrivals were the European colonists and were restricted to those respectful and hard-working labourers, tradespeople and professional classes in difficulty (Ernst, 1991). However, with these new colonists came disease, crime, violence, prostitutes and those who were destitute. The ideal of the new colony, the new arcadia was in tension with the reality of settling in a new country with this becoming apparent almost immediately. Ernst (1991) describes it as "the tension between settlers' and colonists' visions and colonial reality, and between humanitarian ambitions and stern Victorian values…" (p. 67). Also imported were the negative public attitudes that the British had toward their own lunacy and asylums, leading to "an atmosphere of suspicion, self-protection, indifference and lack of local involvement" (Ernst, 1991, p. 72). These characteristics subsequently influenced the rise of the asylum as an institution.

The rise of the lunatic

Missionaries as first European colonists not only brought their possessions and hopes but as Reid and Cramp (2004) state, their Christian and Victorian morality. They go on to to say that

> the new order assembled new realities about who was normal (and therefore who was not), who was knowing and who was ignorant, who was civilised and who was barbaric, who was deserving and who was underserving, and who was good and who was bad (p. 39).

Moral wellbeing was linked to physical wellbeing, thus dirt was linked to disease and immorality to poverty (Belich, 2001). These beliefs carried into the 20th century and advocated the Victorian ethos of self-responsibility and self-help (Bryder, 1991). A second tension was the belief of moral and intellectual superiority of the European settlers both in their imperialist expansions and in relation to the indigenous populations. In tandem with these beliefs was the difficulty in managing those who publicly deviated from these beliefs. In one way, this tension appears to have been managed by the creation of institutions that kept the public safe while keeping hidden those who broke social norms.

These understandings of normality and insanity were used to design and maintain social norms, that is, how one should behave reflecting time and situation (Link & Phelan, 2001). Women, as an example, were committed into the Auckland Lunatic Asylum for social norm infringements. Belich (2001) reports that 41% of the women committed in 1890 were incarcerated for violating 'social norms,' with this increasing to 54 % by 1910. Consequently, the threat of being tossed into the 'looney bin' became an effective method for keeping order. Furthermore, this tenet of morality permeated the burgeoning health services, where services were generally designed to suit the general population of New Zealanders, which, from the 1860s meant mainly Pakeha (Reid & Cramp, 2004).

Lunatics, as they were called in the 19th century, were not necessarily those with mental ill health. Paupers, drunkards, the unmarried, the vagrant or old, as well as itinerant or unskilled workers, along with those who experienced the loneliness and isolation of being away from their families in a strange, new country made up the bulk of the asylum population (Van der Krogt, 2016). Economic distress, as described by Coleborne (2009) and Van der Krogt (2016), was a major reason for committal into the Auckland Lunatic Asylum between 1870 and 1910. Care of those unable to look after themselves reflected the inadequacy or lack of family networks in this new colony and

supported the rise of institutionalised care. This isolation necessitated that inmates were not released until cured as opposed to being deemed 'recovered' as there was no-one to look after them (Ernst, 1991).

The nature of the asylum also signified that custody and safe containment were more important than treatment (O'Brien & Kydd, 2013). With the introduction of the Lunatics Ordinance Act, 1846 (notably early, only six years after the signing of the Treaty of Waitangi), lunatics or those with mental health issues could be kept in jail, public hospitals or asylums (Brunton, 2018). This was modelled on the 'Dangerous Lunatics Act' of New South Wales (1843), reflecting the current discourse of the 'dangerous lunatic', and consequently instituting legislation to protect public safety (Coleborne, 2009).

The rise and rise of the asylum

Prior to 1846, jails and hospitals were used to house the certified insane. Specialist asylums were built in the major cities and their environs in the 1860s and 1870s (O'Brien & Kydd, 2013). Seacliffe, built in 1879 on the outskirts of Dunedin and located in a spacious setting, advocated 'moral treatment' for those needing therapy, similar to the treatment employed in the United Kingdom (Brunton, 2018). Moral treatment consisted of correcting undesirable behaviours through outdoor work alongside medical treatments aimed at treating the physical body. Medical treatments included shower baths, bleeding, the shaving of heads and purges (Ernst, 1991). Some community representatives felt that "lunatics" should be treated benevolently with no expense spared in their treatment and care (Brunton, 2018), however, with the rise in the number of 'incurable lunatics' in the latter half of the nineteenth century there was feeling of pessimism about possible cures. Moreover, there seems to be a contradiction between what was practised and what was aspired to, with most asylums hindered in the treatment of their inmates by a lack of funding which resulted in dilapidated buildings, under-staffing and overcrowding (Colborne, 2009). By the late 1800s, medically trained asylum doctors promoted insanity as a physical disease best treated within the confines of a medical environment, the asylum (Coleborne, 2009). Thus, as institutionalised care of the insane grew so did the profession of psychiatry. As medicine was a male domain until 1900, when women entered medical education, definitions of 'disease' were primarily developed by men (Coleborne, 1900).

Over the latter half of the 19 th century, legislation was introduced to streamline the governance of the asylums as prior to this time there had been no legislation governing what standard of care

should be provided (Brunton, 2018). This included the Lunatics Act (1868) which introduced regular and independent inspection, and in 1876, mental institutions came under central government control (Ernst, 1991). Both legislative changes were important as they legitimised medical specialists' control and subsequent implementation of 'moral management' as a cure. In addition, it cemented the alliance between the medical profession (and their superior knowledge) with state responsibility (Ernst, 1991). I suggest this thinking is still current today visible in government responsibility for health and disability (https://www.health.govt.nz).

Colonial constructions of Health

Keeping healthy was important to the European colonists. This was signified by the individual maintaining a healthy disposition and livelihood, thereby upholding the reputation of a healthy colony (Coleborne, 2009). Thus, the healthy colony was measured in terms of health and illness and this was an important component of government policy. As Colborne indicates "… 'knowing' the population involved representing it in statistical terms and creating a new discourse of epidemiology that would later become central to public health campaigns and practices" (2009, p. 498). Coleborne continues and states the "ordering of categories such as clean, unclean, normal and pathological, healthy and unhealthy" was an important part of imperial and consequently colonial responsibility (p. 497). Whiteness and class came to reflect the image of a healthy colonist. Sanitation became a critical requirement and with the finding of a bubonic infected rat on Auckland Wharf in 1900, a Royal Sanitary Commission was set up to protect citizens bringing "scientific discourse into the realm of public health" (Coleborne, 2009, p. 500). The national health of colonial citizens was considered critical for the national wealth of the country, along with the ideology of racial fitness (Coleborne, 2009). Thus, Coleborne continues, "in the creation of epidemiological knowledge and the articulation of early public health measures, social and cultural discourse also framed disease and its meanings" (2009, p. 501). This, I contend, continues to this day.

The 20th Century

In 1919, syphilis, alcohol, epilepsy, and puberty were listed as the major causes of insanity in the New Zealand Official Yearbook with minor causes listed as masturbation, sexual excess, pregnancy and solitude (Belich, 2001; Reed, 2001). At this time, it was also believed that venereal disease was spread by mental deficiency (Coleborne, 2009). The 1918 global influenza pandemic, spread by World War One (WW1), killed around 30 million people worldwide and in New Zealand led to significant reorganisation of health care and the forming of Public Health Act 1920 (Coleborne,

2009). Similar to developments in Europe, the WW1 diagnosis of shell-shock created new mental health practices locally. WW2 further hastened medical and technological developments and understandings, especially relating to the transmission of disease.

The emergence of the psychological professions

In 1904, the University of New Zealand awarded degrees and was comprised of four university colleges, Auckland, Wellington, Christchurch and Dunedin (St George, 1979). It could take three months to receive a letter from England and books on psychology and associated journals were scarce. Examination papers were both set and marked in England and this potentially meant that prior to starting the new academic year a student may not have received the previous years' exam results. In the early university courses there was no psychology, only moral and mental philosophy with a focus on introspection. There were few graduates and fewer options for employment. St George (1979) notes that "at this distance from the fount of ideas, one could become an instant authority with frightening ease" (p. 5). European and American writers were considered the authorities, however, and highlighting, New Zealand's isolation, St George shares that in 1923, while completing his (psychology) Masters, he had not heard of Freud or Jung. Significantly, the Education Department supported the development of psychological services and training in response to needs of school children and to establish child guidance clinics. However, it wasn't until 1961 that New Zealand Universities established specific courses in what is known today as Clinical Psychology (St George,1979). Psychotherapy as a specialist university training was not available until 1989 (K. Tudor, personal communication, August 22, 2018).

The New Zealand Association of Psychotherapists (NZAP) was formed in 1947 by Doctor Maurice Bevan-Brown who believed that it was "very difficult to be mentally healthy in a mentally unhealthy world" (NZAP, n.d. para. 6). At this time Bevan-Brown noted the very high rate of admissions to mental hospitals along with a lack of recognition of the impact of war neuroses compared to understandings that were current in Britain. Curtis, Curtis and Fleet (2013) state that suicide rates spiked among the elderly in the first decade after WW2, reflecting the impact of shell-shock and war neuroses.

Deinstitutionalisation

Deinstitutionalisation began in 1963 with the halting of any planning for new hospitals mirroring similar trends in the USA and UK (Brunton, 2018). The 'Mental Health Act' of 1969 moved to give

tentative support to community care with psychiatric home visiting services (O'Brien & Kydd, 2013). By 1970, out-patient care with community-based treatment was encouraged. These developments were enabled by the use of psychoactive drugs and reflected economic priorities in health policies (Colborne, 2009). By the 1990s all psychiatric hospitals in New Zealand had been closed with the new focus centred on smaller inpatient facilities alongside hospitals (O'Brien & Kydd, 2013)

Current mental health bodies

In 1977 the Mental Health Foundation (MHF) was formed to concentrate on mental health policy, promote mental health and reduce rates of mental illness (Cunningham, Peterson & Collings, 2017). In 1996, following the Mason Report into poor mental health treatment, the Mental Health Commission was formed and was subsequently subsumed in 2012, into the Health and Disability Commission (Brunton, 2018). The Mason Report was pivotal in developing recent and current policies in mental health, moving mental health services toward a recovery focus (Cunningham et al., 2017). Currently, the Ministry of Health (MoH) is the government body responsible for mental health services. Its work covers mental health and addictions, provides policy advice in collaboration with District Health Boards (DHB), and administers legislation. By the end of the first decade of this century most mental health services were contracted to the DHBs (Ministry of Health, 2017a). Non-government organisations (NGOs), as part of their formal relationship with the MoH and DHBs, have supported a significant percentage of users via drop-in centres, telephone crisis services, family and community support self-help groups (Ministry of Health, 2014).

Primary Mental Health (PMH) care is the current iteration for the delivery of services for those with moderate mental health issues and addictions and, increasingly, for those with more severe issues (Taylor, 2015). PMH comprises of health promotion, prevention, early intervention, and treatment for mental health and/or addiction issues (Ministry of Health, 2017b.). The aim of the PMH is to increase access to 'talk' therapies and psychosocial interventions including General Practitioner (GP) and practice nurse consultations, tailored packages of care (Cognitive behavioural therapy [CBT], counselling, medication reviews) and group therapy. Unfortunately, psychotherapy is not highlighted as a specific service (Ministry of Health, 2017b). PMH services are delivered via DHBs and follow the 'stepped care model', where the most effective and least resource intensive interventions are delivered first (Ministry of Health, 2017b). At-risk groups, being Maori, Polynesian and low-income groups, can access these services free of charge. However, Taylor (2015) notes that for 'other groups', cost, accessibility of services and waiting times act as barriers to these services. Finally, Williams, Haarhoff and Vertongen (2017) declare that demand for mental health services has

increased by 60% since 2008, with the greatest need in those with mild to moderate mental health issues. This, I suggest, reflects an opening of mental health discussion that is occurring currently. They go onto state that support services for "high-prevalence disorders" is meagre (p. 16) and there is growing disparity for certain ethnic groups.

Current state of mental dis-ease in Aotearoa, New Zealand

Sir Peter Gluckman, in his role as inaugural Chief Science Advisor to the New Zealand Prime Minister, highlighted the importance of comprehending our mental health state saying "… in many Western countries mental health (is below) physical health, but we as a society are now seeing (mental health) as the biggest health challenge we… have" (as cited in Carville, 2017, p. A5). Some distressing facts about New Zealand mental health support this statement. The Mental Health Foundation (2014), in their Quick Facts and Statistics 2012/2013 New Zealand Health Survey, state that approximately 582,000 adults had been given a mental health diagnosis of depression, bipolar disorder or anxiety disorder at some time during their lives. Further, and according to the Health Promotion Agency of New Zealand (Health Promotion Agency of New Zealand [HPA], 2018) about four out of five adults, aged 15 years or over, have had experience of mental distress" themselves or know of people that have experienced mental disitress. Additionally, women are 1.6% more likely to have been diagnosed than men in all age groups, while those living in deprived areas will experience an increase in mental health disorders (Mental Health Foundation, 2014).

The Mental Health Foundation goes on to say that mental disorders are considered the third leading cause of 'health loss' after cancer and blood or vascular disorders (health loss is measured by the Ministry of Health in 'DALYS', that is, disability-adjusted life years with one DALY representing the loss of one year lived in full health; 'health expectancy' on the other hand is the expectation of how long one can be expected to live in good health; Ministry of Health, 2016). The most common mental disorders accounting for health loss as at 2014 include schizophrenia at 1.3%, disorders related to alcohol at 2.1% and significantly at 5.3%, anxiety and depressive disorders (Mental Health Foundation, 2014). Specifically, measured health loss for anxiety and depressive disorders was second only to coronary heart disease at 9.3%, and again, women have higher rates of diagnosis than men (Mental Health Foundation, 2014). The Mental Health Foundation (2014) also note that there has been a 20% increase in the use of anti-depressants in the last five years (although they

qualify this by indicating that anti-depressants are also used for other conditions such as pain and sleep disorders).

