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Caseness and Narrative: Contrasting Approaches to People Who are Psychiatrically Labeled

Michael A. Susko
Essex Community College, Maryland

This article contrasts the Caseness and Narrative approaches for treating individuals who are psychiatrically labelled. In *Caseness* a "mental health professional" negatively values those symptoms believed to be caused by a physical pathology. In the subsequent labeling of the "patient" a transfer of ownership of the person's body to the "medical system" occurs. Intervention ensues, by coercion and force if deemed necessary, to stop symptom expression. In contrast, the *Narrative* approach looks upon periods of distress as potentially transformative experiences within the context of a life story. The complexity captured by a "narrative web," the emphasis on a dynamic self able to make choices, and a sense of closure are among the properties that Narrative highlights. This approach also helps redress the power disparity inherent in Caseness by letting the distressed person establish the discourse from which a dialogue can ensue. This article argues that the Narrative approach provides a more humane and healing context for people who are psychiatrically labeled.

Recent times have been marked by a number of autobiographical narratives from psychiatric survivors, one of the most politically powerless groups in our society (Burstow and Weitz, 1988; Oakes, 1991; Spaniol and Koehler, 1994; Susko, 1991). Because ready-made biological explanations of madness pervade in our society, first person accounts offering a different viewpoint have difficulty accessing the mass media and making any sustained public impression. Such stories, from the "inside out," compel us to re-examine the traditional Caseness approach of psychiatry.

Caseness is an intellectual construct that facilitates the objectification of a person in the medical system: the person becomes a "case" or is primarily perceived as one. This article critiques the Caseness approach which dominates the mental health system and contrasts it with a Narrative approach. In brief,

Requests for reprints should be sent to Michael A. Susko, 1927 St. Paul Street, Baltimore, Maryland 21218.

Caseness emphasizes making a diagnosis of illness and stopping its symptom expression. The Narrative approach, on the other hand, supports individuals coming to their own voice by allowing their story to unfold and to be told.

A narrative segment from *Cry of the Invisible*[1] (Susko, 1991) illustrates the basic difference between the two approaches. Joe Green tells of an incident at a state hospital:

> Due to my excessive spiritual reading and my disorientation I started to act out the things I had read. I would throw books on the floor and think I was waking up humanity by vibrating the spiritual energies throughout the earth. An attendant noted this. That night, another attendant took me into a seclusion room and physically wrestled me to the floor. Somebody else put a needle in my back side. They shut me up all night . . . . (p. 198)

Although Joe was trying to awaken humanity, he woke a few attendants instead. No one asked Joe why he was throwing books on the floor, or tried to find out what he meant by "vibrating the spiritual energies of the earth." The Caseness approach required no further explanation for Joe's behavior, having already established that he was "paranoid schizophrenic." Joe was not encouraged to communicate the meaning of his "acting out," as this might be viewed as encouraging the disease (Miller, 1991). Instead, Joe learned to hide the expression of his inner thought — becoming in effect *invisible*. As he goes on to report:

> The next morning I was more docile, frightened. This is what they wanted: orderly, behaved people, so they would only have to observe. From then on, I didn't act out because I would be thrown in seclusion and get the needle. (p. 199)

The Caseness approach labels the unusual experience as a disease entity and seeks to maintain this label — separating the person from "normal" people. The Narrative approach, on the other hand, seeks to place the life story with its difficulties as part of a *common* human experience.

Until the 1860s it was routine for the patient's own account of his or her illness to be taken by ward clerks upon admission to any hospital (Risse and Warner, 1992). This practice of allowing narrative meaning was lost as medicine's attention to what was *natural* for the sick individual — allowing for idiosyncrasy — was supplanted by what was considered *normal*. Clinical practice became increasingly obsessed with comparing "measurable signs" to "standardized norms" (p. 192; see Canguilhem, 1966/1978). A more systematic comparison of Caseness and Narrative, using examples from experiences labeled as schizophrenic, is presented below.

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[1]Throughout this article the author draws on examples from *Cry of the Invisible*, an anthology of first person narratives that he collected and edited from several psychiatric survivors.

The Caseness Approach

The Caseness approach consists of three stages, which follow and reinforce one another in a circular way: (1) identifying target symptoms; (2) making a diagnosis; and (3) intervening to stop or manage symptoms. I will critically examine the assumptions underlying each stage.

Identifying target symptoms. The initial assumption is that a pathology is the sole cause of symptom expression. A hidden and more significant assumption is that the symptoms are to be negatively valued.

Modern allopathic medicine does not typically pay attention to patients' interpretations of their symptoms and illnesses — much less their positive regard for them. Originally the word *illness* signified what the disease meant to the patient while *disease* referred to physical pathology (see Cassell, 1985). In the book *Intoxicated by my Illness*, Broyard (1992) illustrates this view when he describes his search for the "positive metaphors of illness" (p. 18). But generally in recent times, symptom (the person's expressed distress) has collapsed to *sign*, a biological marker (Charon, 1992).

Other societies have not always held such a restricted view. Suffering had meaning and served as an opportunity for cure and spiritual advancement. Indigenous cultures might interpret illness as a "call to enter into association with powers you are less familiar with" (Sullivan, 1993, p. 6). A recent survey cited by Bynum (1991) found that over half of female medieval saints had illnesses that were an integral part of their sanctity. In modern times homeopathic medicine has sought to enhance symptoms to effect cures (Bayley, 1993).

But for mainstream culture, disease, illness, chemical imbalance, and genetic defect have only a pejorative meaning. Where productivity and "survival of the fittest" are heavily valued, disabled people or those who drop out of the work force are stigmatized (Frank, cited in Farber, 1993). The concept of a "diseased mind" carries connotations that are doubly negative. Not only does it evoke disability, but it arouses fear — and implies that a person is not responsible for his or her mind, or is difficult, unpredictable, and potentially violent. The net effect is a marked lowering of the individual's social status.

A second assumption in identifying symptoms is that they can be targeted, i.e., *decontextualized* from personal, familial, and social/historical experience. The phenomenon of "mental illness" is seen as "independent of the environment" (Crammer, 1990, p. 11). This view originates from casework which reduces the personhood of the patient to "a series of medical facts" (Smith, 1993, p. 128) that ignore one's hopes, dreams and fears.

