

Representing Madness: How Are Subjective Experiences of Emotional Distress Presented in First-Person Accounts?

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Close to 600 first-person narratives of madness have been published in English alone, offering invaluable insight into emotional distress from a rarely studied perspective. The goals of this study were (a) to analyze how writers of such narratives present their subjective experience of emotional distress in terms of narrative structure and voice and (b) to examine how the author's purpose in writing the narrative affects its form. Previous studies of physical illness narratives have shown that they can be categorized into types based on structure and style. We asked: Are emotional distress narratives similar, or do they constitute a unique form? Ten such narratives were analyzed, with respect to the following four dimensions: writer's subjective experience, narrative structure, voice, and purpose. The results suggest a typology of narratives of emotional distress that is quite distinct from those constructed for physical illness.

For more than a century, psychologists have struggled to conceptualize human experience, debating psychoanalysis, behaviorism, phenomenology, and cognitive theory, among other frameworks of meaning. A crucial perspective has, however, been conspicuously absent from these debates: first-person accounts of subjective experience. It is as if people's personal constructions of their lived experiences

have not seemed relevant to the field. Only within the past 20 years has psychology begun to change, taking a narrative turn that focuses on meaning-making processes and the ways people construct their life stories in relation to the social environments in which they dwell (Bruner, 1987; Frank, 1995; Josselson, 1995; Kleinman, 1988; Sarbin, 1986; Schafer, 1992; Spence, 1982). Narrative psychologists examine how people construct accounts of their lives, analyzing the structure and content of the stories they tell to themselves and to others about who they are (McLeod, 1997; White & Epston, 1990).

Throughout their lives, people consciously and unconsciously create narratives to organize the chaos of existence into a coherent story. Gonçalves, Machado, Korman, and Angus (2002) contend that “the introduction of narrative order is probably the most fundamental aspect of human knowing” (p. 155). Each person creates his or her own coherent life story that relates the past to the present and imagines possible story lines of the future. This life story, or personal narrative, defines a person’s sense of “self,” a concept Schafer (1992) defines as “a set of narrative strategies or storylines each person follows in trying to develop an emotionally coherent account of his or her life among people” (p. 34).

When an illness (either physical or mental) interrupts or shapes a person’s life story, narrative order and a sense of self are often lost in the chaos and unpredictability that the illness brings. The genre of “illness narratives” reveals how people reclaim narrative order and reshape their sense of self in relation to the illness. Shlomith (2002) says, “Telling, and even more so writing, it seems, is a way of taking control, creating order, thus keeping chaos at bay” (p. 23). DeSalvo (1999) agrees: “Writing gives us back the voices we seem to lose when our bodies become ill or disabled” (p. 183). A writer can, however, structure his or her narrative of illness in a great variety of ways. Every story is unique. The structure of an illness narrative can thus provide insight into the writer’s psyche and the particular ways he or she has made sense of his or her life story.

In the midst of an experience of either physical illness or emotional distress, the voice of the suffering person can easily become lost in the impersonal and sometimes dehumanizing medical discourse. The language and metaphors of the medical model describe, and often dictate, the ways that people conceptualize their own struggles. If a body is considered “broken” when disease strikes, then “to be fixable, the body has to be a kind of machine” (Frank, 1995, p. 88). To capture this view of illness, Frank uses the metaphor of the body as a car that needs to be brought into the shop to be repaired.

Applied to emotional distress, this view casts the mind as a computer with the “mental illness” as a virus that infects functions and disrupts output. Pharmaceutical companies and biological psychiatrists endorse the computer–mind metaphor or the “broken brain” concept in their advertising and research. They make it seem as if medications can rapidly restore “normal functioning,” like downloading a “patch” and then rebooting a computer.

