Chapter 9: Conclusions

> The resolution of distress, if that is what is being sought, is to be won only when two voices struggle to build to a dialogue. (Good, 2001: 225)

The aim of this research was to explore the relationship between madness and narrative understanding both pre and post Enlightenment. In this endeavour, I have attempted to contextualise this research by exploring the historical tradition of the scientific interpretation of people's mad experiences. This tradition marked the boundaries between madness and reason, setting the criteria for what is considered to be normal subjectivity. Examining the ways in which psychiatry asserts its positivist position raises questions regarding the scientific basis of constructs such as schizophrenia. As Leonard (1994) suggests, science "limits our imaginative ability to generate questions" (p.45), and I have argued throughout this thesis that it is this imaginative ability that needs to be rediscovered and engaged with when listening to/reading stories of distress. I have attempted to engage my imaginative ability in this research, following the principle outlined by Csordas; that an analysis of subjective phenomena should focus not on biology or social determinism, nor on a mutually deterministic model, but on "the embodied, speaking person taking up an existential position in the world" (Csordas, 1994: 287). The fundamental reason for selecting the narrative method as a means of exploring the subjective experience of madness, is that it allows for Csordas' "embodied, speaking person", and in doing so, the voice of research can shift away from professional and academic-as-expert narratives, to subject-as-expert narratives.

Reviewing the research on narratives of physical illness and madness highlighted not only the lack of research on narratives of madness, despite the wealth of stories available, but also how the focus on linearity and coherence, and inattention to space has, at best, marginalised complex stories of distress, and, at worst, invalidated them as narratives. Moreover, the dialogical nature of people's narratives, the multi-voicedness within stories, has been largely overlooked. In addressing these areas, I drew heavily on the work of Bakhtin for the analysis of the selected narratives. However, Bakhtin was also pivotal to maintaining an ethical stance in relation to the research in two key respects. First, I wanted the women whose narratives I studied to remain unfinalised; I did not want my interpretation of their stories to become another finalising word on these women's experiences. Second, I wanted this research, and in particular my analysis of Kempe and Barnes, to follow in the tradition of storytelling. As the author of my own story about these two women I wanted, above all, for their experiences to reach the imagination of my readers. Kempe's story is one of self-confessed initial madness, followed by forty years of mystical experiences that were received with respect and reverence by many high clergy, yet were ambiguously received, if not rejected, by civic authorities and lay people. Kempe's story is one that straddles the high drama of Bakhtin's adventure chronotope, and the mundane, yet greatly revealing, detail of his everyday chronotope. It is a narrative where unusual experiences are framed within the hegemonic religious voice of medieval society. Barnes' story is also both mystical and mad, with the mystical features aligning less with religion, and more with the existential philosophy of anti-psychiatry. Medieval and carnivalistic, Barnes' narrative is rich with complex chronotopes, with space and time being integral to her experiences, forging her narrative and communicating, in a very powerful way, her inner distress. Yet, as I argued, her experience of madness, like Kempe's, was

construed within a hegemonic framework. Anti-psychiatry, and I admit I am viewing it from a particular historical perspective, is part of the over-arching narrative of psychiatry. Whilst it is predominantly a narrative of medical identities, it became a monological discourse parallel to that of psychiatry, both of which marginalised the voice of the mad. Barnes' voice is difficult to hear, it becomes, just as powerfully as Laing's, the voice of anti-psychiatry.

As outlined at the beginning of the previous chapter, there are many features that unite the narratives of Kempe and Barnes, yet for me, it is the ways in which their experiences are transformed through the telling of stories, becoming both narratives of madness and narratives of recovery. To both narrator and reader, the self is similarly metamorphosised from mad woman to would-be saint (Kempe) and cultural icon (Barnes). What the trans-cultural and trans-historical analyses of these two women's stories has illustrated is that experiences of, and reactions to, madness are, in many respects, constant across the expanse of time. The role narrative plays in alleviating suffering is similarly sustained across time and space. All this points to the importance of narratives as a means of making sense of experience and transforming the self, supporting my argument that recovery is centred on reconstruction. So what, some may say; why does it matter? It matters for this reason: as I have argued throughout this thesis, the voice and experience of madness has been systematically marginalised by the authoritative voice of science since the Enlightenment. Mary Barnes' medieval narrative of uninhibited madness, endorsed by the modernist voice of psychiatry (albeit a voice critical of traditional psychiatry), is isolated in its infamy. Few names are as well known as hers in respect to mad experiences, and although I suspect her story is familiar to many, her narrative remains read only by a few. So whilst the numbers of

published firsthand narratives of madness are increasing due mainly to increased political awareness, their impact on the voice of psychiatry, the relationship between distressed and doctor, is minimal, particularly for those diagnosed with severe psychotic states such as schizophrenia.