In reductionist thinking the mind is considered a function of the brain. The medical model does not consider that multiple levels of meaning can exist simultaneously, and that any one level can dominate in a given instance. It ignores, for example, that subjective feeling can precipitate

bodily changes, that *after* a feeling "molecules materialize" (Pert, 1993). A dynamic body/mind interaction can give weight to both subjective and bodily meaning. Jung (1958/1991) held that the "more physiological" functions (such as eating and digesting) are intimately related to the "more archaic and 'deeper' symbols" (p. 147).

Joe Green, in his narrative (Susko, 1991), states that his problem was "due to my excessive spiritual reading and my disorientation." Prior to his hospitalization, Joe relates that he experimented in meditation practices, "high energy frequencies" as he later termed it (personal communication, September 1993). In order to "ground himself" while in the hospital, he tried to awaken "the lower frequencies of the earth." Thus, the symptoms, in the context of Joe's story, were an attempt to find his spiritual/physiological balance. Healing the body by making physical contact with "earth energies" has a long tradition among indigenous peoples, as in the Australian aborigines (Mowaljarlai and Malnic, 1993, p. 81). Thus, Joe's so-called acting out not only makes sense in the context he establishes, but in a political way — as an awakening of Western humanity at this historical time, one that seeks to make contact with the "Mother earth" and with ecological values.

Recent versions of *The Diagnostic and Statistical Manual of Mental Disorders* (from the DSM-III to the DSM-IV) make evident the mental health system's drive toward decontextualization. Attempting to be "apolitical," the manuals' authors constructed a "theory-neutral definition" of disorder (Wakefield, 1992) using phrases such as "not be merely an expectable and culturally sanctioned response" (American Psychiatric Association, 1994, p. xxi). But such language does not escape a theoretical orientation. In a historical review, Wilson (1993) criticizes the DSM-III-R for losing the concept of "depth of mind," and "the unfolding of a life over time" (p. 408), as well as minimizing family and cultural influences. A three dimensional approach has given way to descriptions that are "superficial and clearly visible" (p. 408). Any relevance to spiritual reality has been excluded (Lukoff, Turner, and Lu, 1992), excepting a recent V code under "Other Conditions . . ." entitled "Religious or Spiritual Problem" (American Psychiatric Association, 1994, p. 685) for which insurance payment is forbidden. In short, the cost of using this "atheoretical" manual has been to bracket off the subjective dimension (Corin and Lauzon, 1992).

Is symptom identification placed within any meaningful biological context? Psychopharmacological texts and current essays of researchers admit that proof of physical *causation* of "mental illness" is lacking (Lecuona, Joseph, Iqbal, and Asnis, 1993). In a recent symposium on schizophrenia, a researcher stated that if he were captured by neuroscience terrorists and told to "prove that schizophrenia was a brain disease," he "would be very hard pressed" (Pickar, 1990). His best evidence, that 25 to 40% of first episode

patients have enlarged brain ventricles and tissue atrophy, is "a very non-specific finding . . ." about which he says, "I have in no way any implication of what that might be . . . ." In spite of these professional admissions, the disease model is offered to the public as a "scientific" fact.

There is no medical test, blood sample or brain scan that can prove the presence of a "schizophrenic illness" (Leff, 1991; Weiss, 1992). Although some patients evidence disturbance in their dopamine systems or have enlarged ventricles (Willick, 1993), these signs could derive from a number of causes in any given person. The diagnosis depends on the doctor's characterization of a self-disclosure. As Szasz (1993) says, "the evidence for [schizophrenia] is still only the fact that crazy people often talk crazy" (p. 61).

Even if there were evidence of biological differences in "schizophrenics," the Caseness approach would not be justified. In any altered (or normal) mental state, one would expect biological correlates. The brain is a very plastic organ, sensitive to experience. Pert (1993) goes so far as to say that the brain's dynamic receptors "change in shape from moment to moment." Trauma, severe mental distress, as well as drug treatment can cause brain alterations, even damage. But evidence for such changes do not prove that "mental illness" is primarily a *dysfunctional* biological event. Finally, even if "schizophrenia" were biologically based, it would not mean that "brain imbalances" warrant biological treatments. Putting a person in a more loving environment might ameliorate symptoms as effectively or more so than prescribing a course of drug or other biological treatments.

The so-called biological model of psychological distress remains an hypothesis about the relationship between certain neurotransmitters and certain behaviors. The speculative nature of biological psychiatry has led Lehrman (cited in Susko, 1993) to term it *molecular phrenology*. Within this model, Joe Green's experience is reduced to: excessive secretion of dopamine in the limbic area of the brain. Yet, despite the model's emphasis upon biology, the relevant biological context is easily missed. Many environmental toxins, illnesses, or even medical drugs can cause psychosis. Striano (1988) cites several studies reporting that from ten to 50% of patients have *undetected* physical illnesses that "either caused or worsened their psychiatric illness" (p. 6).

This raises the question of what characterizes "mental disorders" and "psychiatric treatment"? For many, the answer is obvious: a caregiver helping a distressed person. However, several forces can impinge on that ideal characterization in any given instance: the psychiatrist as an agent of control over groups that deviate from the dominant social order (Scull, 1991), including indigenous people with their "uncontrolled emotions" (Lattas, 1992, p. 4); the desire to suppress the cries of abused individuals (Miller, 1991); the wish to keep intact dysfunctional families (L. Hoffman, 1981); or a method for dealing with people who are obnoxious, an issue which the literature rarely

addresses (Martin, 1972), except for concerns with "difficult patients" who are often diagnosed with "borderline personality disorders" (see Stone, 1993). Some feminists describe the concept of madness "as a means of dismissing and controlling women" (Ussher, 1991, p. 13). In a feminist analysis of the classic story, "The Yellow Wallpaper," Treichler (1992) describes a "clash between two modes of discourse: one powerful, 'ancestral' and dominant; the other new, 'impertinent,' and visionary" (p. 195). Other factors that can compromise "treatment" include streamlining and standardization of care by insurance companies and the "managed care revolution" (Kuhl, 1994), the "selling of clinical psychiatry" to research needs (Pinheiro, 1992, p. 102), and the pharmaceutical industry and its "accustoming the physician to pharmaceutical largess" (Noble, 1993, p. 380). In his analysis of scapegoating, Williams (1991) believes that "American culture has become a pharmacy" as a way for people to "conceal their own violence by a series of substitutions" (p. 248).