The conceptualization of human suffering in terms of the medical model has serious implications for clinical psychologists as well as for the people they serve. Psychiatric diagnoses often limit people's constructions of new meanings in their lives, which, in turn, may create feelings of passivity and hopelessness (Bannister, 1985; Casey & Long, 2003). The medical construing of people's emotional distress also creates a distance between the client and therapist, because it is quite difficult for the psychologist to foster a therapeutic relationship with a neurotransmitter (Leitner, 1985). As part of their clinical training, psychologists may find it beneficial to read first-person narratives of emotional distress to cultivate an appreciation for the complexities of the human experience (Norcross, Sommer, & Clifford, 2001).

Psychologists may also find first-person narratives to be useful resources in their clinical practices for themselves and their clients. Clifford, Norcross, and Sommer (1999) surveyed 362 psychologists about their practice of recommending first-person patient narratives for their clients to read in conjunction with psychotherapy. They found that out of the 33% of clinicians who routinely recommended such books, 95% of their clients found these resources to be quite helpful in the therapeutic process (see also Sommer, 2003).

First-person narratives of emotional distress provide an alternative to conventional medical conceptions of "mental illness" (Hornstein, 2002, 2003). Metaphors of the body and mind as a machine are replaced by stories of individual lives, each with a unique experience of suffering and healing. The present-day medical discourse of chemical imbalances and faulty neurotransmitters fails to capture the complexities of many people's subjective experience of distress and coping.

In a physical illness narrative, there is often a clear distinction between the individual, who is not seen as fundamentally flawed, and the body that is temporarily "broken." In other words, the "disease model of medicine reinforces this conception of each patient 'having' a disease" (Frank, 1995, p. 85) but not necessarily the person as being labeled by his or her body's diagnosis. For example, "People say, 'I have cancer.' They don't say, 'I am cancer'" (Manning, 1994, p. 169). In the case of mental illness, however, the person often takes on or is assigned a diagnostic label as a part of his or her self-identity. In *Undercurrents*, Manning articulates the problem of not separating the individual from his or her psychiatric label: "Calling someone 'a manic-depressive' reduces a multi-faceted human being to a diagnosis and lulls us into a false sense that those words tell us who the person is, rather than only telling us how the person suffers" (p. 170).

When medical discourse has the power to dictate a person's identity—as in the case of emotional difficulties—it is especially important to take account of first-person narratives. Close to 600 first-person narratives of madness have been published in English alone, beginning in the 1400s (Hornstein, 2005). This genre of "emotional distress narrative" is a practically untapped resource of first-hand data on "mental illness" (the term psychiatrists prefer). Sommer and Osmond (1983) compiled one of the first bibliographies of patient narratives and encour-

aged psychologists to make use of these valuable resources (see also Sommer, Clifford, & Norcross, 1998, for an updated bibliography). In contrast to diagnostic tools like the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. text revision [DSM-4-TR]; American Psychiatric Association, 2000), first-person narratives allow writers to put their experiences into their own words and impose their own structure of cause, event, and consequence in a language unconstrained by medical discourse.

Such researchers as Charmaz (1991), Frank (1995), Hawkins (1999), and Hubert (2002) have shown that illness narratives (physical and mental) can be categorized into types based on structure, form, and purpose. For example, Hawkins created narrative type categories based on authorial intent. The “didactic” narrative serves as a model of experience that the writer hopes can instruct others in the same position. The writer of an “angry” narrative identifies deficiencies in the medical system that he or she has encountered. The “alternatives” narrative is also critical of the medical system, but offers constructive suggestions for change and reform. Finally, the “ecopathology” narrative connects the writer’s personal illness experience to global cultural, environmental, and political problems.

Frank (1995) proposed a different typology to describe accounts of physical illness, distinguishing between “restitution,” “chaos,” and “quest” narratives. These categories try to capture the relation between the person’s illness experience and his or her concept of self. The “restitution” narrative is a story about the power of medicine and doctors, which de-emphasizes the patient’s self-identity. Frank describes the basic plotline of the “restitution” narrative as “yesterday I was healthy, today I’m sick, but tomorrow I’ll be healthy again” (p. 77). In the “chaos” category, in contrast, the self is lost in the suffering and confusion of illness. Published illness narratives, for the most part, would not be in the “chaos” category because, by definition, chaos means having no narrative or not being able to define a situation in words. As Frank notes, “Where life can be given narrative order, chaos is already at bay” (p. 105). The third narrative type Frank introduces is the “quest,” in which the afflicted person “meets suffering head on; they accept illness and seek to *use* it” (p. 115). Rewriting the calamity of illness into a transformative journey of personal growth is the aim of the “quest” narrator (see also Charmaz, 1991).