Attention to stories, both large and small, and being able to creatively engage with another's narrative agency should be central to contemporary healthcare for four reasons. First and foremost, engaging in an ethic of listening validates the individual's experiences as meaningful. It should be unequivocally accepted that the patient is the expert voice, the authority on their own experiences. We have all been in medical consultations where we feel disempowered, disadvantaged, where we struggle to make our voice heard above the preoccupation with diagnosis-making, time constraints and, what is considered from the medical perspective, the best treatment plan. There is great relief to be gained from the belief that one's story has been heard and, more importantly, understood. This initial step of listening and the impact this has on reducing patients' anxieties in the medical encounter leads to the second reason why attention to stories should be central to healthcare. By attending to meaning within the stories, a bridge can be made between the individual and the clinician that could provide the foundations of a dialogical relationship. This relationship will always be imbued with relations of power, this can never be side-stepped, but an awareness of the dialogical positioning of both parties could help reduce the authoritative voice of psychiatry and empower the patient within this relationship. Third, through an opening up of the dialogical relationship, explanation for experiences can be arrived at together as a meaning-making process, explanations that are consonant with the individual's values, culture and beliefs. For the clinician, this may require a shift in thinking, paying

attention to the metaphorical meaning within stories as opposed to the content as de facto. Importantly, the patient should retain ownership of their story, a story that should not be rewritten within a professional paradigm. Retaining ownership of one's story also means retaining ownership of one's life, a factor essential to recovery. Finally, by embracing the medical consultation as a dialogical relationship where power may shift, the individual is more likely to take an active, vocal role in their recovery from distressing experiences, enabling their management of future disturbing episodes. This may result in a reduced need for medical intervention such as medication and hospitalisation.

Whilst there is much to be gained from the importance of patients' stories, the argument begs the question as to how such stories can become central to clinical care. First, Kleinman (1988) notes that between the first and final years of their education, medical students lose their innate ability for eliciting and listening to patients' narratives, gaining in its place the acquired skill of formulating a medical history. As Strauss (1994) suggests, the story can become the key organising structure for a science of psychiatry. Greenhalgh and Hurwitz (1999) highlight how illness narratives may provide the means by which medical knowledge is accumulated and, as such, attention to narrative has the potential to enrich the patient's experience and professional education. Listening to narratives and attention to meaning should be a core clinical skill in the medical curriculum, necessitating a move away from constructing medical histories to eliciting and interpreting stories. Second, there needs to be an openness to alternative explanations and the different tropes used by individuals. Not all unusual experiences are pathological; some may be grounded in spiritual or cultural beliefs.

Patients' stories need to be understood within their value and belief system. Barrett (1998) says this:

> [those diagnosed with schizophrenia] make sense of their experience by means of tropes which, though not mundane, are sufficiently conventional that they provide a bridge to connect that person with the ordinary everyday world, rendering bizarre experiences at least partly plausible. (Barrett, 1998: 485)

For the practitioner, relinquishing the belief in one axiomatic paradigm to acknowledging the co-existence of multiple, diverse explanations is a pre-requisite to the sharing and construction of narratives (Roe and Davidson, 2005: 91). Related to this should be an increased awareness of the different means of narrative expression; for example, religion, music, art and poetry. Language for all of us at some point is too limiting a medium to express such intense emotional stories as madness. Woody (2004), who has written about the dangers of relying on language for expression states:

> I have no doubt that some people do assemble themselves by telling themselves stories about themselves...For some, the image, the melody, the dance are more congenial and eloquent means of expressing and formulating experience than language. (Woody, 2004: 335)