All of the factors mentioned thus far assume that some persons possess "right sense and sanity" and have the expertise to identify those outside such boundaries. These "experts" determine that certain expressions of distress reflect a biological pathology, and are not in fact related to personal, family or larger societal concerns. The professional — with what could be termed a *hyper-rational* form of madness — is ready for the second step.

Making a diagnosis. The basic requirement in this stage is that the diagnostic category already exists. An examination of the construct schizophrenia, however, reveals that it is a soft one (Sarbin, 1990; Szasz, 1993). Experts disagree as to whether the entity actually exists, whether it is a single phenomenon, or whether the diagnosis is a sort of "dust bin" collecting all types of experience (Bentall, 1990). In short, there is little or no consensus on what is being measured or how to measure it (Weiss, 1992). The title of Bentall's article illustrates the diagnostic disarray: "The Syndromes and Symptoms of Psychosis: Or Why You Can't Play 'Twenty Questions' with the Concept of Schizophrenia and Hope to Win."

Professionals admit that there is no single unifying idea that can unite the phenomena of "schizophrenia" (McHugh and Slavney, 1986). Various frames of reference have been offered, including: "a disturbance of cognition" (Hall, 1992); the "failure of historicity" (Mendell, 1976); the "experience of pure objectness" (Frankl, 1952/1986); a "mystical–occult breakthrough" (Lux, 1976); and Bleuler's (1972) belief that the unity and harmony of personality is being "split up." A recent neurodynamic model, based on computer simulations, posits "memory parasitism" which "coercively draws" many different neuronal excitation patterns into a few repetitive ones (McGlashan, 1993).

Diagnosis may appear to be the end result of a diagnostic process, but often it frames which symptoms are noted and reinforced. Barrett (1988) shows

how the diagnosis directs the clinician's attention toward early behaviors which reveal "schizoid" traits and meet the diagnostic criteria, as well as to characterize the person's life history as an "epic of failures," culminating in "schizophrenia" (p. 290).

With naming comes a transfer of *ownership* of the person's mind and body to the professional. If someone's brain is diseased, that individual ceases to be viewed as a responsible owner of his or her mind/body. This logic is legally encoded in the "Not Guilty by Reason of Insanity Plea," based on the concept of "diminished responsibility." The question of ownership has not been altogether lost by some professionals as it was raised recently in the book *Psychosurgery: Damaging the Brain to Save the Mind* (Rodgers, 1992) with a chapter heading that asked "Whose Mind Is It Anyway?" Patients, confronted with forced treatment, can become very aware of the issue. A feminist woman in her 30s, who was hospitalized and forcibly drugged, tore off her hospital bracelet and told the staff, "This is *my* body." Uncomprehending, the staff made her put it back on (personal communication, June 1993). Nurses and attendants, as representatives of the medical system, function as the new owners of the patient's body/mind and use invasive chemotherapy. Some patients have portrayed the hospital as a giant "influencing machine," with their internal organs hooked to it (see Morgenthaler, 1992, plate 21; MacGregor, 1989, plate 13).

Torrey (1972) reports a "Rumpelstiltskin effect" derived from the act of naming. Because a problem is identified and named, there is said to follow a therapeutic effect — by giving the person a sense of control over the problem and offering the promise of cure. But naming can also stigmatize — the word stigma suggesting a physical embeddedness in the body. "Mental illness," which holds to some sort of bodily defect, means one cannot trust his or her body or its resultant thoughts. As for social stigma, Hubbard and Wald (1993) say that history shows that "Grounding difference in biology does not stem bigotry" (p. 95). The racial hygiene movement of Nazi Germany first eliminated mental patients or "useless eaters" (Wikler and Barondess, 1993, p. 41) before using the same methods on the Jewish people. Ethnic cleansing in Bosnia has reached a "neo-biological intensity" (Nixon, 1993, p. 6), and brutalities in South Africa have constituted a type of ethnic cleansing on the "surplus," "idle," or "unassimilable" (p. 12).

Likewise, the "mental patient" can suffer dire consequences from his or her biological label. When the realization sets in that one is vulnerable to forced treatment, that one must take powerful drugs for the rest of one's life — such that living a full life is no longer possible — and that one is caught in a "revolving door syndrome" of repeated hospitalizations, then the "Rumpelstiltskin effect" wears off and the grief sets in. Torrey does not mention what happened to Rumpelstiltskin after he was named. Brothers Grimm tell us: he "sunk into the earth" and "tore himself completely in halves."

There is evidence to suggest that those who accept the label of mental illness have a worse course in their "illness" than those who reject that identity (Doherty, 1975). Is this because medical naming reduces people and their experience to invisibility? Or does such naming lead people to vent their symptoms in yet more radical, extreme ways — making them seem even more "mentally ill"? One could argue that any person who is "freeze-framed" (R.W. Manderscheid, personal communication, June 8, 1993) with an identity as a mental patient finds that identity ultimately damaging. Establishing the ownership of someone else's body through diagnosis creates more helplessness or more extreme manifestations of symptoms. But whether "negative" or "positive" symptoms ensue, the aim of treatment is the same: stop and control symptom expression.

Intervening to stop symptoms. That the goal of psychiatric procedures is to control, manage and if possible *stop* symptoms is suggested by the frequent use of phrases like "treating symptoms" (Dulcan, 1990), "symptomatic improvement" (Nobler and Sackeim, 1993), and "normalizing" symptoms (Spohn, Coyne, Larson, Mittleman, Spray, and Hayes, 1986); and is illustrated by the choice of drugs (neuroleptics such as Thorazine and Haldol) used in the front-line treatment for "schizophrenia." (Research using psychedelics which enhanced symptom expression was conducted in the United States at Spring Grove Hospital in the 1960s and early 1970s, and recently was legalized for very limited use [Grof, 1976; Strassman, 1991].) Early clinicians labeled the neuroleptics as "ataractics" (Bowes, 1958), meaning they offered freedom from confusion or anxiety, but the later label, "major tranquilizers" is a more accurate description. According to one researcher (cited in Susko, 1991, p. 297), the name was changed, once again, to "anti-psychotics" more for political than for scientific reasons.