According to UNICEF (2017) data from 2009-2013, New Zealand has the highest youth suicide rate in the world at 15.6 per 100,000. The latest Ministry of Health (2017) figures state that there were 527 suicides in 2015 with the highest number being among 15-24 age group. Provisional figures, released by the Chief Coroner in August, state that 668 people had died from suicide for the 12 months to June 2018, indicating a worrying increase (Office of Chief Coroner, 2018).

Where women have higher rates of diagnosis for mental health disorders, men have 2.7% higher rates of suicide than women with 6.1 per 100,000 in women compared to 16.4 per 100,000 in men (Mental Health Foundation, 2014). In 2015 Maori rates for suicide were higher that non-Maori (Ministry of Health, 2017). Within Maori male populations, the suicide rate was 25.3 per 100,000 and this according to the office of the Chief Coroner (2018) numbered 97 deaths in 2017/2018, nearly double that of non-Maori. For Maori females, the rate was 2.4 times higher than non-Maori females (Ministry of Health, 2017) and further, Maori are more likely to access mental health services via the judiciary rather than voluntarily, potentially indicating an invisible problem (Bennett & Liu, 2017). People with mental health challenges and especially those with depressive or mood disorders (but not depression) are considered at higher risk of suicide with a University of Otago study finding that those using mental health services have a 4.4 times higher risk of suicide (Mental Health Foundation, 2017c).

Deprivation and suicide

In 2013, Curtis et al., published research stating that youth suicide rates were decreasing compared to the high rates of the mid 1980s, with suicide over the previous ten years accounting for 25% of deaths in young New Zealanders. Although these figures are now dated, Curtis et al., (2013) then posited, that “every ten years the next oldest ten-year age-specific group becomes suicidal” (p. 77). Thus, they highlight that in the 1980s the highest rate of suicide was among the 18-24 year-old age group, in the 1990s 25-35 year olds, then in the first ten years of the new century, 35-44 year olds. These statistics point to an important outcome mirroring the New Zealand economy. Explicitly, the end of post-war prosperity and the rise of neo-liberal policies link poverty and socio-economic conditions as important influences on mental health (Curtis et al., 2013).

A change in government in 1984 brought about significant economic changes reflecting this neo-liberal policy. Specifically, New Zealand moved to a 'user-pays' system. This system was visible in tertiary education, health services, and curtailment of unemployment and disability benefits; along with the deregulation of finance, banking, power, telecommunications, infrastructure supply and export sectors (Curtis et al., 2013). This is further referenced by Bennett and Liu (2017) who posit that these neo-liberal policies led to New Zealand participating in global currents of capital and immigration, resulting in inequity in income and labour. This leads to what the WHO highlights as:

> A person's mental health and many common mental disorders are shaped by social, economic, and physical environments. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk. (as cited by the Ministry of Health, 2018, p.10)

Risk factors include socio-economic deprivation such as stressful lifestyles, limited access to resources including health care and educational opportunities, poor housing and lower self-esteem (Curtis et al., 2013). This is not new, as Cervone and Pervin (2010) state that socio-economic status influences the development of the emotional and cognitive abilities of the individual.

Locally, Sir Peter Gluckman noted that "sitting beneath New Zealand's high youth suicide rate are high rates of family violence and illicit drug use in young people" (Carville, 2017, p. A5). The Ministry of Health statistics of 2011 indicate that there is increased risk of suicide in the most deprived areas of New Zealand, from 8.4 deaths per 100,000 in the least deprived to 14.0 per 100,000 in the most deprived areas (Mental Health Foundation, 2014). Further, the 2012/2013 New Zealand Health Survey states that 17.1% of adults living in the most deprived areas have been diagnosed with bipolar disorder, depression, or anxiety disorder, which is 1.6 times higher than those adults living in the least deprived areas (Mental Health Foundation, 2014). Thus, deprivation risk factors are subsequently conceptualised clinically or diagnostically as pathologies, specifically depression and hopelessness, rather than reactions to life challenges and circumstances (Curtis et al., 2013). This I contend is a critical distinction and one that is discussed further.

Conclusion

This chapter provides a brief outline of the history of madness from the Ancients to the Middle Ages, from the Renaissance leading into the 21st century and acts as a foundation for this research study.

During this period significant philosophical influences on our contemporary view of madness can be seen. This is visible with the impact of the Church and Descartes and relating to the constructs of normal and not normal. Intertwined with these influences are the various approaches to diagnosis and treatment, in particular confinement and moral treatment. These influences, I suggest, are still visible in our approaches to treatment and confinement today.

The European constructs of madness were exported with the colonists to the new imperial colony, New Zealand. During this colonisation period, Europeans brought with them their belongings, their values, and their understandings of social norms and what violated these norms. The rise of the asylum can be seen to reinforce these norms with the removal from society of those who did not 'fit', from vagrants to the lonely. As norms were established, legislation was enacted to protect the 'normal' supporting the development of medical discourse in this imperialist outpost.

This history, I suggest, influences the very sad and frightening statistics visible in mental health/dis-ease/distress in Aotearoa, New Zealand that are current today. Importantly, these statistics also reflect the 21st century economics of living, where economic hardship leads to mental distress. However, this journey through the history of madness indicates there are other contributing factors. Upon reflection, I wonder at what is being missed, what is being silenced, about a potentially deeper malaise that is embedded in Aotearoa, and the mainstream discourse of mental health. This wondering invites a further engagement with the literature, to explore interpretively the potential meanings and understandings that may exist, thus, the following chapter discusses the methodology adopted to frame and guide this exploration.

Chapter 2. Methodology and Method

Methodology

Ontology "refers to our basic beliefs about what kind of being a human is and the nature of reality" (Grant & Giddings, 2002, p. 12). They go onto say that this understanding of ontology is the basis for understanding the relationship between the researcher and what and how we define knowledge, defined as epistemology. Emerging out these understandings, and building my ontology and epistemology, was the critical exploration of which methodology best fitted this endeavour. Additionally, my focus was to champion my question, to give the 'How have we silenced the everdayness of our mental dis-ease in mainstream Aotearoa, New Zealand' a chance to unfold, to develop, to come to completion and, potentially, to arrive at a destination. Therefore, I considered a heuristic methodology, thematic analysis, and a hermeneutic methodology as potential frames to support my question and this exploration.

First, I considered a heuristic methodology. This methodology articulates a way of knowing, simultaneously inviting and investigating the experiences of the self in relation to the external phenomena or situation (Moustakas, 1990; Sela-Smith, 2002). This process, therefore, speaks to the lived experience of the researcher (Hiles, 2008). Potentially this frame fitted my question, however, the heuristic focus on "self-search, self-dialogue, and self-discovery" (Moustakas, 1990, p. 9) leading the researcher to discover previously unknown aspects of themselves drew the focus away from the prime intent of the research question, being the 'how' in 'how have we silenced the everydayness of mental dis-ease in Aotearoa?' Additionally, I wished to expand my focus to include others' interpretations and understandings, reflecting the importance of a mainstream perspective. Hence, the heuristic methodology was not the best option for this exploration.

The second methodology considered was thematic analysis. Thematic analysis analyses and reports patterns across a data set with the researcher "thematising meanings" from these patterns (Braun & Clarke, 2006, p. 78). Although Braun and Clarke posit that thematic analysis is flexible, the descriptive coding of themes and patterns felt confining, not allowing me to play with the data, to explore pathways that materialised unexpectedly and, importantly, to peer behind the text to build new interpretations (Moules, 2002). In addition, articulating a data set would have limited the exploratory intent of the research question potentially predicting an answer. My research question was determined to both encourage and lead to an exploration and interpretation of the data, framed to relinquish the need for an answer, while emphasising the hermeneutic process of

providing context and provoking thinking (Smythe & Spence, 2012). Thus, in investigating these methodologies, the hermeneutic process positioned itself between the heuristic process and thematic analysis and as I shall now detail provided the best fit for this research question.

The interpretive paradigm

An interpretive paradigm seeks to understand what it means to be human and correspondingly, seeks to understand and interpret the meanings we attach to events in our lives (Grant & Giddings, 2002). In the post-structuralist paradigm Grant and Giddings suggest that "no-one can stand outside the traditions or discourses of their time" and further, that post-structural explorations "are underpinned by inter-related theories of discourse, power and the subject" (2002, p. 20). Both these viewpoints are framed by the reflexive position of the researcher. In this research, the boundaries of these two paradigms have blurred. My question requires an interpretive approach, but I also am aware of the power of the dominant discourse serving the dominant social group. In my question, the 'how have *we*' reflects the dominant social group in Aotearoa, as does the 'mainstream'. My question assumes the 'we' to be the dominant discourse, but it is silent, invisible, thus, this interpretive paradigm is used to illuminate, to make visible the 'how' we have silenced the everydayness of mental dis-ease.

The hermeneutic philosophy, interpretation, truth and answers

Hermeneutic philosophy describes how "the interplay of tradition, language, dialogue, experience, and context contribute to its theory of interpretation (Freeman, 2008, p. 388). In ancient myths, the Greek God Hermes, was bearer of messages from the Gods to humans and was known as a trickster (Moules, 2002). Moules goes onto say that Hermes "has the character of complication, multiplicity, lies, jokes, irreverence, indirection and disdain for the rules" (p. 2) along with mastery of puzzles, invention and creativity and, significantly, "the capacity to see things anew" (p. 2), while "pestering us in different directions" (p. 3). Hermes in his role provided the bridge between the Gods and humans and, perhaps, the gap between humans and the understandings of themselves. This playful orientation has been permission giving, unfettering my imagination, while being mindful of the critical perspective that is a necessary part of this methodology.

The practice of hermeneutic interpretation was traditionally used to interpret biblical and theological texts in the 17th century (Moules, 2002). Schleiermacher in the 18th century, theorised

two forms of interpretation (Freeman, 2008). The first, being how people interpret the everyday world around them, including texts as was traditional and the second, where the understanding is unclear and needs a specific lens to contextualise the interpretation. Moreover, this lens considers not only the text, but also the political, social and cultural contexts, current and historical that may be shaping the interpretation (Freeman, 2008). Heidegger expanded these principles to highlight that we, as humans, are never isolated in our understandings of our world, articulating "Da-sein, or being-in-the-world, as a *thereness* of being that is distinguished by the capacity for self-reflection concerning.. (our).. own existence" (as cited in Moules, 2002, p. 7).

Brown and Heggs (2011) further expand this perspective and state "hermeneutics permits a range of interpretation, some of which may be seen as being closer to the truth, yet no interpretation is final" (p. 296). Thus, placing myself in this interpretive paradigm, I am to ask the question, explore the text, the literature, and myself, wrestling with my desire to find an answer, while knowing that this is not the hermeneutic way. When I have had a felt sense of an answer in these explorations, although not *the* answer, this has often created an expansion in understanding, leading to different pathways as more data is acquired and explored.

Text, what is hidden.

In the 20th century, Gadamer highlighted the reciprocal role of the researcher, the importance of understanding the role of historical context and, that all understanding is bound in and to language (Dowling, 2004; Moules, 2002). Gadamer thus emphasised that humans experience the world through language and language is the conduit that brings experience into understanding, simultaneously revealing the viewpoints of the text and the reader (as cited in Dowling, 2004). Grondin goes onto expand this by saying that "hermeneutics peers behind language; it ventures into the contextual world of a word, considering what is uttered, but at the same time what is silenced" (as cited in Moules, 2002, p. 3). Thus parts are left unsaid and remain hidden (Freeman, 2008). This dimension of 'hidden-ness' is of particular interest to the present study which attempts to explore what was unsaid, what has been left out, hinting toward what had been 'silenced'.

What I bring

Gadamer emphasised the interpretative lens to describe the encounter between reader/researcher and text, articulating it as a 'fusion of horizons' (as cited in Moules, 2002, p. 9). Moules points out that this horizon is what is seen from any particular viewpoint with the range of vision extended by

the fusion of different standpoints. Thus, the reader brings their own unique perspectives to the text, potentially creating a deeper understanding. These perspectives are grounded in the researcher's preconceptions or biases, or fore-meanings and structures of thinking, leading to creating new horizons, new understandings (Gadamer as cited by Boell & Cecez-Kecmanovic, 2014). Additionally, it is important to note these new horizons may not be better but different, allowing for the alternative interpretation (Dowling, 2004).

My fore-meanings and structures of thinking are, as Schuster states (2013) "imbedded in conceptions and notions I have of others and myself" (p. 198). They are entwined in and by my past and are grounded in da-sein. As researcher I had to remind myself to look beyond my own need to find an answer, to explore the less interesting or the texts that didn't initially speak to me, that didn't fit with my interpretation. I had to learn to be mindful of both my responses to the text and what the text said to make space for the critical responses to what I was reading. Schuster further encourages the researcher to be wary of the interpretation that becomes a "projection of myself through the text" (2013, p. 12). This research, therefore, acknowledges my viewpoint of growing-up with the felt-silence and this search for the words to articulate and to *unsilence* this interpretation of the silence.

Am I getting in the way?

I am continuing to confront, wrestle with and then navigate the hermeneutic dichotomy. This has appeared again and again as two sides, two views, in what is said and what is unsaid, what is seen and what is unseen or what is limited and then what is expanded, truth and mistruth, meanings given thus meanings denied, and finally, concealment and *unconcealment*, as in the Greek word 'aletheia' (Moules, 2002, p. 7). This dichotomy has been felt as a "flux", an immersion in the not knowing (Caputo, as cited in Moules, 2002, p. 17). Moreover, as this exploration has progressed, this flux has become a familiar although an uncomfortable and disconcerting research partner.

Rigour

I have found the hermeneutic methodology to be a fixed framework that paradoxically, allows flexibility reflecting its interpretative approach. The 'fixed' nature of hermeneutics as a social science discipline reflects academic rigour or as Moules notes "meticulous scholasticism" (2002, p.

13). Moules goes onto emphasise believability, transferability, credibility, and validity as part of the scholastic endeavour. These disciplines frame the journey or process that builds toward and potentially reaches an outcome. She continues and states that the reader must decide for themselves if the outcome is believable, that is, if the fit, fits, and there is a landing (Moules, 2002). Transferability indicates that both the contexts and outcomes are applicable to other research contexts, while expanding my and reader's horizons, with the power to create something new. If the reader has been able to follow my journey, my understandings and my interpretations, this fulfils the criteria of credibility. Validity, Moules goes onto say, is the experience of application opening new possibilities. In this journey I have been guided by these standards and this framework.