Previous research on illness narratives has been largely focused on physical ailments (see also Mattingly, 1998); accounts by those labeled “mentally ill” have been ignored by psychologists and scholars writing on health. Hubert (2002) did study women’s madness narratives, but focused “on the political aspects of psychiatric treatment” (p. 19) and not on the subjective experience of emotional distress itself. Similarly, literary critics, such as Edwards (1989), Keitel (1989), and Caminero-Santangelo (1998), have analyzed madness narratives in terms of their structure more than their psychological dynamics. Hawkins (1999) analyzed physical illness and emotional distress narratives, but focused exclusively on the writ-

ers' narrative purpose. In this study, we examined a selection of first-person madness narratives along several key dimensions: the writer's subjective experience of distress, the structure and voice of the narrative, and the relation of the writer's purpose to the narrative's form.

There is a wide range of possible combinations of narrative structure, voice, and purpose for the writer to choose from in constructing his or her account. As Robinson and Hawpe (1986) point out, "experience does not automatically assume narrative form. Rather, it is in reflecting on experience that we construct stories. The stories we make are accounts, attempts to explain and understand experience" (p. 111). Previous research has shown that narratives of physical illness can be categorized into narrative types based on their structure and form. In this study, we asked whether narratives of emotional distress were similar to narratives of physical illness or whether they constituted a unique form. We examined how each writer chose to construct his or her narrative and whether the narrative presentation was in some way related to his or her subjective experience of emotional distress. The information collected from the analysis of a wide variety of accounts of emotional distress served as the basis for the creation of a typology of such narratives.

METHOD

Selection of Narratives

In our preliminary work, we read more than 50 first-person accounts of emotional distress and then selected 10 narratives to analyze in depth for this study. This study was carried out in the context of the first author's senior honors thesis, and thus we chose to analyze formally only 10 narratives due to the time constraints of an academic year. Five of the 10 texts included the experience of being in a psychiatric facility; the other 5 did not. Only narratives where the hospitalization was longer than a week were included in the first group. The rationale for including institutional and noninstitutional narratives was to see whether the two groups have a qualitatively different subjective experience of emotional distress, and to assess the effect that hospitalization might have on the style and structure of the narrative.

We were also careful to include no more than two narratives (in each group) from any one diagnostic category of mental illness so as not to overrepresent any one type of experience in the analysis. Narratives written by more than one person (patient and family, doctor and patient, etc.) were also excluded because the main focus of this study was on the writer's subjective experience of emotional distress. The time period in which the narratives were written was not used as a selection criterion, although an effort was made to select no more than two or three narratives from any one decade.

The gender of the writer was also not used as a selection criterion; however, we did have a fairly balanced (6 men and 4 women) group of writers in this respect. Previous research on gender differences and mental illness has focused mostly on prevalence rates for certain diagnoses and on men's and women's differing attitudes toward psychiatric treatment options. There was no particular reason to expect differences in a person's subjective experience of emotional distress as a consequence of his or her gender, so it was not a factor that we chose to analyze here.

We included Grandin's (1995) *Thinking in Pictures* in this study even though her diagnosis of autism is not at present considered a "mental illness" in the same sense that schizophrenia or depression are. Autism—or more specifically in Grandin's case, Asperger's Syndrome—is currently regarded as a neurological condition with an onset unrelated to emotional trauma or other psychosocial factors. Like several other narratives in this study, however, Grandin's is the account of an outsider who feels that the ways she thinks, feels, and experiences the world are different from those of "normal" people. Among Grandin's purposes in writing *Thinking in Pictures* is to give nonautistic people a chance to understand the first-person subjective experience of living with autism. Because one of the purposes of this study was to examine how the writer's subjective experience of emotional distress influences his or her narrative presentation, we included Grandin's book because it primarily focused on her emotional difficulties and struggle to integrate her experience of autism into her overall life narrative, much like the other texts we chose.