A basic, if unstated, assumption of the third step is that if a person's symptoms are stopped, his or her pain or distress will be lessened. In the 1950s researchers noted that the drugs' primary effectiveness was in reducing psychomotor agitation, the outward expression of distress. As for the inner feelings of delusions and hallucinations, H.L. Gordon (1958) cited studies that they were only partially controlled, with one quarter to one half of the people showing no improvement. Contemporary researchers allow for substantial groups of people who are "non-responders" (Kane, 1990; Lecuona, Joseph, Iqbal, and Asnis, 1993). As Theodora, in *Cry of the Invisible* states, "The drugs don't stop the pain but the scream of the pain" (p. 156). A person confined to a psychiatric hospital could be left in the intolerable position of being in intense inner pain without the ability to physically express that pain. And if, as some models hold, hallucinations or delusions are present to distance people from their pain or traumatic memory, then symptom removal may open the floodgates to the original pain (Hill and Goodwin, 1993). For

any given person, the question needs to be raised: will control of symptoms increase or lessen pain?

One may also ask whether it is always good to stop or lessen pain. Change, any growth experience, may cause what Jung called "the suffering of individuation." Ironically, the avoidance of pain has been said to form the essential characteristic of "mental illness" (Peck, 1978). This avoidance of pain — the clinical focus on stopping symptom expression — may characterize the existing system. It may describe a client who avoids issues he or she needs to face, or a psychiatrist who simply increases drug dosages in response to increased distress in the patient. Indeed, the psychoanalyst Masson (1991) characterized his teachers as "shut away from these private worlds of pain . . ." (p. 52).

A second assumption of the last step is that treatment is symptom specific— that somehow *only* the undesirable expressions can be removed while the larger person remains unaffected. Yet early researchers readily compared the effects of Thorazine to those of lobotomy — in the days when lobotomy held little negative stigma (Fishbein, 1958; Kalinowsky, 1958; Kinross–Wright, 1958). That the drugs produce a global flattening affect is well established, as is the fact that they have been shown to produce a host of iatrogenic diseases (Breggin, 1991; Martensson, 1991; see Saraceno, Tognoni, and Garattini, 1993, table 3-3). Ex-patient narratives are replete with reports that the drugs make one feel like a "zombie," that they cause "a glass wall between us," to more elaborate descriptions such as "reductive–reactive," that is, "I had reactions to them, and they reduced my ability to cope, by causing so many reactions" (cited in Susko, 1991, p. 36).

Ironically, psychotropic drugs often create behaviors that more readily identify the person as "mentally ill." Baldessarini (1990) illustrates:

> It's very easy to confuse bradykinesia with so-called negative symptoms of schizophrenia. It's very difficult to differentiate the restlessness of akathisia from agitation in psychotic illness . . . . You have to pinch yourself, force yourself to think differentially in every case, every day, as to whether you're overdosing and causing part of the problem that the patient is having.

Are the symptoms or is the person being stopped? And if the treatment has indeed stopped the person, is not the person "decontextualized," thus buttressing the initial assumption that the person's experience is simply biological?

A routine manifestation of the third step is *pressured* treatment — verbal argument, and at times coercion, such as threatening continued hospitalization until compliance. Lucksted and Coursey (1992) found that 30 to 40% of clients in rehabilitation programs have been treated forcibly or threatened with removal of a benefit. Although used on a minority of people, forced treatment has a chilling effect on the larger group. Residents come to know that, if necessary, force can be justified by an expansive definition of "danger

to self or others" (Thompson, personal communication, March 12, 1994). The implicit ideology of force in psychiatry, illustrated with vocabulary such as *target* symptoms, *intervention*, and *front-line* worker may be said to represent the culmination of a type of "military mentality that medicine often adopts" (Mount, 1993, p. 61).

In summary, the Caseness approach focuses on identifying symptoms that are negatively valued and assigns them a medical diagnosis. Labeling facilitates the transfer of ownership from the person to the medical system, which allows that system to use force when necessary to stop expressions of distress. The Caseness approach engenders a certain story and meaning, but it is essentially the same story for *everyone* who is so labeled: "I have a mental illness caused by a chemical imbalance in my brain. To control this disease, I must take medication for the rest of my life." Undergirding this is the realization that, "If I refuse treatment, force by medical people can be used against me."

The Narrative Approach

The essence of the Narrative approach is that it helps the person find meaning within the flow and context of a life story. Narrative typically has a temporal frame — a series of actions leading to a turning point or climax. This process reveals character, what in autobiography is called an "act of self identification" (Good, 1992, p. 102). Narrative also has a theme or moral, what Maine (1993) terms *emplotment* — the ability to come to a point. Thus, narrative differs from chronicle (as in string of biological signs) because it establishes a significance to the physical sequence, one that reveals deep structure and brings a sense of closure to the "patient" (Charon, 1993).

Here, the literary tool of narrative is offered as an alternative to Caseness for understanding and helping people labeled with mental illness. While Caseness already advances a biological meaning, Narrative tends to have no predetermined answers, and allows people to establish their own explanations. Thus a woman who sees her problem in terms of feminist ideology should have a therapist familiar with those beliefs — one who could engage in dialogue from that frame of reference.

This paper does not offer treatment modalities making use of narrative concepts, as some psychoanalysts have already done (see Vitz, 1992). Instead, it puts forth the assumptions necessary to reframe our orientation out of which specific treatment modalities may develop. The Narrative approach can be examined as a three step process: (1) allowing the story; (2) using a narrative as the frame of reference; and (3) supporting the story's transformative potential.

Allowing the story. Letting the story unfold assumes a positive value for symptoms or expressions of distress. This assumption has its roots in philosophic thought from Plato's expression of "divine madness" to the

Renaissance scholar Ficino (see Moore, 1990) who believed that "poetic madness" could calm a soul experiencing "disorder and dissonance" (p. 98). The medical literature holds analogous beliefs dating back at least to Pinel's (1806/1983) *A Treatise on Insanity*, wherein he observed that some patients show "paroxysms of active insanity" that are "salutary efforts of nature to throw off the disease" (p. 42). A minority of contemporary professionals admit potential value in "psychiatric episodes" (see Miller, 1990), and occasionally the literature carries titles such as Corin and Lauzon's (1992) "Positive Withdrawal and the Quest for Meaning," and Burnham's (1984) "Symbolic Vessels for Voyages of Self-cure." But such views are the exception in a profession that focuses on the deficits of persons labeled mentally ill.