Method:

First steps

Understanding the process of a literature review was the first step in this study. Boell and Cecez-Kecmanovic (2014) suggest a literature review structure as first defining and limiting the problem. They add that important components of the review include critical assessment and examination of existing knowledge that adds to the current body of knowledge with nil or minimal replication, weaknesses and challenges with suggestions for further research (2014). Critically, they highlight that the literature review is an "open-ended process through which increased understanding of the research area and better understanding of the problem inform each other" (2014, p. 130).

Defining the problem and consequently the topic question, however, proved to be challenging. I knew there was something unspoken and silenced that I had grown up with but searching for something that is silent and hidden proved to be one of the first of many stumbling blocks. Unknowingly this was my first encounter with moving between the parts and the whole as I tried to articulate what I wanted to find out reflecting the process of the hermeneutic circle (Boell & Cecez-Kecmanovic, 2014). I had numerous descriptive words but yet no links, no directions that captured my search. Thus, my first step in trying to find something that was hidden was to brainstorm and mind map my topic.

First words

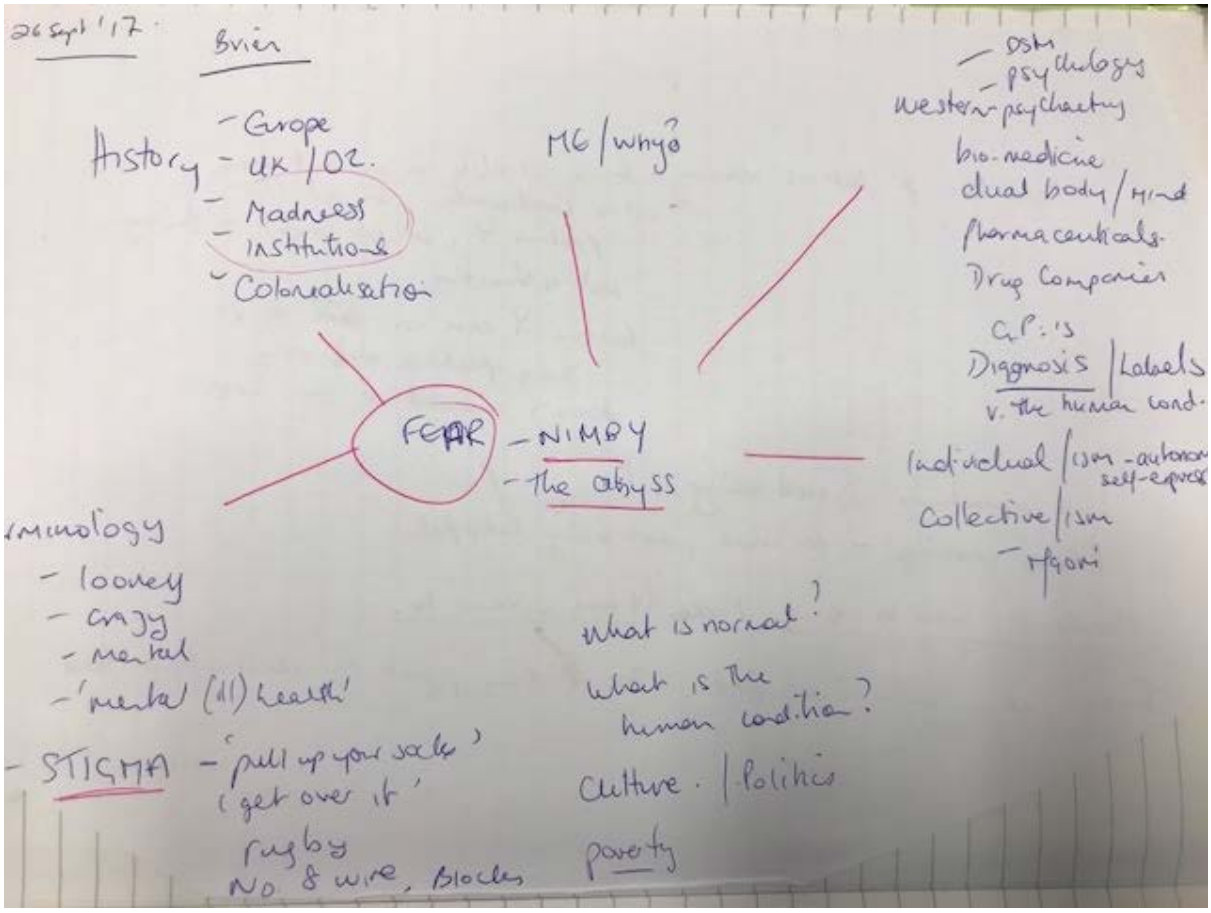

Figure 4. My second mind map

From this map I started making lists of words that fitted or resonated with my initial question. These words became the tools used in the library and data base searches. For example, using such words and phrases as 'mad', 'history and mad', 'New Zealand, mad, history' produced thousands of potential hits, and potential articles. These first searches were almost 'stabs in the dark', highlighting that this initial foray was too big, too vague and needed both limiting and defining. I felt even at this early beginning, overwhelmed and wondering how to grasp and articulate the unspoken and unseen that had enveloped my childhood. I continued this floundering search in hope rather than something systematic and eventually found articles that hinted at the direction I should explore. This floundering, paradoxically, compelled me to realise that I needed an anchor, a base, to both hold me and additionally, allow me to springboard into other directions. This base became the European history of madness, and although a brief foray, it gave me a platform on which to stand and survey various pathways and horizons.

Base camp

This historical base was pivotal in my understanding of hermeneutic philosophy and as Heidegger stated, "interpretation is not just a meaning; it is grounded in a whole set of background practices, a kind of pre-understanding that makes knowing possible" (as cited in Boell & Cecez-Kecmanovic, 2014, p. 262). Using this frame, my historical base not only gave me a place to stand and look forward to the present but a place from which to reflect, to make links and interpret. Unexpectedly, it emerged as a pivotal component in my findings. Further, Gadamer similarly articulates history as tradition and said, "we may not like what tradition has done, we must account for it, we must take it all up and own it, and we must then speak to the very influences of tradition" (as cited in Moules, 2002, p. 11). To build on this, I re-interpret what Frame wrote from "the future accumulates like a weight upon the past" (1984, p. 9) to, *the past accumulates like a weight upon the future*, as I journey from this chosen base to attempt to interpret and understand the silences that may keep us bound today.

Circles and spirals

Boell and Cecez-Kecmanovic (2014) posit that the hermeneutic circle is a process of relating parts to the whole, the whole to the parts and back again, understanding that this process is always incomplete. This reflects the interpretative process of understanding the text, being the 'part', engaging with my understanding of the context as the 'whole', while accounting for my pre-understandings and then returning to the text with greater understanding. This movement between the parts and the whole, reflecting the hermeneutic circle, attempts to create layers of understanding through multiple readings of a single text or different texts within the main body of literature. As I enter the circle, I bring my pre-understandings with me. These are my prejudices, biases, history, traditions, culture and my way of being in the world (Moules, 2002). I then explore the literature to arrive at a momentary understanding, hopefully an 'aha' moment before returning to the circle with the greater understanding, a new horizon (Freeman, 2008).

My own interpretation of the hermeneutic circle is of a spiral creating richer understandings as I delve deeper into the "searching, sorting, selecting, acquiring, reading, identifying, refining" (Boell & Cecez-Kecmanovic, 2010, p. 134) circle while 'analysing and interpreting via the mapping and classifying, critically assessing, and developing the argument' circle (Boell & Cecez-Kecmanovic, 2014). These two circles intertwine like converging ripples on a pond, both contesting for dominance. In this research, I have sometimes felt the loss of direction, the overwhelm of not

moving forward, continuing around and around the ripples. Smythe, Ironside, Sims, Swenson and Spence (2007) call this the "unutterable circle of writing" (p. 1395), not knowing where I am in the line, opening to listening, and attempting to trust in a process that has yet to come to fruition. Leaving the hermeneutic circle by saying enough is enough or by saying 'stop' to the journey with no end has proven challenging (Smythe & Spence, 2012). Within this, the academic time frame has been both limiting and supporting helping me to say 'stop'. Although this has sometimes been reluctantly as there seems to be many circles, spirals, and, horizons yet to explore. Moreover, I can now discern the difference between the overwhelm I have experienced many times and saturation, with the latter reflecting the diminishing novelty and value (Boell & Cecez-Kecmanovic, 2014).

Practical pathways

As my exploration continued, I often used 'reference tracking' (Boell & Cecez-Kecmanovic, 2010). To begin I would sometimes read just the abstract and conclusion of an article, then if relevant read more fully, reading in detail the reference list, and finally, researching the references. The reference lists often gave me ideas, words or topics to explore that I hadn't previously researched. For instance, I found the topic 'help seeking behaviours' and although I was looking for 'help hindering behaviours' the former enabled me to articulate and explore the latter. Often, I wrote down words or phrases that seemed pertinent, for instance, 'force', 'human-ness' and, 'othering'. My large dissertation notebook filled with pictures, arrows, diagrams, and cuttings becoming the diary of my work, a place where my imagination could roam and not become lost. I created a main heading in this notebook called 'observations' to highlight my landings. For instance, an observation highlighted the 'importance of defining my words, clarifying the cliché, establishing its meaning and what I mean, to avoid deeply embedded invisible meanings', reflecting my desire for credibility (Moules, 2002). This is seen in Figure 5.

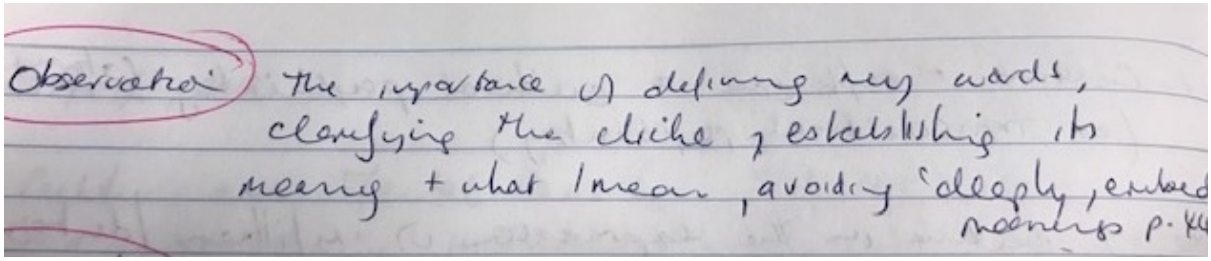

Figure 5. Observation about understanding the importance of clarity

On reading about madness, I noted that for every word describing madness, there was an opposite that kept 'us' safe, illustrated in Figure 6.

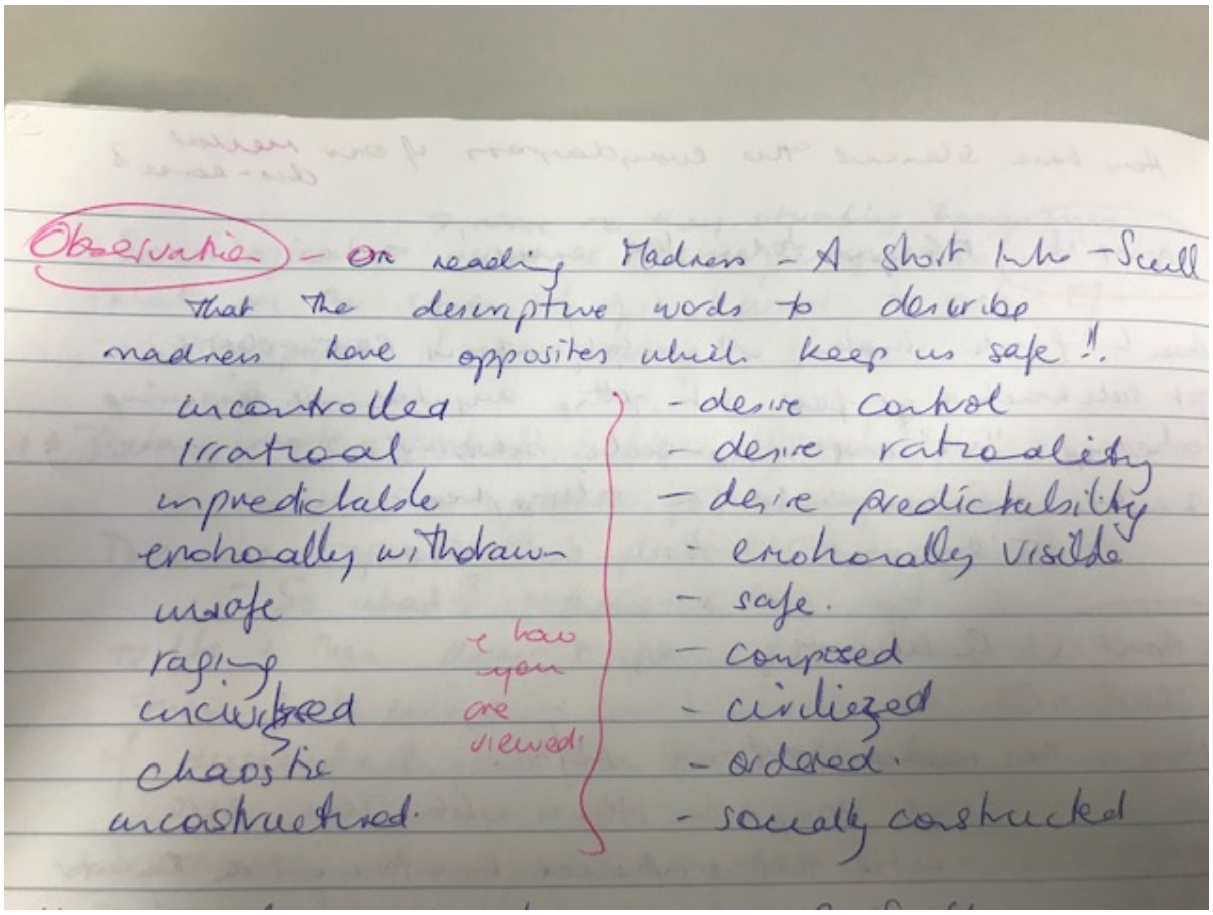

Figure 6. Observation detailing words describing madness and their opposites expressing safety.