Table 1 summarizes the narratives that were selected for analysis and the criteria used to differentiate them from one another.

TABLE 1
Narratives Selected for Analysis

<i>Title</i>	<i>Writer</i>	<i>Date Published</i>	<i>Diagnosis</i>
Hospital accounts			
<i>A Mind That Found Itself</i>	Clifford Beers	1908	manic-depression
<i>The Snake Pit</i>	Mary Jane Ward	1946	nervous breakdown
<i>Wisdom, Madness and Folly</i>	John Custance	1952	manic-depression
<i>Out of the Depths</i>	Anton Boisen	1960	schizophrenia
<i>Undercurrents</i>	Martha Manning	1994	depression
Nonhospital accounts			
<i>The Diary of Vaslav Nijinsky</i> (unexpurgated edition)	Vaslav Nijinsky	1999	schizophrenia
<i>A Season in Hell</i>	Percy Knauth	1956	depression
<i>Holiday of Darkness</i>	Norman Endler	1982	depression
<i>Thinking in Pictures</i>	Temple Grandin	1985	autism
<i>An Unquiet Mind</i>	Kay Redfield Jamison	1995	manic-depression

Procedure and Analysis of Results

To explore whether first-person madness accounts constituted a unique narrative form, we analyzed the 10 narratives in terms of the writer's subjective experience of distress and the structure, voice, and purpose of the narrative that he or she wrote. We then created categories for each of these four dimensions to help us make sense of the narratives' similarities and differences. We wanted the categories we proposed to be broad enough to apply to any narrative of emotional distress, which is why we intentionally chose a broad range of authors, diagnoses, styles, structures, and time periods.

To concretize our analysis, we constructed a set of questions for each narrative characteristic (subjective experience, narrative structure, voice, and purpose) to generate a profile of each of the 10 first-person accounts (see Appendix). These questions were designed to be general enough to evaluate any emotional distress narrative and sufficiently comprehensive to generate useful information for the creation of narrative typologies. We wanted to explore the range of ways that people experience emotional distress and construct narratives to describe those experiences.

Using our set of questions for each narrative characteristic, we analyzed each narrative and pulled out quotes that we felt "answered" each question. For example, to investigate Custance's (1952) subjective experience of emotional distress described in *Wisdom, Madness and Folly*, one of the questions we asked was: Are metaphors and/or symbolism used to describe the narrator's experiences? If so, what kinds? One of the quotes that we felt answered this question is one in which Custance is describing "a metaphorical table-land" (p. 63) to relate his experience of manic-depression to the reader: "Normal life and consciousness of 'reality' appear to me rather like motion along a narrow strip of table-land at the top of a Great Divide separating two distinct universes from each other" (p. 29).

In our analysis of narrative structure, one of the questions we asked was: Is there a turning point in the narrative that distinguishes the predistressed narrator from the postdistressed narrator? In *Undercurrents*, Manning (1994) describes a clear distinction between her self-conceptualization before and after being hospitalized for her depression:

Being hospitalized on a psychiatric unit was, for me, like crossing over into a different state ... There has been a loss of innocence in it all. Some reckoning, in a real life showdown, of my own vulnerability, my capacity for unraveling, the limits of my effort and will. It is knowing that I am capable of falling, that I am fragile ... To know the force of the avalanche and my powerlessness over it is to feel myself in brand-new territory. (p. 186)

One of the questions that we asked in our analysis of narrative voice was: Is there a clear distinction between the narrator's distressed self and the

nondistressed self? In *A Season in Hell*, there is a clear distinction between the voices of Knauth's (1975) distressed and nondistressed selves. For example, while in the grips of a debilitating depression, Knauth says, "I was stumbling along in a void, alone, forsaken, coming from nowhere, going nowhere" (p. 9). In contrast to the bleakness of his distressed self, the voice of Knauth's nondistressed self "nourished an active joy in the fact of being alive" (p. 5).