Various approaches do exist that have a positive regard for expressions of distress. One fundamental is that the "breakdown" represents a death/rebirth experience — a passage where the person "dies" to old ways of being in order to grow and become more whole (Perry, 1990). Kaam and Healy (1967) believe that the theme of "recurring death and rebirth of personality" underlies world literature (p. 63). To illustrate, we may turn to Chretien de Troyes, the first major Romance writer of the Middle Ages. Artin (1974), in a literary analysis of *Eric and Yvain*, sees "Yvain's lapse into madness and his return to sanity as typologically imitative of Christ's death and resurrection" (p. 216). Mochulsky (1970) states that the three brothers in *The Brothers Karamazov* represent stages in the life of Dostoevsky. Alyosha, for example, is a symbol of the writer after his imprisonment, when he experienced a "regeneration of his convictions" (p. xvi).

Indigenous rituals also embody the death and rebirth theme. Eliade (1958) described such rites in which "initiatory death is often symbolized . . . by darkness, by cosmic night, by the telluric womb, the hut, the belly of a monster" (p. xiv). According to Eliade, the individual who emerges from the ordeal has a new and different being.

People undergoing "schizophrenic breaks" frequently use death and rebirth metaphors. We find a clear example, that of "melting," in "Jack's Story" (cited in Susko, 1991):

> Something inside me was dissolving in a way I could not stop. To control it, I usually took a cold shower, four or five times a day, or as many times as necessary. (p. 50)

The Caseness approach holds that Jack is experiencing somatic hallucinations and is engaging in obsessive–compulsive behavior. But Jack explains the phenomenon differently:

> [The melting] was a loosening up of tension. The body armor that had made me distant and afraid was breaking down. Usually my body and muscles were tensed, keeping my feelings guarded, and protecting me from painful feelings. The "melting," as I

> understood it, was not only a result of the release of subconscious feelings but a breakdown of my usual means of protecting myself from awareness outside my normal range of consciousness. (p. 51)

First we note that Jack ascribes a positive value to his experience: the melting allows him access to his feelings. Jack's melting is a "dying" to an old rigid way of being and presages new life.

To understand the melting phenomenon, one may turn to the archaic symbolism of water. Eliade (1952/1991) held that water was preeminently a "killing," dissolving symbol, and thus "rich in creative seeds" (p. 158). In a process called *Solutio*, Renaissance alchemical texts speak of powerful emotions dissolving the body, or its "materialistic egotistic attitude" (Moore, 1990, p. 100). Perhaps in modern times a person going through a crisis/life passage can experience "inner waters of dissolution." In any case, psychiatry would miss this possible interpretation due to what Kirmayer (1992) calls "a hyper-rationalism that ignores the significance of bodily felt meaning" (p. 323).

The vulnerability of the "schizophrenic" experience offers parallels to that of indigenous youth who progress through tests, including periods of isolation and fasting in order to enter into full adult society. Initiates may act helpless like infants (relearning to eat and walk), experience altered or visionary states, or go through symbolic wounding or dismemberment/re-memberment (see Sullivan, 1988). In the Amazon, initiation is held to be comparable "to that of crabs and other animals that have shed their old shells or skins" (Hugh–Jones, 1979, p. 120), and represents an attempt to gain a "new skin." Not only does "schizophrenia" in Western societies typically occur during young adulthood, but the individual may experience "regression" that mimics infancy, somatic feelings of falling apart, and states of consciousness that have been compared to the initiatory call of the shaman (Goldwert, 1992; Silverman, 1967). Combining anthropological and psychological models, Mason (1993) asks us to "re-vision clients' pathology into a desire for initiatory experience" (p. 4). Van Gogh provides an example when he compares periods of inner turmoil to a "molting time," where after a period one emerges renewed [cited in Monroe, 1992, p. 20].

Psychoanalytic attempts to understand "schizophrenia" have at times offered a death/rebirth interpretation. Pious (1961) describes the experience as an encounter with *nadir*, which is "figuratively a momentary death" (p. 51). Symptomatic behavior becomes in effect a "progression from the nadir" with definable stages moving toward increased health and integration. More recent transpersonal theories (Grof, 1992) hold that the struggle through various birthing stages or "perinatal matrices" serves as a gateway to the transpersonal domain, to a mystical connection with all beings.

Our society generally fails to provide rituals of initiation. The turning of youth toward illegal drugs has been termed as a "disorderly and desperate

expression of this need" for initiation (Zoja, 1989, p. 58). In drug use however, the rebirth experience precedes the death experience — where the taking of the drug is the birth and the coming down from the drug is the death. One wonders whether psychiatric drugs, insofar as they are neurotoxic and disabling, mimic a symbolic death and lead to a premature natural one. Hallstein (1992) goes so far as to say that hospital stays (for physical illness) mirror the liminal nature of initiation rites. "Lying thus stripped, isolated, pulled away from the family and community, facing possible mutilation, pain, or death, the patient is presented with the possibility of confronting the ultimate meaning of his or her existence . . . " (p. 252). But one questions whether such "rites" in the mental health system, that inflict pain involuntarily and incur permanent stigma, risk being experienced as *torture* — an "unmaking" of the person and the destruction of his or her voice (Scarry, 1985).

In what could be seen as a type of death/rebirth experience, *catharsis* makes use of symptom expression to achieve healing. In this approach old wounds and traumatic experiences, often going back to childhood, must be "discharged" for healing to occur (Scheff, 1979). Large percentages of psychiatric survivors have suffered from some form of past abuse (Rose, 1991). Such traumas will naturally seek release, provided a safe setting is established. In psychoanalytic language, Bromberg (1991) and Balint (1968) describe the process as one of benign or therapeutic regression. A considerable literature has developed around the phenomenon of *dissociation* stemming from past abuse, and the need for the fragmented self to reintegrate (see Spiegel, 1993). At times the person simply needs a proper container for his or her symptom expression. One ex-patient, who "had too much going on inside," saw her times in the hospital seclusion room as beneficial because that allowed her "to play out her story" (Edith, personal communication, March 18, 1994).