On reflection, I could see these observations visible in those early notes, led to tentative understandings and finally, the main threads of my findings.

Mainstream

Researching academic literature was initially difficult as the topic was too big. Reflecting this 'too bigness' I became more disciplined in this search, highlighting key words and phrases in academic journals and books. This led to focussing on introductions and conclusions, and if applicable, expanding into reading results and discussion sections. Reflecting the importance of these headings

I have structured this project around these key terms ‘introduction, results, discussion’ to establish an-easier-to-follow pathway.

Mainstream as an umbrella term became critical in these searches to highlight the relevance of its everydayness and although terms like mad and madness were important, I was searching for the unspoken and the silent in the mainstream. Therefore, and in using the literature that had informed my base, I moved beyond these terms to explore tangential pathways that led to both dead ends and new options. To explore the mainstream of Aotearoa I regularly investigated mainstream news media (but not social media as this was beyond the scope of this project), for instance, The New Zealand Herald (https://www.nzherald.co.nz).

In the latter half of 2017, The New Zealand Herald highlighted mental health issues in its ‘Break the Silence’ theme. I cut out articles that mentioned phrases and words that spoke to me, landed in me, and said ‘this is important’, sometimes without knowing why. These mainstream sources mentioned websites, and this led to exploring these specific New Zealand pathways, including for instance, the Ministry of Health (https://www.health.govt.nz) and the Health Research Council of New Zealand (http://www.hrc.govt.nz). In these two I used the word ‘mental’ as my search term and this linked to the relevant literature. The Mental Health Foundation was especially productive and with subscribing to their News I have received a regular email bulletin referencing new international resources, new New Zealand research and resources, book reviews, resource reviews along with the latest New Zealand news in mental health. This led me to other relevant New Zealand websites including The Sociological Association of New Zealand of Aotearoa New Zealand (http://www.saanz.net), New Zealand Sociology (https://www.nzsociology.nz) and The New Zealand Psychological Society (http://www.psychology.org.nz) where archived material was available for public viewing. I also researched the NZAP website, however they only have material available for members.

Mainstream literature also highlighted current and popular terminology, such as stigma and loneliness. These terms developed into critical pathways of research. Potential pathways kept appearing, for example, from previously participating in a formal research project using Eisenberger’s Cyberball experiment measuring the effects of inclusivity and exclusivity. Or to reading popular magazines that talked about loneliness as the new disease. From these readings I investigated quoted authors, for instance, Cacioppo (2008). Further, having seen the television

campaign ‘Like Minds, Like Mine’ to combat stigma, I was able to research literature specific to this topic reflecting mainstream New Zealand.

Conclusion

Locating the study in a hermeneutic interpretative paradigm has given me a framework to sit more comfortably with the interpretations gleaned from the history of madness, my historical base. This framework emphasises the importance of context and the text situated within that context. Thus, in reading the text and in endeavouring to peer behind and beyond the words, I have tried to understand and make meaning from what has been written. This has been a complex process with an emerging awareness of what is not there, what has not been written, directing me toward what has been silenced.

In these readings I have been cognisant of my childhood perceptions and the dominant discourse of my normal. Therefore, in looking at the text, I have endeavoured to reflect on the structures of my thinking, the many lenses that I look through to see my world and, how these views may be influencing my interpretations, my understandings. This has been my part in the reciprocal process of interpretation, which highlights my part in the journey of making the invisible visible, leading to new horizons.

Moving around the hermeneutic circle and along the hermeneutic spiral, from parts to a whole and back again, I have wrestled with the ‘not knowing’. This has been a challenging and complicated process and, in attempting to locate what has been hidden there has been a struggle, a wrestling with the potential of not arriving at an answer, indeed, not arriving anywhere. Additionally, I have noted the importance of scholasticism and rigour that are not necessarily comfortable partners with provocative thinking and imaginings. Both these approaches have been challenging.

Practical pathways of research included academic and non-academic literature. The latter reflected my understanding of mainstream which became a focus in endeavouring to situate the ‘how’ of my question in Aotearoa. This led to alternative resources and pathways

Rather than being a straightforward linear process, enacting the hermeneutic process has been complex. Thus from defining the question, to articulating my base, to the process of arriving at my results and, in the discussion, interpreting these results. Reflecting on this hermeneutic process I have explored many pathways and I have arrived at an answer, however not necessarily ‘the’

answer. This emphasises a journey into the unknown guided by the hermeneutic process. The following chapter is a representation of what has occurred during this process.

Chapter 3. Results

'ka mua, ka muri'

My arrival to this place in my journey is captured by the Maori proverb *ka mua, ka muri* which means *walking backwards into the future*. Gadamer similarly declared that we cannot overstep our shadows noting that "we are connected in a continuous thread with our past, with traditions, and with our ancestors" (as cited by Moules, 2002, p. 1). Thus, and echoing my introduction, I started with the desire to create a base or platform, in order to investigate the 'how' of 'how we have silenced' by looking backwards into this history of madness. I began by exploring the European history of madness which flowed like a strong current into New Zealand, seeping into and creating the foundation for New Zealand's colonial history of madness. This first base was to hold me, to use as a springboard into a voyage of discovery about this history, these traditions, and the patterns of influence. Combined, these permeated like a current of water battering over the rocks of time in a fast-moving stream creating in Gadamer's words a "historically effected consciousness" (as cited in Freeman, 2008, p. 387). I used this base to reflect on themes that were potentially influencing the patterns of silence visible today. I attempted to peer behind the text to interpret what had been unsaid and what had been silenced, searching for alternative interpretations. These themes are interconnected concepts reflecting my arrival at a place that makes sense of this journey. Simply put, there are two concepts which, when combined create a force that acts to silence our mental dis-ease. The first concept is our need for connection, incorporating both evolutionary and psychological understandings. The second is stigma, which includes the processes of 'othering', self-stigma, silence and isolation. Part of this second component includes those attempting to seek help and consequently, what keeps them stuck, silent. These two concepts can be viewed as competing tensions which, when combined with historical concepts of normal create a momentum, or a force that acts to silence our mental dis-ease. This force is my overall finding and is discussed as the final result.

The need for connection.

In this section, I briefly explore the human need for connection by placing this human need within an evolutionary context that entwines with the environment. The result is an impact on psychological development. This construction can be framed as symbolic interactionism, how people interpret, construct and give meaning to their behaviours. This in turn, builds to societal understandings and a social and cultural lens by which to view the world (Germov, 2009; Shaw, 2013). From this understanding, I link to attachment theory and, finally an understanding of the impact of isolation. This need for connection is part of our 'human-ness' which stems from our biological and social needs, our attachment system and, a fear of loneliness and isolation. These three components reflect our need for connection and are not only intertwined like threads in a yarn but, additionally, are closely connected to the impact of the next two findings; stigma and the Force.

Evolution

Evolutionary psychologists suggest that we all inherit similar psychological mechanisms, tendencies and abilities. These, in turn, lead us to respond to our environments as adaptations to support the successful evolutionary outcome of our species (Cervone & Pervin, 2010). Such mechanisms include sexual attraction, caring for children, altruism, emotional responses to events and objects, and universal emotions such as sadness, disgust, fear, joy and anger (Cervone & Pervin, 2010). Further, we grow, adapt, and survive in a social environment reflecting human gregariousness (Trotter, 1916). This gregariousness or social environment is fundamental to our survival and over time, ensured the survival of our species (Cervone & Pervin, 2010). From our ancestors in the hunter-gatherer world, connection and social co-operation, ensured not only our physiological survival but our cognitive development (Cacioppo & Patrick, 2008). Cervone and Pervin (2010) note the continuing debate in understanding human development being is it all nature (genetic and psychological inclinations that ensure survival), all nurture (the influence of our surrounding environment), or is it both? They add that the most current perspective reflects this latter notion, and propose that personality development is a combination of our biological brain impacted by evolutionary forces along with the influences of our environment on individual experiences. Current advances in neuroscience confirm this viewpoint (Jones-Smith, 2016). These perspectives set the scene in understanding psychological needs today, along with understanding the influences of culture and environment.

Our psychological needs are a mixture of overlapping physiological, psychological and emotional motivations (Habermacher, Ghadiri & Peters, 2014). Based on Maslow's hierarchy of needs of the 1940s, Habermacher et al., (2014) cite Epstein's 'Cognitive Experiential Theory' as the most current and comprehensive model to articulate psychological needs that underpin human motivations. Epstein lists the four needs as self-esteem (self-worth and the valuing of oneself), attachment (bonding to others and the trust of others), pleasure (in feelings of positivity and reward) and finally, the combination of orientation and control (as feelings of freedom and autonomy in creating a coherent and consistent view of the world; as cited in Habermacher et al., 2014). Further, I suggest there is an overarching theme of developmental improvement that permeates these four needs, being the desire for self-realisation or self-actualisation. This suggestion is supported by Maslow (Cervone & Pervin, 2010). This drive for self-actualisation weaves into the western ideology of individualism and, significantly, Luke (as cited by Foster, 2007) suggests that this view of self lies wholly within the mind. Extrapolated, therefore, an illness or distress of or in the mind, is a threat to the individual self (Foster, 2007). This threat to self becomes a component of the self-stigma process (discussed below) and is likely to hinder self-understanding and help-seeking behaviours.

Additionally, Solm (2018) suggests that our needs are the basic emotions that trigger behaviours. These behaviours then cause us to initiate action plans in order to ensure survival. For example, Solm articulates that learning what to fear is a critical component and occurs mainly in childhood. It is also interesting to note that Solm highlights that because of our limited conscious capacity, the process of fulfilling these needs is largely unconscious. Both viewpoints of Solm feed into the learning of stigma and the attachment system.

There are additional points to note. Habermacher et al., (2014) and Solm (2018) make two observations. First, that there are neurobiological systems for each need which reflect current neuroscientific developments. Second, that attachment to others and specifically to the primary care-giver is critical to human development. To highlight the importance of these needs, Habermacher et al. contend that violation or non-fulfilment of these needs leads to "stress responses in the systems ... decreased psychological and physical well-being … (and to)… a disruptive biological environment in the brain" (2014, p. 10). Cervone and Pervin (2010) state that not only does our brain reflect these evolutionary forces and our needs, but also our individual experiences of our environment and culture.

Our culture is a key component in our growth; reflecting both internal and external influences. Culture defines our needs, our experiences of our emotions, how we express our feelings, and how we relate to others and ourselves (Cervone & Pervin, 2010). Claiborne, Drewery, Paki and Chu (2014) expand this concept by affirming that human development is a "process of progressive changes" (p. 4) over time reflecting human biology, human needs, human connections, environment and culture. Notably, they articulate that everyday reality or, in my term 'everydayness', is the composition of human created interpretations or concepts of culture that change over time. Accordingly, everydayness is socially constructed. Culture then has both explicit and implicit guidelines, transmitted between generations via symbols, language and rituals (Helman, 2007). These guidelines inform the members of the group "how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods and to the natural environment" (Helman, 2007, p. 2). Thus, Helman summarises that "culture can be seen as an inherited 'lens' through which individuals perceive and understand the world that they inhabit and learn to live within it" (2007, p. 2). I suggest this is also a hermeneutic lens. It follows that, individual development in current euro-western environments is reflective of cultural integration rather than biological evolution (Claiborne et al., 2014). I would contend, however, that that this is only one perspective in understanding the 'everydayness' of our reality. Another critical component, for example, is the environment of our formative years and specifically, our attachment to our primary care-giver. This is now discussed as attachment theory.

Attachment Theory

Attachment has been fundamental to the evolution of humans and is fundamental to their ongoing safety and survival. It is based on a biological function to keep the infant close to its caregiver and protect it from predators (Bowlby, 2007). Attachment styles, as internal working models, can be observed over a life time from infancy to old age. Human infants "are programmed to develop in a socially co-operative way" (Bowlby, 2007, p. 10) and over their life span, seek company to avoid isolation. This leads to the conclusion that "anyone who has no such base is rootless and intensely lonely" (Bowlby, 1979, p. 132). Attachment theory predicates itself on a behavioural system of attachment primarily evident in infant/child, parent relationships (Cervone & Pervin, 2010). The attachment between the primary care-giver and infant supports the development of an internal working model reflecting the infant or child's relationship to significant others (Cervone & Pervin, 2010). Moreover, attachment styles reflect "infant temperament and maternal sensitivity" (p. 25) where maternal sensitivity originates from a self-reflective state and is expressed as thinking and

feeling about the infant's mind (Fonagy, 2001). This is, in itself, more likely to encourage secure attachment (Fonagy, 2001).

Secure attachment as the internal working model is optimal (Bowlby, 2007). Disturbed attachment styles, impact on self-understanding and intimate relationships and thus, create psychological disruption. If the attachment and the internal model is not secure (deemed either avoidant, anxious-ambivalent or disorganised), there is potentially a profound effect on emotional functioning which manifests in childhood, adolescence and, or adulthood (Cervone & Pervin, 2010). Consequently, attachment theory can be used to explain personality disturbance, emotional distress, and detachment culminating in psychopathologies. This is further supported by current neuroscientific developments. As Cozolino states "the brain is a social organ… (with) attachment constructs and relationships at the heart of the development of both adaptive and maladaptive behaviours in children and adults" (as cited in Jones-Smith, 2016, p. 640).

To emphasise the importance of attachment, Bowlby concludes that "there are, in fact, no more important communications between one human being and another than those expressed emotionally, and no information more vital for constructing and reconstructing working models of self and other than information about how each feel towards the other" (2007, p. 177). In these words, I suggest, the negative effects of stigma and isolation find a ready home.

Loneliness and isolation.

