

8 Why Fiction Matters to Madness

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My thesis in this paper is that in ‘fiction’, or to be more precise, in metaphorical, poetic modes of signification, there may inhere great value, even therapeutic value, to the individual who is attempting to survive the depredations of intense distress. Moreover, my argument is that for the self to speak of its own experiences of madness and trauma there may be an imperative – an imperative necessary to survival as a self – to step outside the constraints of a purely informational mode of discourse. Such a modality of speech is very familiar to those of us who use mental health services. It is a discursive mode sanctioned by authority, a discursive mode which surrounds us, interpellates us, even before we begin to speak, a mode which translates the extraordinary, the bizarre and the profoundly disorientating into the medicalised language of diagnosis, prognosis, symptoms, and treatment. Within this discursive realm, experience which challenged rationality and conventional narrative framings of the world is *remade*, and through this remaking is changed beyond recognition. These medicalised, positivistic modes of speaking about experience may be, I want to argue, not only inadequate, but actually harmful to the individual employing them.

The thinking informing this paper was prompted in part by the recent renewal of interest in and expansion of the cognitive behavioural therapies. Readers will be aware of the government’s announcement, on World Mental Health Day 2007, that £170m will be spent by 2010 on increasing access to psychological therapies for depression and anxiety. More personally, my thoughts were prompted by a conversation with my own NHS psychotherapist who I had been seeing fortnightly for several months following an eruption of severe distress in my life. Although nominally working within a CBT framework, I was fortunate that he was willing to step outside the limits of that psychotherapeutic approach. Using a reasoned, informational style of discourse, I had been trying for some time to describe to him a particularly distressing and bewildering series of mental experiences. However, I was finding it very difficult to do so in such a way that anything I felt to be meaningful or approaching the nature of those experiences was said. Instead, what my speech had made present in the room was an account which ran parallel with, but never met, my experience; between what had been said and what had not was a gap which seemed unbridgeable and absolute. I voiced my frustration at this, and my therapist suggested I ‘try speaking differently’,

abandon my attempt to make everything clear, and to try using a more creative approach to signify distress.

Self-consciously at first, I did what he suggested. I told him a story in which I was transformed into a winged beast which inhabited a desolate landscape, a beast whose language was unknown to me, who communicated with animals rather than humans, and who would periodically spontaneously catch fire. At the end of the story, motivated by a compulsion to explain myself rationally, I began haltingly to try and interpret what I had said, but the therapist cut me short and suggested that interpretation was not important, that it was fine if meaning remained unfinalised and open, and that if I felt I had said something which mattered to me, which held significance for me, then that was enough. He was right. In that conversation I felt I had come closer to revealing my 'truth' than I had in any previous therapeutic encounter. Given that I have been a user of mental health services for over thirty years, this seemed significant.

The importance of modes of speaking other than the literal and the rational was noted by one of the most influential proponents of the model of 'narrative identity', Paul Ricoeur. Ricoeur repeatedly insisted that fictional as well as non-fictional narratives are important to the construction and maintenance of human identity. Thus, he argued that, "Fiction contributes to making life, in the biological sense of the word, a human life" (Ricoeur, 1991a, p.20). Narrative fiction "is an irreducible dimension of self-understanding" (p.30) by means of which we experiment with possible identities and identifications. In addition, with regard to the value of a purely informational discourse, Ricoeur (1991b, p.130) asserts that "it is in the moment of the emergence of a new meaning from the ruins of literal predication that imagination offers its specific mediation". For Ricoeur (1991c, p.189), self-knowledge "is an interpretation", and the "privileged mediation" of this interpretation draws on the narrative modalities of both history and fiction.

Such insights are probably familiar to us all. We will almost certainly assent to the proposition that in order to represent the experience of being human a form of language other than instrumental, rational discourse is needed. Our experience is freighted with uncertainty and doubt; our ecstasies and griefs cannot be adequately captured in mundane speech; we pass through moments where the self is dark to itself; our experience of time is often paradoxical and complex; and so on. However, for the mad, there may be a particular *urgency* to the call for other modes of speech. This is because living with severe and enduring distress means to exist, to a greater or a lesser degree, in a universe whose limits are strictly defined by authoritative discourses which close down the possibility of imagining oneself differently, of reconstructing the story of the self – of finding different, better, horizons under which to live. To live under such horizons, I suggest, might restore a sense of dignity and

worth to the vulnerable excluded subject. To live in such a space may open the possibility of 'health'.