Another metaphor for positive valuation of symptoms may be called "running to the opposites," a term used by the Greek philosopher, Heraclitus. The therapeutic notion that cures may be effected by opposites, that the induction of an opposing passion can rid a person of a disturbing one, was further articulated in the Renaissance (see Jackson, 1990). According to Jungian analysts, one sometimes goes to extremes to redress an imbalance. People who assume little or no responsibility in their lives may, during a breakdown, suddenly feel responsible for everything. A person shut off from inner exploration may be suddenly penetrated by "beams," exposing innermost recesses. At times, the psyche goes to the periphery of human experience so that the center can be found.

The positive regard for symptoms assumes that, in crisis, the psyche naturally moves toward healing, toward finding authentic identity. Sass (1992a) suggests that those diagnosed with schizophrenia suffer from too much meaning, that they grapple "not with entities but with Being" (p. 109). Perry

(1987) describes the "psychotic process" as "the spontaneous emergence of the central archetype" (p. 16). Miller (1991), using more everyday language, states, "*My illness helped me to hear the voice of the child I once was, the voice I had tried to silence for so long*" (p. 33, italics in original).

One may consider that a person suffering distress bears a privileged truth (A.W. Frank, 1993). Thevoz (1992), the curator of the *Collection de l'Art Brut* in Switzerland, believes that the "mad" delineate and make clear structures that are in everyone's psyche. Artists such as Jackson Pollock and Lenora Carrington had breakdowns which helped them come to their distinctive art form (Chadwick, 1991; Landau, 1989).

Symptom expression is not always transformative and healing. A Bosnian woman, who repeatedly screamed in distress, was described as "frozen in her story" (see O'Mara, 1994, p. D2). Symptoms may turn into a destructive spiral and possibly stop the person's life for years. There is also the danger of "the seduction of madness" (Podvoll, 1990), feelings of specialness and "grandiosity" that could keep the individual imprisoned in a symbolic world. Still, we should not mistakenly assume that symptoms are always negative. The Narrative approach asks us to re-examine our bias against symptom expression and look at the communication inherent in it. We must ask, as Cohen (cited by Burnham, 1993) did during his lifetime of clinical practice: "What are these symptoms trying to solve which the person can't solve in any other way?"

Positive valuation of symptoms creates a power ambiguity. If the person is having a transformative experience, something of potential value to the individual and the society at large, that experience is something to protect and support. This was, in part, the rationale for isolating people during initiation rites; not only to protect them, but to protect society from the overflow of their spiritual energy (Buckley and Gottlieb, 1988). J.W. Perry (personal communication, May 11, 1994) believes that the experience of "schizophrenia" can go beyond "personal individual initiation." In times of cultural crisis the individual may assume a "prophetic," "semi-revolutionary" role and become an agent of cultural change and revision. Once a doubt is raised as to the power status of the modern "mentally ill" person — the possibility of respect for what may be a life passage and/or a message for others — the way is open to use narrative as the frame of reference.

Using the narrative as a frame of reference. Frustrated by "profound disciplinary failures," various disciplines ranging from sociology to medical anthropology are turning toward a storied approach — in what has been termed the "narrative moment" (Maine, 1993, p. 17). In the arena of psychology and mental health, a variety of terms have emerged, including "illness identity work" (Estroff, 1992), "autopathography" (Couser, 1991), "hysterical narrative" (Showalter, 1993), and "survivor discourse" (Alcoff and

Gray, 1993). Such works may have their historical origin in "conversion narratives," which are "often attended by visions, hallucinations and impulses to atheism or suicide" (Fichtelberg, 1989, p. 46). More recent "autobiographical essays," favored by existentialists, describe the experience of "dislocation," and one's coming to an identity that is "provisional" and "incomplete" (Good, 1992, p. 102). *Change* is the essential feature in these varied narrative types: the transformation of the self or one's persona (Barros, 1992) in a richer, more complex direction (J.S. Gordon, 1993).

Narrative has the ability to convey the inherent thickness and richness of life events (B. Allen, 1985). If the consciousness in "madness" is inherently shifting (what Felman (1978/1985) describes as "its energetic alteration, its endless metamorphosis" [p. 54]), then narrative would be an apt tool to convey this quality. When Fleischmann (1988) writes in her journal, "Voices inside, the inescapable 'I' . . . and the heart, too, is never still" (p. 86), we have a much richer feel for her inner state than a clinical note such as "pt. hearing voices."

Narrative can convey complex notions of the self. Recent anthropological views have challenged the standard assumption of "the egocentricity of the self," to one that is more dynamic and fluid (Lewis–Fernandez and Kleinman, 1994). Hermans, Rijks, and Kempen (1993) see the self constructed as a "polyphonic novel," with multiple voices engaged in dialogue. Such a novelistic view may come closest to the "schizophrenic" experience with its shifting, "alternative frames of reference" (Sass, 1992b, p. 131).

Putting experience within the "narrative web" (Rushdy, 1993) can lead to insight. Narrative organizes the chaos of experience, establishing connections between events (Charon, 1993). What might otherwise be seen as isolated and senseless symptoms of distress reveal themselves to be meaningful parts of a person's life story. In *Cry of the Invisible*, Theodora recounts that she suffered a gang rape, then was hospitalized a month or two later. At no time did the professionals ask if there had been a recent trauma, and when she finally volunteered the information to a nurse, she was not believed. Only after she told her story for publication did it become apparent to Theodora that there was a connection between her attack and subsequent hospitalization. Through the narrative process, people come to see that earlier life events and patterns are dynamic forces acting in the present.

There is a narrative "fit of truth": an event is meaningful and true because of the way it fits in the life story (Vitz, 1992). We listen and read how a seemingly minor event can be the hinge on which the story moves. In *Cry of the Invisible*, Ron tells of a patient he sees "with his hands and feet turned inward" caused by the effects of neuroleptic drugs (p. 110). From that point, Ron's life is changed and he becomes an advocate, to fight what he calls the bio-coercive model of psychiatry.