Loneliness and isolation are closely linked to attachment theory, our human needs and our environment. We are social beings and as a result, social connection and obtaining personal meaning are fundamental to both individual and societal development (Cacioppo & Patrick, 2008). Our social brain has an evolutionary drive for connection which, gives rise to "reciprocity and interdependence with other members of our species" (Cacioppo & Patrick, 2008, p. 262). This links to the evolutionary mechanisms discussed above. As a species, our social evolution and the need to be in groups and relate to other human beings ensured our survival. In a nutshell, we need each other to survive, and conversely, loneliness and isolation, are detrimental to our survival as a species and, especially, to the individual.

Feeling lonely is part of being human, but loneliness reflects a "persistent, self-reinforcing loop of negative thoughts, sensations, and behaviours" (Cacioppo & Patrick, 2008, p. 7) which leads to a

feeling of disconnection. Given this is a prevalent issue in today's society, this suggests that the importance of social connection has become less important over the last few decades.

By way of example, the United Kingdom (UK) appointed a Minister of Loneliness in early 2018. This was the result of an estimated nine million people in the United Kingdom acknowledging their loneliness. In view of this, loneliness was subsequently labelled as a health hazard and an epidemic (British Red Cross, 2016). The psychological impact of loneliness includes lower self-confidence with negative beliefs and emotions, anxiety, mood disorders, feelings of anger and frustration, isolation, and thoughts of self-harm and suicide (The British Red Cross, 2016). The British Red Cross (2016) further report that these psychological factors intersect with behavioural factors (being disengagement and isolation, poor work habits, insomnia, and not looking after oneself) and biological factors (increasing illness and negative health symptoms) which culminate in an identity crisis. Those with additional mental health issues are also perceived as being at greater risk. It is interesting to note as an aside that 'loneliness' seems to be seen as either a mental health issue, a social health issue, or both, and, importantly, is visibly traversing different social constructs. In my view, it is likely that loneliness, is emerging as a defined or officially recognised mental health issue. Whether this is accepted by the public is another question.

Social connectedness and social bonding are critical for our well-being. Their opposites, banishment and isolation, are both a traditional and current form of punishment. Fear and isolation are key components of loneliness. This points to an evolutionary aspect of our early selves, being the need to keep safe from predators, via enforced and maintained social connectedness. Further, loneliness "disrupts key cellular processes deep within our body" (Cacioppo & Patrick, 2008, p. 34) and without our connectedness to others, has significant physiological effects. Habermacher et al., (2014) adds that social rejection triggers a neurological response as pain hubs in the brain further emphasising our need to belong.

Research indicates that social connections influence health positively in multiple ways. This is called social buffering (Birmingham & Holt-Lunstad, 2018). Social buffering or social support mitigates the effects of stressors such as dysfunctional relationships and work difficulties. In their research, however, Birmingham and Holt-Lunstad (2018) caution that developmental factors, childhood experiences, and biology may moderate the positive impact of this buffering. They add that quality and diversity of social relationships have a greater health benefit than a larger and less connected social network, highlighting the importance of genuine relationships. The opposite of social

buffering is called social aggravation, which negatively affects social connections and relationships. Social aggravation consists of failed support and can have deleterious physiological (linked to disease and dementia) and psychological effects and these in turn, are linked to depression and anxiety (Birmingham & Holt-Lunstad, 2018). Similar to both these processes and the effects of stigma, social aggravation can develop from a cycle of loneliness, where the lonely interpret social interactions negatively and consequently, come to expect failure in social relationships.

Conclusion

Connecting with and to others has ensured our survival as a species. We make such connections via psychological and physiological mechanisms which reflect our need for a social environment. Specifically, our psychological needs (being self-esteem, attachment, pleasure and autonomy) link to the overarching desire for self-actualisation (Cervone & Pervin, 2010). Linked to these needs is the impact of the attachment styles to our primary caregiver as discussed by attachment theory (Bowlby, 2002). Disturbed attachment styles can, conversely, lead to psychopathologies from childhood to adulthood while non-fulfilment of our psychological needs leads to diminished physical and psychological well-being (Habermacher et al., 2014). Further, loneliness and isolation, were shown to have negative outcomes, and are currently considered a health hazard in the UK. These components not only entwine with each other but, importantly, with our environment and our culture. Thus, culture has been shown to play a key role in our psychological development, as culture is the lens through which we view the world. This reflects my understanding on the impact of culture and our history on mental health as it seeps into the everydayness of living. These three intertwining components, being evolutionary mechanisms, attachment behaviour, and the effects of loneliness and isolation have led to the next finding, stigma, or standing from the historical base, 'other' and 'othering'.

Stigma and the process of othering.

The words and themes highlighted in my analysis and interpretation of the history of madness specifically around the 'other' and 'othering', and those who were normal and those who were not, lead to the finding of stigma. There is significant research on stigma. This finding, therefore, explores the research highlighting how stigma and the cycles of stigma are associated with and impact on mental health. First an understanding of other and othering is given linked to the

emergence of stigma from a historical perspective. Insiders and outsiders are discussed showing how stigma is learned in childhood. Cycles of stigma and self-stigma are explored, and understandings of their processes are given leading to a conclusion.

Other and othering

From early times, madness was articulated by difference to the norm, with an emphasis on the corporeal to explain differences (Thumiger, 2017). These differences were expanded from the Greeks' holistic viewpoint, emphasising the health of the body, the spirit, vitality and life-force, visible in the four humours, leading to the 17th century understandings of temperament and physical health (Scull, 2011; Thumiger, 2017). The legacy of this later time, according to Thumiger (2017), was a normative standard of mental health and soundness, along with the beginnings of symptomology, etiology and nosology. I contend, however, that in addition to this legacy, there is another more significant and dominating thread articulating madness – being the 'other' and 'othering'.

The development of the lithograph and photograph led to a visually defined concept of the deviant, articulated as the other, consequently, leading to othering. With the theory of physiognomy given scientific status, the mad could be now 'seen' and subsequently, confined (Gilman, 1982). The seeing and confinement was and is currently, an important component of how we view mental health. This concept has maintained a societal and conceptual distance between the insane and the normal, while emphasizing the emerging dichotomy between, for instance, beauty and health, ugliness and disease, those who were visibly confined and those who were visibly free (Gilman, 1982). This conceptual separation, I suggest, allows the sane person to freely imagine the mad, both creating and cementing the other, and othering. These are the components of the modern-day label of stigma.

The popular understanding of stigma, in my words, 'being in judgment of another who is different' does not allow for the depths of how stigma works and its effects. Goffman gives a more specific definition of stigma being "… a blemished person, ritually polluted, to be avoided, especially in public places" (1963, p. 11). This concept of stigma dates back thousands of years and can be found in early Greek mythology where a visible blemish was viewed as a sign of God's displeasure (Finzen, 2017). Thus, the slave, criminal or traitor could be identified by a sign cut or burned into their body signifying something morally bad or unusual (Goffman, 1963). Moving to the 19th century, the mentally defective could be identified by their bodily characteristics and blemishes. This is linked to

the rise of physiognomy as discussed in the history of madness, where pointed ears, cranial or growth abnormalities were visible signs of madness. Link and Stuart (2017) suggest that at this time mental illness was viewed as a social problem reflecting a hereditary defect rather than a medical one, and as previously suggested, confirmed the moral degeneration of those stigmatized. Go forward another century and the term applies more to disgrace and the "blemishes of the individual character" (p. 14) rather than physical manifestations (Goffman, 1963). Over forty years later, however, physical appearance is still one of the signals that elicit stigma (Corrigan et al., 2011).

Insiders and outsiders, how I know you are different

Stigma is learned in two ways (Corrigan et al., 2011). The first is the development of attitudes about and toward groups "based on the sum of our interactions" with the group (Corrigan et al., 2011, p. 33). Second, understandings about groups and therefore stigma, is learned from myths, folklore and other representations including media. The media, by sensationalising negative behaviours and social taboos, signal what is socially unacceptable regarding deviant or inappropriate behaviour (Roach Anleu, 2009). In New Zealand, the MoH (2016) suggests that negative reporting by the media regarding mental health issues make it less likely people will ask for help, create misconceptions about what mental illness and services are like, amplify the feelings of shame and isolation that those with mental health issues may be experiencing and significantly, reinforce stereotypes that people with mental health issues are to be feared and are dangerous. An example of this 'fear' occurred in Auckland in 2016, where a man turned himself in to police for the murder of a jogger in an inner-city suburb. The randomness of the attack created a ripple of fear in the greater area (Smith, 2016). Although this person was later found not guilty by reason of insanity, the media reported the individual as having 'mental health issues', potentially compounding a public stereotype that those with mental health issues are liable to attack, leading to the not-in-my-backyard reaction, the place where this exploration started. Furthermore, and I suggest critically, by implicating the individual as responsible it distracts from wider social failings.

At a societal level, insiders and outsiders, maintain the cohesion and survival of the group. This, for instance, is visible in the exclusion of those who are different (visible or otherwise) or those who are perceived as untrustworthy (Loch & Rossler, 2017). Thus, in-group cohesion or attachment is maintained by the prejudices and stereotypes attributed to the out-groups. This seems to be an important point that links in with loneliness and the isolation that is both a symptom of mental illness and a characteristic of mental health stigma especially within the cycle of self-stigma.

Common to psychotherapeutic theory and understandings, research by Mueller, Callanan, and Greenwood (2016) suggest that children by the age of five can distinguish between good in-groups and bad out-groups along with rules of social desirability. By age seven, they have learned to stigmatise and model the silence that is perceived to surround mental illness (and it is interesting to note this research is trying to articulate this silence). They go on to suggest that there are two general mechanisms involved in the learning of these attitudes. The first is where "children connect labels verbalised by parents with associated emotions, and link these with certain individuals and groups" (Mueller et al., 2016, p. 63). This filters into the second process, the learning of attitude via conformity, where children learn to conform to implicit rules of behaviour of how other people should behave. This begins with the child who models him or herself on significant others in their environment. Environment and culture surround and shape the individual in their development and expression of the real self (Johnson, 1994). Goffman emphasises this concept by stating that "we learn to live in the eyes of others, seeing ourselves through their eyes" (as cited in Scheff, 2014, p. 111). This is borne out in examples of unconscious mechanisms, and can be seen, for instance, in the protecting and moving the child away from someone who is visibly different. Or, it can be via misattribution, where the child associates adult discomfort with a person with behaviours that break social norms. Finzen (2017) suggests in meeting a person with a mental illness, the anxieties and defensive reactions of the 'normal person' are triggered and reliance on usual social expectations are not available and as a consequence, greater social distance is desired and given. An added anxiety is the fear of contamination, that we may be contaminated by their mental illness (Arboleda-Florez, 2017). Consequently, the 'not-in-my-backyard' attitude that was so aptly articulated by David Seymour and that was considered to be on the rise nearly twenty years ago has not yet abated (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999). Mueller et al. (2016) add that there is a lack of research in this area which aligns with my own difficulty in researching the 'silence'.

The cycle of stigma

Link and Phelan (2001) define stigma as a co-occurrence of labelling, separation, status loss, stereotyping and discrimination and add that "… for stigmatisation to occur, power must be exercised" (p. 363). Based on Link and Phelan's definition I see this as a cycle of stigma as detailed in Figure 8 following.

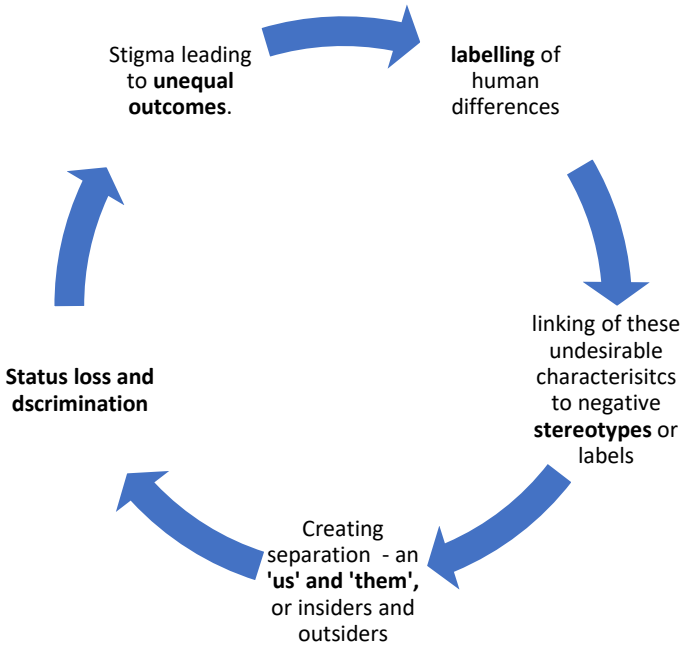

Figure 8. Cycle of stigma inspired by Link and Phelan's definition (2001)

Labelling

The first step in this cycle is labelling and reflects the "social selection of human differences" (Link & Phelan, 2001, p. 367). The majority of human differences are ignored for two possible reasons. First, we don't have the cognitive capacity to continually process the multitude of differences encountered daily. Link and Phelan (2001) suggest this simplification reflects a cognitive efficiency that occurs automatically at a pre-conscious level freeing up space for other cognitive workings. Secondly, Goffman states only those attributes that are incompatible with our beliefs of what an individual should be (the perceived normal) are then stigmatised (as cited in Finzen, 2017). Accordingly, labelling rests on the mostly unconscious simplification of these human differences varying over time and place (the latter, for example, seen in the rise and demise of physiognomy of the 19th century). Labelling thus links to a stereotype, impacting either the individual or the group, or both.

Stereotypes

Stereotypes are what the public or people think negatively about a group or individual resulting in prejudices (Krupchanka & Thornicroft, 2017; Sheehan, Nieweglowski & Corrigan; 2017). Prejudices are the agreement with these stereotyped thoughts and/or emotional reactions such as anger or fear. Common stereotypes for mental illness include perceived dangerousness (with an increased desire for social distance), incompetence and unpredictability by not conforming to social norms, and finally, shame (Corrigan et al., 2011; Cunningham et al., 2017; Link et al., 1999; Sheehan et al., 2017; Yeh, Robert, & Thomas, 2017). It is important to note that in a 1971 study on emotionally laden events in psychotherapeutic sessions, shame highlighted as an episode, occurred more frequently than all other emotions combined (Lewis as cited in Scheff, 2014).