To unpack these last assertions further, it is worth referring to some of Foucault's contentions concerning the vexed relationship between reason and madness. Reason and madness, he argues, have become "external" to each other, "deaf to all exchange [...] as though dead to one another" (Foucault, 1999, p.xi). This schism exists in order to secure the hegemony of reason, a hegemony predicated on the exclusion of madness. Indeed, reason's very identity is dependent on its power to exclude – to admit the language of madness would be to collapse not only its power but its essence. Therefore the subversive truths of madness have been silenced, deemed nonsensical and worthless. And because of this breach, to represent madness in the language of reason is a categorical impossibility, for "by assuming an appearance in the order of reason" madness becomes "the contrary of itself" (Foucault, 1999, p.107).

Thus, to speak of the experience of madness in the language of 'reason', and here we might gloss this term to include scientific, medicalised discourse, does a kind of violence to the experience so addressed. Experience is wrenched from the perplexing, the singular, the aporetic and is cloaked in the monologue of reason. This is what happened to me in the early part of that psychotherapy session, and it has happened on many other occasions when I have sought psychiatric help. This is hardly surprising. The textures of madness and trauma include a host of characteristics which by their nature resist the literal predications of fixity and reference. Such characteristics include: nameless and consuming distress; objectless and inconsolable grief; radical alterity; paradox; terror; haunting; temporal and category dislocations; the suspension of logic; chaos; stasis; too much speech; too little speech; obsession; the darkness of the self; self-alienation and loss; the continual return of history; multiple voices. To represent such experiences in the language of medicalised reason is to change them into something else.

Such concerns accrue greater significance when we remember that 'mental illness' is not like other illnesses. Whereas physical illness affects a part of the self, 'mental illness' is often seen and experienced as a condition which potentially affects the whole person. Moreover, when 'mental illness' is at its most acute, the subject's experience will be that there is nothing other than 'illness' present. I *become*, in effect, my 'illness' - which shadows every aspect of my identity. Many, perhaps most, current medical interventions treat the 'symptoms', or content, of distress/illness as of little importance, or at least proceed from a view that the content of distress is something to be 'recovered' from. Whether using drugs or CBT or a combination of the two, a teleological view implicitly structures the therapeutic encounter in which distress is a problem to be 'overcome'. The content of distress thus comes to resemble waste which must be cleared so that living can begin. Yet, if the individual is

consumed by her distress, then the corollary of this stance is that the whole of her experience is regarded as a problem to be surmounted and of little value. Therefore, the whole of the *self* is waste which must be discarded. In the throes of an acute distress which is co-extensive with her very existence, the individual will thus come to understand that *she* is of no value, that *she* is a problem or a symptom to be overcome.

This pathologising of the very self is exacerbated by the language of diagnosis and treatment. If my experience is wholly or in the majority defined by distress then the label attached to my distress will subsume all that I am. My experience of distress (as with my experience of anything else) will be unique, refracted as it is through the complexities of my history, my class, age, gender, race, education, and so on. Labels such as 'schizophrenia' or 'depression' relegate me to a pre-defined category which is not tailored to my unique singularity, and do a violence to the intrinsic strangeness and richness of my experience.

The medicalised language of illness is a discourse sanctioned by power and hard to resist when one is in the limit-state of radical vulnerability. If I introject this discourse what emerges is a kind of death-in-life. For now that I have a label to attach to my distress I am no longer an individual whose distress is refined and defined by my history, my imagination, my oppression, my singularity; rather I have become an instance in a broad category. Moreover, that category is there to define something useless, something without value, something to be moved through as quickly as possible so that I can return to 'living'. With all treatment aimed towards recovery and 'better functioning', living is something which will happen in the future. My present existence is without value or meaning, and, deprived of these signifiers of humanity, I have become a thing, waiting, hoping, for revivication. Through introjecting the discourse of illness, my experience of distress becomes flattened, homogenised, hollowed out of meaning and nuance. No longer a complex individual, I am 'depressed', 'schizophrenic' – and my complexity has been subsumed under those labels. Tragically, when I come to believe that is who I am, there will be little of me left. Eventually the powerful story through which I have been authorised to understand myself becomes who I am. Now I will label the richness of my experience as symptomatic; I begin to ignore it, cease to perceive its strangeness.

The irony of all this is that a road through the agonies of distress which leads to a more comfortable existence may be found through enriching rather than depleting the sense of self. I have written about this elsewhere (Stone, 2005) so I will not rehearse the arguments again here, but in brief I would contend that attending to and articulating the texture and particularity of experience, including the experience of distress, strengthens one's sense of selfhood, and that this in turn works to ameliorate the destructive power of distress; readers may also want to look at the work of Larry Davidson (1992;

2005) and James Glass (1989; 1993; 1995) on selfhood as a ‘therapeutic resource’. What I do want to add here, however, is the necessity of reconceiving the theoretical concept of narrative identity under the signs of the momentary and fragmentary. Arguments concerning the role of narrative in selfhood can easily imply that the self narrative will necessarily be a coherent, ‘whole’ entity. In order not to disqualify vulnerable subjects as subjects, ‘narrative identity’ needs to be distanced from any implications that the self-narrative should be ‘complete’ or conclusive. In contrast, a conception of narrative and identity might be advanced in which vulnerable subjects’ lives are honoured by attending and granting importance to the contingent, the passing, the incoherent or incomplete, the frangible.