Although narrative illuminates connections to past events — revealing the determinedness of events — it also casts the person as active in making decisions, even in the most seemingly determined of events. Sarbin (1990) states that it is critical for people to perceive themselves as "agents trying to solve existential and identity problems" (p. 280). Even though Jack succumbed to coercion to take psychotropic drugs, he repeatedly heard an inner voice telling him that he was "about to make a big mistake" (cited in Susko, 1991, p. 53).

A sense of narrative itself is necessary to gain a moral sense (the ability to give an "account of oneself"), as well as to expand our ability to perceive different sentiments (Tirrel, 1990). In the article "When Narrative Fails," R.C. Allen (1993) holds that people can live authentic lives only when they come to emancipate themselves from a larger dominating story, or when they see how their own story is embedded in a larger one.

The narrative lens helps us see the texture and connectedness of events, including the self as a dynamic agent, able to make choices. The Caseness approach, in bringing its energies to bear on making a differential diagnosis, can easily miss these elements. The point is shown explicitly in a case study (Barrett, 1988) that compared tape recorded interviews to the written record. Paul Lawrence, a psychiatric patient diagnosed with schizophrenia, revealed that a friend died from a drug overdose a week before his own breakdown. Paul then makes comments like, "I can talk to him spiritually . . . . [I have] communication with the spiritually dead" (p. 281). Later he reports that his friend is warning him: "Get help! Get help! Help yourself!" The interviewer focused several questions on the way Paul worded this communication, trying to fit it into the criterion of an *exterior* voice for the schizophrenic diagnosis. Meanwhile, the fact that his friend's death is of significant concern to Paul was left unnoted in the case record; nor that Paul's experience of it could be a critical resource for his healing. This example illustrates a fundamental flaw in Caseness: its failure to bridge the divide between doctor and "patient." It has led Charon (1993) to state, "No wonder they miss one another in the dark" (p. 95).

In telling his or her story, a person *names* the experience, and so establishes the discourse from which any explanation proceeds. Explanation may be framed as a search for meaning, a problem in relatedness, or as a cry of outrage against abuse or oppression. Michael O., for example, sees his core problem as a moral crisis, his inability to make a true confession, to really tell someone what he is feeling (personal communication, October 1993). The poet Roethke framed his "manic episode" as a mystical experience he had with a tree: "Suddenly I knew how to enter into the life of everything around me. I knew how it felt to be a tree, a blade of grass, even a rabbit" (cited in Balakian, 1989, p. 34). The naming can lead to what Emerson refers to as a "higher sort of seeing."

Not all people have the articulateness of a Roethke, and there is often a "narrative darkness" (Charon, 1993) or a silence within narrative that can only suggest the inexpressible. As one writer from a Canadian collection of ex-patient stories put it: "Between these pages is a wild sea raging, uncontrollably. Its enormous waves engulfing me in tortured silence that *no* language can describe" (Fleischmann, 1988, p. 82). Caseness would tend to erase those silences or describe them as void. But a narrative view might compare this silence to what Crites (1989) calls "sacred stories," stories too deep to be told, where the "story itself creates a world of consciousness" (p. 71).

Since people sometimes exaggerate and project their anger, the question can be raised as to the reliability of the narrator. R.C. Allen (1993) even refers to "narrational frenzy," a frantic attempt to find identity by making up stories. But the Caseness approach, also dependent on self-report, is inherently liable to distortion and incompleteness. If people are told that their mind is imbalanced, would it not undermine their confidence? If forced treatment or pressured treatment is in the air, would not one circumscribe his or her own self report? And memory, essential to constructing one's story, may be impaired by psychiatric drugs. Rarely do professionals admit this, as does the psychoanalyst A. Miller (1991), who wrote that psychiatrists "employ dangerous drugs to destroy the very thing that has potential to heal him [the client]: namely, his memory" (p. 31). Recent research (Hoffman and McGlashan, 1993) suggests that "dopamine down-regulation" by neuroleptic drugs has "especially profound effects on working memory" (p. 15). Literature that advocates for expanded use of shock treatment refers to its "profound memory disturbances" (Nobler and Sackeim, 1993, p. 46). Ironically, ECT advocates cite studies that permanent damage is confined to "a subset of patients who subjectively complained about their memory" (Calev, Pass, Shapira, Fink, Tubi, and Lerer, 1993, p. 137).

Rather than establishing a new ownership and power disparity, as in Caseness, the Narrative approach encourages respect for the other as a full partner. From doctors or therapists who "possess" the truth in a monologic fashion, we move toward descriptions such as "ritual companionship" — a term used to describe the initiate's guide in indigenous cultures (Sullivan, 1988). Kierkegaard (1844/1980) identifies the key element of such a companion as one who participates in the other's suffering, such that "it is his own case that is in question" (p. 120). Morson and Emerson (1990) explore Bakhtin's dialogic conception of the truth, one that allows other voices "the direct power to mean" (p. 239).

By its very nature, the story invites us to enter into the lived world of the other. Such involvement entails imagination, exposure to one's own pain and joy, as well as a willingness to be involved with the mundane needs of the other — traits from which professionalism may seek to distance itself.

Admittedly, there is a risk of being *submerged* in another's story, slipping into "raw romanticism," as McHugh (1994) would say. But it is only by entering into another's story, while maintaining one's own identity, that a true dialogue can ensue.

After taking a narrative of a person's life story, I find that a unique bond is established. The one who tells the story grows in stature and becomes a political equal. The feeling of connectedness to a ritual companion can become the way in which the person reintegrates into society — in some cases as a prophetic witness. When a person goes through his or her "breakdown" experience, and names it with the support of a ritual companion, a dynamic for change is released. This leads us to our third and final consideration.

Supporting the transformative power of story. A transformative impact usually follows the allowing of the story, telling the narrative, as well as its publication. May (1991) refers to a "Phoenix" effect — a new self rising from the ashes of a traumatic physical illness. Frank (1993) believes that "At the core of any illness narrative is an epiphany" (p. 41).

There has long been a key assumption in the Narrative approach: that healing imagery arises during periods of deep psychological distress (Sechehaye, 1951). For Joe Green it was the "lower frequencies of the earth"; for Jack it was "a flowing and milky type of energy" (cited in Susko, 1991, p. 49).