Furthermore, shame has over time, replaced physical punishment as a tool in controlling behaviour at a societal and an individual level (Goffman, cited in Scheff, 2014). Additionally, this process has become invisible because the feeling of shame is both uncomfortable and taboo. In modern western societies, independence is venerated, potentially leading to the hiding of emotions and the alienation of the individual at the cost of relationship (Scheff, 2014). Scheff adds that with the favouring of the cognitive world of thought and behaviour (and I propose emulating the Cartesian split), the social-emotional has been suppressed. I suggest that this is part of New Zealand norms of behaviour, where the 'pull up your socks' is part of the 'get on with it' and the suppressing or silencing of social-emotional communication. Importantly, shame is both an internal felt-sense and an external judgment, reflecting a jeopardised or broken connection, threatening our need to bond (Scheff, 2014). Janet Frame, a New Zealand literary icon, after eight years in Seacilffe shares an example of shame when she states "… I had missed so many experiences in ordinary living that my 'firsts', out of step with the 'firsts' of others, were felt to be a cause of shame" (Frame, 1984, p. 93) reflecting this struggle to bond, be part of the normal, and the mainstream.

Us and them

Stereotypes create a separation, with the separation articulated as an 'us and them'. Labelling and stereotyping help maintain social norms and social solidarity, visible as the in-groups and out-groups (Finzen, 2017). In-groups create and use the out-group to maintain solidarity. Outsiders, according to Finzen (2017), are the recipients of "negative attributions, mistrust, disdain, and hatred" (p. 112)

Outsider behaviour is visible as social deviation, taboo breaking, violence or in an attack on society. Here I am reminded of William Golding's themes in 'Lord of the Flies' as an example of a torturous demise of outsiders, or more horrifically, the outcomes of the Holocaust.

Sadly this 'us and them' labelling is also embraced by those stigmatised (Iley & Nazroo, 2007; Link & Phelan, 2001). The label becomes a 'master-status' taking on all the characteristics of the label whether real or not, producing a self-fulfilling prophecy of difference. For instance, the diabetic may say 'I am diabetic' or similarly the schizophrenic, 'I am schizophrenic' in contrast to someone diagnosed with cancer saying, 'I am cancer, or I am heart disease'. The 'I have heart disease', or 'I have cancer', is very different from the label of 'I am schizophrenic', or 'I am epileptic', which confirms the latter's outside status, and articulates their identity. This labelling can also occur at a group level, when the 'deviant person' aligning with their label, joins those who are similarly labelled, becoming an 'organised' deviant group (Iley & Nazroo, 2007).

Status loss and discrimination

Status loss and discrimination in this cycle is conferred by the stigmatiser and sometimes embraced by the stigmatised (as above). A participant in a New Zealand study by Peterson et al., (2008) shares:

> It is like the ugly hat that has been left on the shelf all this time – a misconception about what mental illness is. But now, I have become the person that wears the ugly hat – being described as crazy, dangerous, and someone that others need to stay away from (p. 27).

Hence, the person perceives their mental illness to be their blemish, their difference, validating their 'outside' status, and status loss resulting in discrimination. This in turn, strengthens the 'insider's' status and power allowing the stigma to occur (Krupchanka & Thornicroft, 2017). Yeh et al. (2107) suggest that the stigmatiser, with the unconscious connections of their "cognitive, affective, and behavioural reactions" (p. 98) create the negative stereotype, which collectively embeds in our cultural perceptions of mental health. This to me is a silent negative, the greater the stigma, the more powerful the stigmatiser becomes, sustaining the 'insider', 'outsider' positions.

Unequal outcomes

This is the final step of the cycle of stigma. In a study by Peterson et al. (2008) a participant further articulated:

> You don't feel safe when you go out and about – people tend to have a go at you – they can see right away you are different, and you get abused for that, so I don't go anywhere" (p. 35) and further, "the medical health system is bad. The nurses are the worst. They hold you back- don't let you think about doing better things. Always tell you not to go for a job or to think about something really hard before doing it in case you start it and can't finish. They sow the seeds of doubt (p. 39).

This is the predicament, that is, in trying to counteract the stigma, the stigmatised may confirm the stigma which consequently and inadvertently, consolidates unequal outcomes, leading to "the general pattern of disadvantage" (Link & Phelan, 2001, p. 380). This also highlights the power exercised by those in authority whether intentionally or otherwise. Examples of unequal outcomes cross a variety of domains and include, for instance, school failure, unemployment, difficulty with relationships, housing, medical assistance along with life chances and general psychological well-being (Link & Phelan, 2001; Marie & Miles 2007; Yeh et al., 2017). Additionally, research has indicated that those with a mental illness are less likely to receive equivalent physical health care as compared to those without a mental illness (Corrigan et al., 2011; Krupchanka & Thornicroft, 2017). Both examples reflect a power imbalance and again this could be viewed as either an intentional or an unintentional outcome

Self-stigma

"I know the effort she makes to be normal" (Cardinal, 1984, p.9)

The self-stigma cycle, as seen in Figure 9 on the next page, begins with perceived difference and leads to being stigmatised (the historic equivalent of othering), isolation and not seeking help. To expand, Loch and Rossler (2017) identify self-stigma as an individual with a mental health condition who perceives societal stigma, internalises it, feels diminished self-esteem and self-efficacy, and consequently, inhibits recognition of the problem and the process of recovery. Further, if that individual believes that others will devalue and reject people with mental illness, then they will apply this rejection to themselves (Link & Phelan, 2001). This internalised stigma is a process of "identity transformation" (Stuart, 2017, p. 500) that both leads to and creates shame, social withdrawal, feelings of isolation, depression, anxiety, a lessening of hope and belief in the future, a poorer quality of life. These factors help create the secrecy element. According to Goffman (1963) this manifests as a managed identity with additional feelings of inferiority, a secret inner life, moving

around their social group with care and planning or passing off symptoms, for instance, as a physical disorder. This *other* life is tiring and hard work, with the person vigilant about being seen or found out and accepting that he or she is indeed the person that is stigmatised, which is so aptly articulated by Cardinal (1984) above. This is confirmed with research by Peterson et al. (2008) where research participants commonly stated that they hid their diagnosis from family to protect themselves, maintaining their managed identity. The individual then begins to isolate themselves, behaving in self-protective ways in anticipation of stigma related rejection, creating a negative loop leading to greater isolation (Cacioppo & Patrick, 2008; Loch & Rossler, 2017). In my view, these components both individually and when combined, help create the silence and 'everydayness' of our mental dis-ease as they are kept hidden. This leads to the unfortunate outcome of remaining isolated and distressed, not seeking help.

Figure 9. Cycle of self-stigma inspired by the definitions of self-stigma

Seeking help

"The resistance which my mind offers to opening these doors is formidable" (Cardinal, 1984, p. 170).

People in need of mental health help tend to distance themselves from potential help to avoid any association with a potentially 'mentally deficient' label, referred to as 'label avoidance' (Corrigan et al., 2011). Research with young Australians found that mental illness was viewed as a personal weakness confirming the stigma, and consequently, hindering the process of help-seeking, and the stronger the view that mental illness was a personal weakness the less likely they were to seek professional help (Bee Hui Yap, Reavley & Jorm, 2013). Later research by Cheng, Wang, McDermott, Kridel and Rislin, (2018) indicated a significant number of their college student sample, who had greater self-stigma and lower mental health literacy (for example, attributing anxiety to stress rather than a chemical imbalance), were less likely to seek psychological or counselling help. Furthermore, Zaske (2017) and likewise Cheng et al. (2018) suggest that perceived stigma and the fear of being stigmatised not only inhibits those in seeking help but those that start treatment potentially not completing treatment with the added consequence of keeping them from pursuing their own life goals. This is the paradoxical outcome, needing help but not be able receive it. Cheng et al. (2018) add that recognising a problem with one's own mental health is the first step in seeking help and aiding this initial step is mental health literacy. Simply put stigma is a major barrier to recovery to mental illness (Yeh et al., 2017).

In New Zealand, Curtis (2010) notes that "although young people are at a high risk of suicide behaviour, young people are unlikely to seek help, especially from professionals, and the small percentage that do may be at less risk that the remainder" (p. 700). Comments detailed by students in this article confirm this, stating that:

> It's seen as a weakness. Suggesting it can be a slap in the face, and I think you don't realise how much the tough Kiwi thing affects everyday life. You can't show you are struggling with something – especially struggling emotionally (p. 710).

Most heartfelt was Curtis' later comment being "yet despite suicidality being relatively common in this sample, concern about stigma, and the potential harm to relationships was a key factor in choosing not to seek help" (2010, p. 713). This perception of weakness appears not to be uncommon. Williams et al. (2017) citing statistics from the 2003-2004 National Mental Health

Survey, indicate that nearly two out of five people did not seek help for a mental health disorder or mental distress, concluding this cycle of self-stigma.

Conclusion

Stigma, from these understandings is an influential component entwined with the human need for connectedness, while conversely entrenching insider and outsider status and belonging. Stigma, I put forward, has a significant impact on our mental health that is largely invisible. Furthermore, from the historical and visible signs of stigma to the invisibility of shame and secret inner lives, stigma, self -stigma and their associated processes are, I suggest, a significant driver in the everydayness of mental dis-ease that is current today. Stigma learned in childhood, leads to a process of stigmatising, presented as a cycle of labelling, stereotypes, us and them, with status loss and discrimination leading to unequal and damaging outcomes. This process can lead to the cycle of self-stigma, a cycle of self and societally perceived difference, which is then internalised leading to diminished self-esteem and self-efficacy. The outcomes of both cycles are significant, in inhibiting recognition of the problem, not seeking help, and leading to a managed, secret identity. In New Zealand, a high incidence of not seeking help was noted, reflecting the belief that seeking help was considered a weakness. In conclusion, stigma and stigmatising cycles are processes that today are invasive and invisible, and combined with the first finding, the 'need of connection' lead to the third finding, the Force.

The Force

I arrived at this third finding having reflected on the historical base, and I can see that this base, although its purpose originally was to hold me, to give me space to reflect, to ponder and play as Hermes did, has now amplified into something much bigger. This is the hermeneutic process, and as I have used the interpretive lens to peer behind the text it has brought me to this finding, this new horizon, to what I have named as the Force.

This Force is a continuous, intertwining braid, a strong current that links our past, our traditions and our ancestors, to the creation and experience of what I consider is the felt-silence of mental dis-ease today. The Force is not fleeting or transitory, it is a *FORCE*, a strength, an intense coercive drive that dictates how we currently view 'normal' and consequently mental health. This Force permeates our lives, it is invisible, and is so familiar that it is an everyday part of our lives, and this is what I view as

the everydayness of it. Thus, it is the Force that is silent and keeps us silent as we do what we have done before, what we have grown up with, what we feel as safe, what we have traditionally done and what our ancestors did before us. Grant and Gidddings (2002) contend that we cannot stand outside the traditions and discourses of 'our' time, and I suggest, that this is the unseen thread in the Force, the silence of the dominant discourse serving the dominant social group. The components of the Force may be known to many, however, the sum of these components, what makes up the Force, are I suggest, invisible. Therefore, it has to be named, separated, shown to be different, be made visible, shown to be the Force. Moreover, it has to be named to stop its invasiveness, to create change by making it visible to all, its everydayness needs to be made visible.

Thus, I see the Force in the history of other and othering, the articulation of the normal reflecting the current discourse of normal, as it has done through the ages. I see it in the herd, the need to belong, the evolutionary force needing to connect for survival, along with the fear of being outside the herd, outside the mainstream. I see it as stigma, in the cycles of stigmatising and self-stigma, keeping the insiders in and keeping the outsiders out, keeping those who need help, constrained. Figure 7 following illustrates my visual understanding of the Force.