Such a conception of narrative identity is perhaps more likely to emerge if the vulnerable subject is sanctioned to employ poetic metaphorical speech. The fragmentary story I told my therapist had no conclusions; its meaning remained obscure, yet still its telling resonated with my experience of distress. I would go further, however, and suggest that poetic, metaphorical, speech is the only adequate way in which the extraordinary experiences of madness and trauma can be represented and imagined by the self to the self and to others. In these modalities of speech, there inheres the possibility that the individual may re-emerge into or reclaim the richness of their own experience, may re-enter the realm of the human, may rediscover that they are not dead, but alive. It is this possibility which Julia Kristeva (1989, p.99), herself a psychoanalyst as well as a theoretician, alludes to in her book on melancholy when she writes:

Sublimation’s dynamics, by summoning up primary processes and idealization, weave a hypersign around and with the depressive void. This is allegory, as lavishness of that which no longer is, but which regains for myself a higher meaning because I am able to remake nothingness [...].

In the context of madness or trauma, such a ‘speaking otherwise’, the weaving of a hypersign in order to remake what had been denoted as nothingness, may be particularly beneficial. It may help one escape confinement in medicine’s positivistic text, may acknowledge complexity and uncertainty, may help restore dignity, may help one hear a song which plays in even the darkest moments.

One of the best examples of this discursive mode I know of is Susanna Kaysen’s memoir, *Girl, Interrupted*. Writing of her hospitalisation with BPD, Kaysen adopts a poetic, novelistic, literary style. Her account is conveyed via impressions, allusions, and the relation of fragmentary episodes through which the autobiographical subject and her madness are hinted at rather than pinned down. Moreover her account is specifically aimed at countering the positivism of psychiatry; indeed, a central concern in *Girl, Interrupted* is Kaysen’s resistance to the notion of a fixed, lifeless self pinned down and defined by medicine’s narratives, or as she describes it, “one moment made to stand still

and to stand for all the other moments, whatever they would be or might have been” (Kaysen, 1995, p.167). There are two interruptions in Kaysen’s account. Her distress, and subsequent incarceration in hospital, interrupted Kaysen’s life, but the static representation of that interruption (in the form of her psychiatric history) excludes the possibility of mobility and progression and reifies the transient. *Girl, Interrupted* is Kaysen’s attempt to recover that ossified self and release it into a more fluid realm. As if to emphasise the contrast between her impressionistic narration and the definitive, positivistic narratives of medicine, Kaysen includes photographic reproductions of medical documents relating to her illness in the memoir. This starkly highlights the radically different stories of her experience. The medical narrative exemplifies a “monologue of reason about madness”, as Foucault (1999, pp.xii-xiii) describes “the language of psychiatry”, its unidimensional and flat statements at radical variance with Kaysen’s poetically nuanced account.

In conclusion, then, the value of poetic, literary, metaphorical modes of representing experience is various. Firstly it is a way of granting *attention* to the content of distress, rescuing that experience from lifelessness and death. Secondly, it is an acknowledgement that human experience can never be adequately mapped in scientific informational discourse. Thirdly, it accords to the experience of suffering a dignity and value by transfiguring ‘symptoms’ through the language of myth, poetry, metaphor. Fourth, it allows for experience to be reimagined and understood in ways which are not available in medical discourse. Through use of literary form, unconventional grammar, etc., the text may approach, for instance, the ‘permanent simultaneity’ of traumatic being. Fifth, the use of narrative and language constructs the self as fundamentally incomplete, overdetermined, uncertain.

This last point is crucial in that our narratives of ourselves are always incomplete, because our existence is psychologically, linguistically, discursively, physically, bound to and constructed by the other/Other. Indeed this understanding is key to what it is to be human and to live an ethical existence. Literary poetic speech is defined in part by its openness to multiple interpretations and its resistance to closure. As such it leaves room for the experience of alterity to haunt its margins. (Again, this haunting stands in stark opposition to narrative universes of diagnosis, prognosis, recovery etc.)

If different modes of speaking are not made available, or sanctioned, then the clinical encounter may consist of two discourses – that which is produced by the permitted modes of speaking, and that of a kind of talk which tries to do justice to strangeness. One discourse will be present while the other to a greater or lesser extent will be unspoken, even unthought. In such a conversation, experience will remain untouched by what is said. And because untouched, unheard by the other, will not even remain experience for very long, but will be soon forgotten, erased, with the vulnerable subject ‘resurrected’ into a kind of living death.

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