Symbols work, in part, because they *mediate* pain, as opposed to encouraging a flight from pain. This function can be made clearer with an example from my own "breakdown" 20 years ago. My psychiatrist believed that periods of turmoil were necessary for growth to occur. Likewise, he believed that he should "support the disorganization" (Adams, 1989), and did not prescribe psychiatric drugs or shock treatment. Here is a vignette from my own experience, first citing the nursing report in my medical record.

> 1:35 P.M. Patient assisted out of bed and told to walk to the end of the hall and sit down to write his thoughts on the pad. Patient very slowly staggered to the table at end of the hall, but did not write anything.

This note was but a pale reflection of my inner experience:

> At the last safe table in the universe, I'm pushed and placed into the last safe chair. The whole universe has changed into this hard, square table of suffering wood. I place my hands on it, then take them away for it only makes the pain worse. Somehow, I'm already on the inside. When will I join them in pain?
>
> On the table I spy a crumpled piece of metal. Is this what I've done to my friend? — the Savior who's been forced through the Hitler Machine's endless fire and grinding. Is this all that's left of him? A bit of metal, I can barely see glimmer?

In the midst of this painful and seemingly "paranoid delusion" there emerged a symbol of hope. The "bit of metal" was experienced as a spiritual presence

small enough to reach me in my pit of despair. Fragmented like myself, it became my invisible ritual companion.

Manifold interpretations of this symbolism are possible: a Jungian might hold that the table represented a mandala of the self and that the bit of metal was its center. Schafer (1983) might describe such "pathological signs" as "bits and pieces of the shattered self trying to protect itself, heal itself, and continue its growth" (p. 217). A theologian might interpret it as a call for our society to find spirituality in the most disguised and rejected of forms (Caussade, 1861/1987, p. 22). But in the Caseness system, a patient who just stares at a bit of metal, exhibits only a "negative sign" of schizophrenia.

Perhaps an essential transformative effect of going through the "psychotic process" is that the person becomes more feeling oriented, as Jack did after his melting. Perry (1990) says that after the old self dies off, "the warmth is there, the trust relationship, the lovingness. And that's really the fruit of this whole process" (p. 6). In a recent study, Ortolf (1994) compared a number of ex-patients and found that those who had crisis episodes with *more florid* symptoms came to a higher level of functioning with a greater affective awareness.

If the story is allowed, there follows the transformative effect engendered by its telling. Broyard (1992) suggests that it is natural for a person who has a physical illness to "make a story, a narrative, out of his illness as a way of trying to detoxify it" (p. 21). Insofar as the essence of madness is silence (Felman, 1978/1985), narrative offers an antidote. In dealing with the tension between one's "heroic madness" and a deflationary telling, Felman (1978/1985) suggests that the more balanced identity emerges through a process of revision. And if there is a corrective "shrinking," then there can also be a corrective expansion, where "desire is wrought" out of a "narrative web" (Rushdy, 1993, p. 95). According to Rushdy, it is not thought or reflection that awakens love within us, but rather the stories we share with each other.

The telling of the narrative has an integrative effect (A. Miller, 1991). As Jack explained (personal communication, December 1992), "Instead of it going round and round your head, it becomes a part of you." In part it happens as the "shadow side" of the self which has been invisible comes into view. In part this happens through the validation of the story by another.

There remains the transformative impact of the act of publishing narratives. Giving the person's story the dignity of print radically empowers the individual. People in our culture recognize the power of the printed word, and may read with compassion what they would not believe if it were only spoken. The narrative also reveals the abuses that are perpetrated against the story's protagonist. In an anthology, the repeated pattern of stories shows that a dark side of the mental health system exists and cannot be explained away as paranoid ideation. Because of the validation offered by making public one's account of suffering, the person finds his or her status markedly enhanced.

A published narrative helps people "find their own tribe," as an ex-patient, Josie K., stated (personal communication, March 1992). An anthology allows others to realize they are not alone in their suffering. Part of "craziness" is feeling that no one else compares to you. Campbell (1991) refers to testimony as "a primary means by which clients transform themselves from marginalized, isolated victims to historical subjects and members of a vital subculture" (p. 369). This feeling of connectedness extends to the cosmological. After the publication of his story, Josie dreamt that he was a giant who climbed to the top of a mesa, and reached out and touched the sky (personal communication, March 1992).

Summary and Conclusion

In this paper I have suggested that the "life story" or Narrative approach is a far more fruitful construct than the Caseness approach. In *Schizophrenia as a Life Style*, Burton (1974) defines "schizophrenia" as a thwarting of one's life story. It is when one's story has been stopped that the person becomes "crazy." Thus symptoms become expressions or cries against that stoppage — which tends to have its roots in the past, sometimes going back to childhood. If the psyche possesses a natural movement toward healing, we may expect to find the way out of "psychosis" encoded in the symptoms.

This article has shown narrative to be a useful tool for understanding the complex phenomena called schizophrenia, within a frame of reference that allows it as a potentially transformative experience. Narrative is robust in its ability to pick up detail while at the same time establishing connections — making for a narrative unity and truth. Highlighting change helps the person refuse "schizophrenia" as a fixed state, and view it instead as a process or passage. A narrative calls forth one's moral responsibility with the self as an active agent — traits important for change. Narrative dignifies one's communication to the larger society, exposing realities which are not usually allowed expression. In contrast, the Caseness approach tends to fix the "schizophrenic" process, it "chronicalizes" the person by establishing a monologic discourse with a predetermined meaning, and thus elicits passivity and compliance. Any value in the experience is discredited.

Ultimately, whether one chooses the Caseness or Narrative approach as the guidepost to understanding the psychiatrically labeled, is an expression of a deep-seated philosophy. If our goal is to control, manage, or shut down expressions of deep suffering, the Caseness approach is sufficient. If, on the other hand, we see something of potential value in the "breakdown" experience for the person and for ourselves, the Narrative approach can serve as our frame of reference.

If symptom control is our ultimate standard, we may be willing to condemn people to half-lives and quarter-lives: the individuals often lose that creative edge and dynamism that enable them to make a valued social contribution. In the context of a life story, this choice represents a marked diminution or a premature end. If the Narrative approach is our touchstone, the qualitative measure — the richness of a person's life — is our concern. We will be judged by how we become a part of this story — whether we have thwarted the person's life story, or allowed it to deepen and blossom.

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