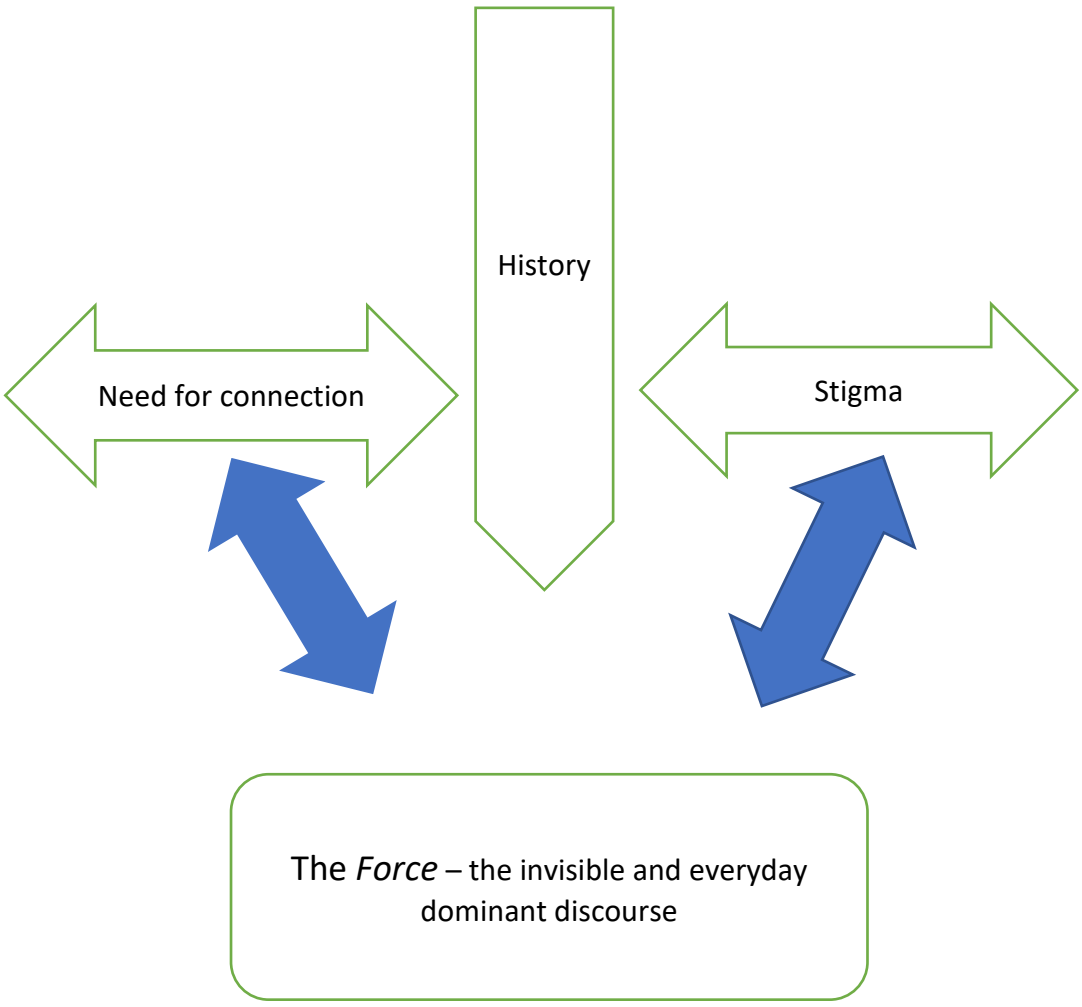

Figure 7 – My interpretation of how the need for connection and fear of stigma feeds, maintains, and intertwines with the Force

In describing and communicating the Force, this coercive drive, I wondered how it had influenced me, my growing up, my felt-understandings of the myth of 'normal' visible as the silence, and how the components of the Force had kept me stuck? Now I see that in learning about difference and other as a child. I learned that to be safe I had to stay within the herd and I had to support the mainstream for fear of being on the outside, thus, aligning with my environment's construct of 'normal'. I can see that in maintaining the normal, the Force, I stopped any thought of help seeking, remaining in my wondering of difference, my own wrestle and felt-tension with 'normal'. These discourses, what I call my 'knowing', have over time become the norm reflecting 'everyday knowing' or in my view, the everyday silence of knowing and not knowing, visible and invisible. These are the effects of the Force.

A lived human life

People in good health can, for instance, be sad, angry or unhappy and this is part of a 'normal' lived human life (Galderisi, Heinz, Kastrup, Beezhold & Sartorius, 2015*).* Everyday problems of living can be labelled within medical discourse as pathologies, for instance, 'depression' or 'anxiety', however, they are potentially the result of significant deficits in housing, employment, and social services (Horwitz & Grob, 2016). Therefore, the social deficit as the core issue is not addressed for a myriad of reasons potentially becoming invisible and part of the Force. In New Zealand, Durie suggests that by focussing on the life situations of people, that is, the cognitive and emotional symptoms associated with poor physical health and living conditions and, not the disorders, current health services can promote wellness throughout the life of an individual (as cited by Williams et al., 2017). Virchow expressed this more poignantly and said "… the improvement of medicine would eventually prolong human life, but improvement of social conditions could achieve this result more rapidly and successfully" (as cited in Germov, 2009, p. 9). Thus we have emotions and we have stressors of living, and if these are constructed negatively as failures and otherness, as have appeared to have

been done historically via the Force, then our negative perceptions of our human-ness and health will result in escalating mental health struggles as seen in our mental health statistics.

Is normal not normal?

Observing this Force and its everydayness, its articulation of normal and different, I wonder at its influence on our perception of function and dysfunction in current mental health discourse. Horrifyingly, does the Force perpetuate an illusion of normal, that if we were able to stop and observe, is not normal, but dysfunctional? Moreover, is our reality, for instance visible in our human and societal constructions of money, trade, busyness, house and home, and pollution of our world and so on, actually a thinly veiled 'madness'? Do we perpetuate this myth of normal in fear of our true reality? Was this the myth of normal that I wrestled with as a child? Does the query to help-hindering behaviours lie in the Force and its everydayness?

Moreover, are the outsiders, those outside the herd, the mainstream, struggling in a fight against the Force? Are they branded by the normal in trying to maintain a normal, their normal, that is different? Within this, does illuminating the Force into something visible help articulate the everydayness of dis-ease that if expressed on a continuum is normal to all? I have asked these questions not to lead to or suggest answers but to highlight the journey that has led to this arrival, to this point in the journey. This point is an arrival to these questions, these horizons, a point to commence a new hermeneutic spiral, a future direction.

Conclusion

The Force heralded an arrival in this journey. It spoke to and acknowledged the force of history in our present-day understandings of mental health and ill health. As depicted in Figure 7, our need for connection and the understandings of stigma act as lateral, coercive drivers of the Force. They both contain and maintain the Force, keeping it invisible, by threatening our need for connection, highlighted by insider and outsider status. The Force distracts the individual from their own human-ness, indeed, blame is given to individual for their disorder with the life situation removed from the equation. These conclusions now lead to the discussion of these results

Chapter 4. Discussion

The hermeneutic way

In this discussion, I have endeavoured to weave together the threads of my findings, the findings that emerged from my base, creating the whariki, the woven mat. As I have sat on this whariki, woven with my understandings and my interpretations, I have pondered, endeavouring to peel back the layers of meaning, leading to the exploration of new horizons, to arrive not at *the* answer, but *my* answer.

When I walked backwards into history, I was able to stand and observe this journey of madness from a distance, albeit this was from a position of power and judgment reflective of my interpretative stance. In this position however, I also wrestled with immersion in the social constructions of *my* time, and what I have perceived as my societal 'normal'. This position has both been my hermeneutic circle and my hermeneutic spiral. The former has given me tools to explore and the latter, moving me deeper into understanding not just the words describing this history but what is hinted at, unspoken or has emerged as an overarching tenet growing over decades or millennia. These threads have also taken me in and out, and finally, around the hermeneutic spirals, moving between the parts and the whole and back again.

My search for an answer to the question *'*how have we silenced the 'everydayness' of our mental dis-ease, in mainstream Aotearoa, New Zealand?' started with a review of the history of madness. This was for the purposes of creating a base or a springboard to explain why I felt a constraint that still exists in society today. All the while I was aware that my prejudices and biases, fore-meanings and structures of thinking would influence my interpretations and understandings; reflecting the hermeneutic process. This history of madness (including influences of the myth) led to my articulation of the Force. The Force reflects on and embodies what Gadamer called a 'fusion of horizons' (as cited in Moules, 2002). This is the hermeneutic way. And, as I finish writing, I again wrestle with 'is this enough?'. This reflects the place where I now stand, different from before, with new horizons and possibilities stretching before me.

My question and everydayness.

My original question, 'how have we silenced the 'everydayness' of our mental dis-ease, in mainstream Aotearoa, New Zealand?' was difficult to define at the start of this journey. This

question has since developed into asking 'how has the Force and *everydayness* silenced mental dis-ease in mainstream Aotearoa, New Zealand?' This everydayness is critical because as part of the Force it is silent, and invisible, and such a familiar part of our lives that we don't see it or look for it. Put simply, it has become *everyday*. The Force and its everydayness permeate our culture, and our lives. Critically, it the lens by which we view health, and thus, health discourse. It has the strength and dominance of hundreds of years of visible and invisible history, which both nurtures and maintains its presence. Its momentum is ongoing. It is a dictator; threatening those who attempt to make it visible by 'othering' them, pushing them out of the herd.

Further, we unknowingly feed the Force's power by failing to acknowledge its presence in the everydayness of our lives. From this position, more questions arise. For example, is the Force embraced as an 'everybody is doing it, so it must be right' assurance? Or is the non-acknowledgement symptomatic of not wishing to engage in the painful realities of our human-ness. Additionally, is the Force confounded and enforced by the societal binary of normal and different? This process of non-acknowledgement has been eased and enhanced, I suggest, by the embrace of *reason* embodied by measurement. By measurement I mean a measure of what is normal and what is different. Those who are 'normal' are deemed safe in knowing they are normal. Like an anchor, this view orientates the normal to support the Force. Consequently, the not-normal are defined as outsiders. Moreover, where no orientation is available, there is often a need for a culprit, someone or something to blame. In other words, as an alternative anchor. I wonder if the outsider becomes the person to blame and is labelled the culprit because, with their outsider status, they are easier to blame? They are a natural target of victim.

So what?

This arrival, however, abruptly took me down to the bottom of a spiral, it confronted me. *So what?* My hermeneutic journey now led to this question. 'So what' if history, stigma, and our need for connection fuel the Force? So what if the Force is silent but dominating, keeping me and others stuck in an illusion of individual and societal health? Are we not okay as we are in the mainstream? Does the Force, the everydayness of our living, our willingness to embrace this Force really matter? Mental health is being resourced, I am practising psychotherapy, I am helping people who are struggling and, in light of this, I have a felt-sense of both wonder and completion. Hence the question 'so what?' confused me. In my struggle with this question I reached the bottom of a spiral that had depleted me of words. I felt empty, stuck, tired, and unable to read or write. This emptiness seemed to last weeks. I wrestled with it, fought it, and wondered at its all-consuming

invasion. It held me stuck and unable to move forward. What was this *so what?* The answer arrived, as it commonly does, in waiting, in bearing the flux, and it was shocking. It had been staring me in the face but, in my fear, I hadn't seen it. Its presence, like the Force, had been invisible. With its arrival I felt diminished, poleaxed, and lost for breath.

The answer was simple. The 'so what?' confronted and challenged my felt-need and desire to be part of the herd or the mainstream, where I feel safe and anchored. I did not want to be different or perceived as different. Being different feels too hard, too tiring, and it is easier to glide along with the mainstream, and to abide by the rules of the Force, and be part of its everydayness. This feels shocking. I further realised that this shock at my 'so what' was borne out of a fear in recognising that I have a choice to see and acknowledge the Force, the illusion of 'normal' and perhaps most significantly, that I can choose to be different. My journey has made something visible that was invisible. It has created a voice which hasn't been heard before. This new c*hoice* wants me to proclaim a decision, to choose to *do* something differently. But it is too hard. It is too scary. My anchor to and, safety within the Force feels too strong.

From another perspective, and in the context of New Zealand's chilling mental health statistics, is this feeling an example of the Force and my reaction to the question 'so what?' In querying 'how do we not see we are perpetuating the problem?', am I colluding with the Force through personal choice, whether consciously or unconsciously, by inaction? Further, in choosing inaction, what is the consequence? What will happen then? This is the 'so what' question.

The felt-irony of my 'so what' continues. In presentation of this study, a squirming acknowledgement arises within and is articulated as a deeply felt wish to fit in with the mainstream. I desire this study to be viewed as worthy and not just a pass, but a mark that confirms overtly that I fit with the mainstream, the herd. This presents a conundrum within me, a desire for a mark that publicly affirms my 'fit', running parallel to or juxtaposed against the deprecation of the desire to fit. I am wrestling with the knowledge of what I have made visible, what was previously silent. My investment in a 'good' mark, or my desire to do well is a tangible expression of my part in acquiescing. It demonstrates my commitment to my role in maintaining the Force. Conversely, while attempting to stand outside the Force, I am trying to articulate what I believe to be invisible. If I make the Force visible, I risk my difference and outsider status being confirmed. If I fail to establish the Force's presence in society today, as the Force dictates, I remain safely in the herd and the Force

remains invisible. This is the dilemma of the Force, acquiesce to the mainstream, or be ousted as other and different.

Meaning making and some implications

The individual

The impact of the Force and its components on the individual are significant. In terms of the mental health statistics discussed initially, the Force is also potentially devastating. The impact of the historical forces of physiognomy, constructed social norms, and separation of the 'other' provide a felt-sense of safety for the 'normal'. This is visible in the processes of stigma which have created a culture or mainstream body of thought that has enveloped us and kept us stuck in the illusion of 'normal'. This illusion, invisible and silent in nature, is the result of society's acceptance of the separation between 'normal' and 'other'. This normal, with the support of the components, the need for connection, stigma, and the Force, keeps those who have the felt-sense of being 'other' or different to hide their felt-sense of shame or failure at their human-ness while yearning to be *normal,* mainstream, to keep within the herd. This inadvertently feeds and sustains the illusion of normal. In keeping this illusion growing, the individual not only keeps their own 'other' hidden, in doing so supporting the mainstream 'normal', but is unable to acknowledge their 'other'. Perhaps, this felt sense of weakness, expressed as normal and other, keeps many people stuck in their misery and confusion, and unable to ask for help? Is this the outcome of 'it's seen as a weakness…' (Curtis, 2010, p. 710)?

The therapist and therapy

In approaching and attending therapy, the client has taken a significant step in acknowledging the part or parts of their 'other' and their not 'normal'. However, the historical and cultural discourses, expressed as the Force and as 'normal and 'other', are in tension with the client's need for connection. The felt sense of 'stigma' may be hidden in layers of distress that impact on their therapy and, unknowingly, not only inhibits their commitment to therapy, but the initial sessions and ongoing session, and the therapeutic process. Additionally, part of these mainstream cultural beliefs may, as Roach Anleu (2009) states, reflect not only the social constructions of normal and abnormal, but how the biomedical model has interpreted and categorised illness and health. For instance, pathologising distress that may be an acute expression of dis-ease and the everydayness of the Force.

Our evolutionary influences, attachment styles, and the subsequent effects of isolation impact on stigma and self-stigma. This gives psychotherapists additional insights into what clients are experiencing, thinking and feeling, with further avenues to explore. This human-ness and felt outsider status can be over-shadowed by the visible and proximate traumas and dysfunction that clients bring to their therapy. In psychotherapy, clients are encouraged to explore the full range of their emotions in a safe and holding environment (Weiss, 1993). This component of therapy can be expanded to explore the social and environmental mental health discourses that the client may unknowingly be living. Indeed, discourses which may also be keeping them constrained due to historical and culturally learned patterns of behaviour. In bringing these understandings into therapy, this may encourage the client to understand their need to belong, in tension with their fear of not belonging. Further, it may help to understand the felt sense of stigma and its associated components and processes. Understanding current social constructs, that is, the Force, may help the client reframe their perceived difference in order to further support the therapeutic relationship and therapeutic process.