Working with individuals within their preferred form of narrative expression and within the metaphorical frameworks used, may lead all parties to an enhanced understanding of unusual phenomena, as well as reducing negative features associated with such

experiences, such as social isolation, anxieties and low self-esteem. Corin and Lauzon (1992) argue that:

> An approach centered [sic] on the meanings and strategies developed by the patients would, instead, promote the development of rehabilitation strategies based on an understanding of the personal stance the patients adopt toward their world, of its dynamic, of its points of strength and fragility.
>
> (Corin and Lauzon, 1992: 277)

Third, in relation to schizophrenia, recovery should be a pivotal word. Whilst the role of narrative is more readily accepted in relation to illness, both the terms 'narrative' and 'recovery' are widely dismissed in relation to schizophrenia due to the absence of traditional narrative form and, at times, the silence that features in such states. However, as I argued in the previous chapter, both selfhood and narrative agency can still be present within incoherence and silence. Silence can not only be meaningful, it can be central to recovery, as people engage with a circular timespace or 'cartwheeling' process as described by Good (2001). It is not therefore that people suffer narrative loss in diagnosed conditions such as schizophrenia, but more that their narrative is inaccessible to others, either through a failure of words to articulate the experience or through a failure to listen to the rich complexity of subjective experience. The reconstruction of one's story and transformation of one's self is more than a by-product of recovery, it should be a central process that practitioners engage with. My final point in relation to how narratives can become central to clinical care, and this again is intrinsically linked to all the points above, is that there needs to be greater reflection on

the values and beliefs of the practitioner and the ways in which these influence their practice.

As in all cases, there are aspects of this research that have been touched upon and paths not followed in favour of other elements. I want to outline some of the areas overlooked as a basis for further study. First, at the beginning of this research I chose to explore, as a comparative area to narratives of madness, narratives of physical illness. This decision was not based on the assumption of them being phenomenologically similar, but on the historical alignment of physical and mental illness and the parallels between the professions of medicine and psychiatry. I expected, and indeed found, differences and gaps in this research that did not account for the narrative experiences of madness. However, useful as this was, in retrospect it may have been more illuminating to my subject matter, to study narratives more similar in genre to those of madness; for example, narratives of trauma, for which there exists a rich source of interdisciplinary literature (see Stone, 2004). Similarly, given my argument that Kempe's and Barnes' accounts are narratives of recovery, I could have examined the wealth of research on recovery.[1] At the beginning of this study though, I tried to leave aside my assumptions about recovery, attempting not to pre-empt Kempe's and Barnes' stories as ones of redemption, which in many ways they turned out to be. So whilst I referred to some of this literature in the light of my analysis, I did not want the Western assumptions that underpin recovery (i.e. a straight, progressive trajectory towards health), to be the impetus behind this research. Bakhtin's writings on the chronotope and Peter Good's analysis of Bakhtin's work in relation to psychiatry, were far more revealing in my analysis of Kempe and Barnes, as they captured the complex, circular and multi-

[1] Whilst recovery is extensively studied in psychiatric and psychological health research, research on narratives of recovery is minimal.

dimensional nature of recovery, which could provide the basis for future research questions. For example, in what ways, if any, does phenomenological time and space change during unusual experiences? How is this affected by institutional environments? By what means can people's chronotopes be engaged with within the therapeutic relationship? Bakhtin's work on voice and dialogism could also be used in future research. His writings on polyphony are directly related to the work on voice hearing and could add further theoretical credence to this growing body of research, as well as providing another framework for voice hearing to be understood within. Finally, narrative research should not only be undertaken on those coherent, written narratives, complex as they are. Research on narratives of madness should strive to access people's incoherent, atemporal narratives, and endeavour to access those spaces where such narratives may be heard; the day room of a psychiatric ward or a Hearing Voices group, to give two polarised examples. Furthermore, like clinicians, narrative research can give people the means to express their experiences in different forms: words, pictures, photographs, video and drama.

If I wanted the reader of this thesis to take away just one thought from it, it would be this: what is needed in psychiatry, medicine and narrative research is a more inclusive definition of narrative that enables us to engage with meaning and what it means to be human. The stories we tell of our lives are important. They are central to our sense of self and belonging and, in times of trauma, they are pivotal to making meaning out of apparently senseless experiences, becoming the cornerstone of recovery.