Finally, therapy may provide the opportunity to articulate and encourage health literacy. This is the ability to differentiate between general life challenges, stressors, and the symptoms of mental disorders (Cheng et al., 2018). This then assists the client to understand the influences of their own upbringings whether in New Zealand or further afield. This could create a ripple effect, where potentially help-hindering behaviours are acknowledged and consequently, others are encouraged to explore and embrace help-seeking behaviours.

Training and policy

The impact of the Force on training, education and governmental policy is potentially significant. However, some questions still emerge; similar to questions that have been discussed above. For instance, is psychotherapy possibly just another herd with notable good intent, supporting the silence but from a different stance (involving self-sacrifice and portraying the face of beneficence)? Further, do training and policy (within for instance, both government and DHBs) unintentionally and unknowingly maintain the mainstream or the illusion of the Force and everydayness? Does psychotherapy training and, on a macro level governance and policy, need to reflect on the acquiescence and maintenance of the Force and its everydayness? Does this acquiescence perpetuate the Force, the mainstream, the illusory perception of normal? All of these concepts are visible in policies that maintain the conditions which, I suggest, are visible in New Zealand's mental health statistics, high suicide rates, New Zealand's high incarceration rates, and, perhaps even in our high poverty statistics? If this support of the Force and its everydayness is maintained, then is the

upward trajectory of these statistics likely to continue? The difficulty is to step outside of this thought process or feeling, to be different and other, and potentially risks marginalisation, othering, and discrimination. These dilemmas narrate a choice; a choice to make visible the Force, to step outside it and, this was represented by my experience of being stuck in my 'so what'.

What are we failing to notice?

The range of what we think and do
Is limited by what we fail to notice.
And because we fail to notice
That *we fail to notice*
There is little we can do
To change
Until we notice
How failing to notice
Shapes our thoughts and deeds.

Laing shares his thoughts on 'noticing' in this short poem which reflects how we excel at not noticing (as cited in Zweig & Abrams, 1991. p. xvi). This poem encapsulates my perception of not noticing the silence around the Force, and our dis-ease.

We are an island nation, and yet we are entangled with an economic and global world based on neo-liberal policies that, I suggest, significantly influence how we live. We aspire to an individuality, except the Force suggests to me, that we adhere to the collective way of being and of living, while living with these opposites felt as a tension. Is this tension also the felt-sense of an illusion – the illusion of the ideal of health, happiness, freedom and of individuality? Or is the illusion that we believe we are doing the right thing, and are being duped by the Emperor's New Clothes? Or is the illusion dis-eased and like the Emperor's New Clothes we refuse to see what is right in front of us? Are there two realities that seep into each other? In one reality, is there the madness of the western world where people collectively choose to live, unsustainable, and living in a way that does not make sense but is brutally present? In the second reality, does the mainstream support this illusion and this dis-ease, because of the Force, thus, maintaining a sense of continuity, a direction that helps sustain our identities, preserving the dominant discourse? Claiborne et al. (2014) suggest that New Zealand as a nation values individuality and fairness, and therefore, is less influenced by euro-western knowledge as an authority. I disagree and wonder if there is a void in our national identity, a felt-sense of searching for belonging that manifests as a collective malaise that the Force hides.

Strengths and limitations

In reflecting on this exploratory journey, I have learned much, including obtaining a greater understanding of my childhood 'normal'. Importantly, I have both a felt sense and intellectual appreciation of the multiple factors that have been influential in creating and maintaining this silence and myth of normal. I am cognisant that this discussion is potentially an answer, or answers, but not necessarily *the* answer. This is not disappointing as the door remains open to further questions and theories to explore, reflecting the validity of this research. Moreover, this reflects the hermeneutic process of which my interpretations, biases, and perspectives are a formative part. I concede that the factors explored are the ones I considered relevant to understanding New Zealand's discourse on mental health. However, they are not the only factors, and this may be considered a limitation of this research. A different researcher, with their own unique childhood experiences may have created a different base to spring-board in a different direction, to a different outcome. This reflects the transferability of this research and the hermeneutic process.

A second limitation emerged from some imaginings in cobblestones. I spent many years in England and, coming from New Zealand, loved the historical structures, the old buildings, and the cobblestones. I have often wondered about these visible cobblestones, embedded in the ground, embedded in history, the events of life brushing each cobble then moving onto the next. They are held by the ground and in turn, hold what is above. They direct us, hold us, and keep us on the path moving forward or backward but not off the path. Within these imaginings and the Force, I have wondered about 'change' and the 'ability to change'. Do the cobbles hold too strongly to those who walk upon them, inhibiting change or making change more difficult? Or, alternatively, is the change more predictable, slower, and easier to embrace because of being held by the cobbles? With these cobbles in mind, I have contrasted the position of New Zealand's history with no cobbles. Are we able to embrace change more easily? Are our roots shallower and our pathways imported? Is our history visible only in our land? Is 'our' Force of history less powerful because we do not have the physical and metaphorical cobblestones? In other words, is there less to hold us and less to feel held by? Is our history, or the historical Force less directive, and like pieces of flotsam on the water, we are buffeted by international currents and trends, not held by our history? Are we holding on to a conventional colonial connection that is possibly frayed, tenuous, perhaps now even imaginary?

Importantly, what of our indigenous people? I wonder if the land is their cobble stone. Their knowing of their cobblestones is much closer to an 'of' the land knowing, in tangata whenua. From the mainstream perspective, they are the indigenous people. From their perspective, they are the tangata whenua, same meaning yet two different perspectives. In the colonising process, were the

tangata whenua forced to adopt the mainstream discourse, a new way of life, and an economic and culturally different reality? This reality may have reflected the Force, embedded in everydayness, which they knew to be spiritually false, unsustainable and detrimental to their well-being? Is this the Maori malaise, not just the disenfranchisement and legislation subduing and dominating Maori cultural practices but the 'mainstream discourse' (Bennett & Lui, 2017; Williams et al., 2017)? And is this what has been transferred through generations? Moreover, it must be asked, have we projected onto Maori our collective shadow or the shadow parts of our mainstream discourse, expressed in the 'silence', in the Force (Zweig & Abrams, 1991)?

These questions have emerged as I have related parts to the whole, and back again, creating new horizons while engaging in the hermeneutic circle. Likewise, they are points of arrival, directing the pathway to the next spiral. However, they speak to a significant limitation. My intention in this study was to find my meaning-making by staying within *mainstream* and consequently, Pakeha discourse and to not step outside this. By staying within this frame, to view the multiple dynamics from within the frame itself I have been able to make visible the silence, and the silencing dynamics. However, not looking at the Force and the everydayness from a different cultural lens has been a limitation of this study and one that has rich potential for further exploration.

Gaps and Future Directions

Much is beyond the scope of this research journey. Nonetheless, there are gaps that have been highlighted suggesting future opportunities in peeling back more layers, acquiring deepening understandings, seeing new horizons, reflective of this hermeneutic journey of discovery and interpretation. In describing the history of mental health New Zealand much has been missed. Furthermore, research into teasing apart and deepening our cultural understandings of New Zealand mental health discourse may benefit the visibility of psychotherapy as a preferred therapy option. For example, greater understanding of help-hindering behaviours embedded in the New Zealand cultural mainstream discourse may give the opportunity to specifically target these obstacles. As mentioned, psychotherapy as a therapy of choice seems less visible compared to other therapies such as psychology, CBT and counselling.

Other opportunities for future research could potentially explore the influence of gender (male or female perspectives), matriarchal or patriarchal ideologies, and/or the influence of ethnicity on mental health using the Force and its everydayness as a pointer, a framework. Nor have I discussed the effects of the intergenerational transmission of mental health beliefs that may be impacting

individuals, yet research indicates that stigma is primarily learned in the childhood, in the home environment (Mueller et al., 2016). Further topics include teasing apart the fear of the threat to self, which for instance, may be visible in an 'acting-out, a survival strategy of the Force; potentially leading to understanding help-seeking and help-hindering behaviours that are embedded in the Force and its everydayness. I think these would be rich topics to explore.

This segues into a significant gap that this work has not been able to explore, that is, traditional and current Maori perspectives. This feels like a significant loss with Maori, as detailed in the introduction, experiencing a higher incidence of mental health challenges than non-Maori. Traditional Maori mental health understandings support a collective context as compared to the western framed individual, biomedical model of medicine (Bennett & Lui, 2017; Germov, 2009). These fundamentally contrasting perspectives allude to a tension at the primary and cultural level of care. Moreover, Bennett and Liu (2017) suggest that "a secure cultural identity may mitigate the effects of exposure to adversity" (p. 96), however, expanding this concept is beyond the scope of this study. Future research could explore this pathway of how New Zealand cultural identities have been socially constructed with multiple influences, additionally, leading to therapeutic understandings for both therapist and client.

I briefly discussed attachment theory as part of the human connection paradigm, however, this was limited and left many gaps that invite further exploration using a psychotherapeutic theory framework. Moreover, I suggest psychotherapeutic theory could deepen the understandings I have shared of stigma, the human need for connection, which combined with the history of madness led to my concepts of the Force and the everydayness.

In this literature search I have briefly touched on social constructionism and tangentially, the systemic culture of health. Roach Anleu (2009) describes this as humans making meaning of their reality and constructing meanings to describe this reality. Claiborne et al. (2014) further suggest that this discourse describes the social constructions that are so taken for granted that they appear invisible, and yet are dominant and powerful. Mainstream discourse in New Zealand regarding our attitudes to mental health is, I suggest, and in general, negative, with much hidden and unspoken as described by the Force. Exploring these mainstream social constructions and discourses further, would I believe, illuminate more of what has been silenced.

Fulford, Sallah and Woodbridge (2007) suggest a perspective from a post-logical empiricist philosophy would support multiple ways of approaching mental health, rather than the current singular, bio-medical scientism, oriented model. Linking into mainstream discourse, social

constructionism and post-logical empiricist philosophy suggests an exploratory perspective to move away from our normal and abnormal classifications. This, for example, is where some culturally normal modes of distress are interpreted as pathology, discussed above and as seen in the DSM or the ICD. Combining the authoritative influences of psychiatry and psychology with the influence of the DSM and ICD supporting mainstream discourse and the concepts of the Force and everydayness may be another avenue worthy of exploration. However, I do contend, that this method of classification is less authoritative and directive within the discipline of psychotherapy. The examination of this topic may also highlight ways in which psychotherapy could become more available and visible in New Zealand.

In conclusion

At the start of this journey I asked, 'how have we silenced the everydayness of our mental dis-ease, in Aotearoa, New Zealand?'. This question has developed into 'how has 'everydayness' silenced mental dis-ease in mainstream Aotearoa, New Zealand?'. This everydayness was articulated as a Force, a silence that has not just trickled down through history, but has been a growing strength, a powerful presence. This Force is a dictator, using difference and othering to control, threaten, and to punish by excluding those that wish to articulate or choose difference from the felt-safety of the herd. This Force permeates our culture, our felt-sense of normal and yet, is invisible, silent. It manifests as a dis-ease, a felt need to remain safe within the mainstream, paradoxically confirming and isolating those who are different, those who are outside the herd.

The exploration into the history of madness, the need for connection and stigma resulting in the Force, has impacted my internal anchor, where I stand as a psychotherapist and importantly, my view of my world. I have articulated my concept of the Force and the illusion of normal, and this has given me an expanded perspective, a different standpoint from which to see a new horizon. In making visible the Force, I acknowledge my own part in creating and perpetuating the illusion of normal. With this knowledge, I have been presented with a choice, to stay within the mainstream, or move out of this strong current, move outside the herd. This choice is another binary, both liberating and terrifying. Liberating, as I no longer feel driven to support the momentum and influence of the Force and no longer need to corroborate with or appease my felt-tension of normal. Nonetheless, this choice is potentially terrifying, as I feel unsure of this new standpoint, this new horizon. From a therapeutic and therapist perspective this horizon may support greater understanding of the 'normal' of the client, with an opportunity to explore their perspectives and

felt-sense of normal. But perhaps this is contingent on my ability to use this knowledge and make this choice, to stand outside the herd.

I am grateful to have had the opportunity to explore my passion articulated as the felt silence, sustained by the hermeneutic philosophy that supports both academic rigour while empowering the interpretive lens. This framework gave permission to explore and play with the text and literature, choosing new pathways, while highlighting the importance of taking time to consider my biases and fore-meanings, ultimately leading to converging ripples, new horizons. Within the hermeneutic paradigm this is an arrival, the start of a new spiral, however stepping outside this paradigm, I am left in a flux, with knowledge but no reference point, aware that I might be potentially standing outside the herd, forging an unknown path.

As this journey concludes, I ask if this study has connected some of what makes up the 'how' everydayness has silenced mental dis-ease in Aotearoa, and what are the threads, the components, the influences? In doing this, can I also articulate an answer that communicates what David Seymour was so afraid of and finally, what is the myth?

David Seymour warned his constituents that some of the residents in the Housing New Zealand development may have social and mental health issues. Reflecting on this research journey, I can now understand and express Seymour's felt fear of the other, the not normal, the different, the outsiders who sit outside the constructed discourse of normal. Seymour unknowingly articulated this silent and felt-fear of the 'other', the myth that portrays our construct of mental illness and mental health. He unintentionally shared his felt-sense of the Force, how it has shaped his outlook, his cultural lens, supporting his mainstreamness, his need to belong to the herd, and how to keep safe from the other. The Force feeds the need for connection, the practices of stigma, keeping the 'other' separate, constrained by their cloak of their other, outsider status. It has been present throughout history, imported into New Zealand, embedded by the colonists into mainstream discourse until it was invisible, a part of ourselves, unseen. Alongside this Force, is our bio-medical model that historically separated our physical health from our mental well-being, classifying symptoms and constructing illness, determining the normal and the not normal, and consequently, how people should be treated (Roach Anleu, 2009). It is perhaps time to make the invisible visible, understand our human-ness and see our illusion of normal, the Force, to see the Emperor's New Clothes.

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