The last dimension of analysis that we looked at was narrative purpose, and one of the questions we asked was: Does the narrator write to share a divine message, religious experience, or revelation? Boisen (1960) explains that the main purpose of writing *Out of the Depths* was to present his "central thesis that certain forms of mental disorder and certain forms of religious experience are closely interrelated" (p. 9). He goes on to further describe his narrative's purpose:

I offer it as a case of valid religious experience which was at the same time madness of the most profound and unmistakable variety. In this record I have brought together such material as may throw light upon the origin, meaning, and outcome of that experience. (p. 9)

Once we finished identifying the quotes, such as the ones outlined previously, that exemplified each of the four dimensions of narrative analysis, we generated profiles of each of the 10 first-person accounts based on the results of our analyses. These narrative profiles helped us to organize our findings coherently and to identify common themes and patterns that emerged from our analyses.

After we compiled our sets of questions for each of the four dimensions of analysis and had begun to write up the narrative profiles, we surveyed a small group of college students to see how others would use the categories we proposed. The purposes of surveying the students were (a) to see if their categorizations of the narratives were consistent with the researchers' interpretations and (b) to receive feedback about the clarity, comprehensiveness, and usefulness of the categories we had created. These students were all members of a seminar on first-person narratives of madness taught in the psychology department at Mount Holyoke College. Three of the 10 narratives used in this study (*Wisdom, Madness and Folly*; *Holiday of Darkness*; and *The Diary of Vaslav Nijinsky*) had also been read and analyzed by members of the seminar. At the end of the semester, students were asked to categorize each of these narratives using the system that we had outlined. There was a high degree of agreement among the students as to how they categorized these three writers' subjective experience of emotional distress: Thirteen out of the 16 students (81%) concurred with our categorizations of subjective experience for each of the three narratives surveyed.

There was more variability in students' evaluation of these three narratives in terms of structure, voice, and purpose. Some students who completed the survey felt that a given narrative might fit into more than one category. To better under-

stand why there was more variation in the ways that students evaluated the categories of narrative structure, voice, and purpose, we conducted in-depth interviews with two of the students who completed the survey. As a result of these interviews and from the suggestions that other students wrote on their surveys, we refined categories that were not sufficiently clear, eliminated those that were too general or overlapped with other categories, and made sharper distinctions between the categories of subjective experience.

Finally, we compared and contrasted the five narratives that were hospital accounts to the five nonhospital accounts in terms of their narrative categorizations. The result of this comparison allowed us to evaluate whether hospitalization makes for a qualitative difference in terms of subjective experience of emotional distress and a writer's presentation of his or her narrative. The results of all these analyses were then systematically compared, and a formal typology of first-person narratives of emotional distress was proposed.

RESULTS

Summary of Results

The goal of this study was to examine whether narratives of emotional distress constitute a unique form. Three clearly defined types of subjective experiences of emotional distress emerged from our analyses, which we have named the "traumatic interruption," "revelation/purposeful suffering," and "continuity" experiences. After we systematically compared each writer's subjective experience to the structure, voice, and purpose of the narrative that he or she wrote, and then compared the hospital accounts to the nonhospital accounts, we created a typology of first-person narratives of emotional distress. Our results demonstrate that the experience of emotional distress is different from the experience of physical illness, and there are types of narrative presentation unique to this literary form. The categories for subjective experience of emotional distress and the three overall narrative types are summarized in the following sections.

Types of Subjective Experience of Emotional Distress: "Traumatic Interruption"

In this type of experience, the person's life is thrown into a state of chaos due to the sudden, unexpected onset of an emotional crisis. The emotional distress may also end as suddenly as it appeared. Writers often describe the emotional crisis as being analogous to an ambiguous physical illness, like the flu, in that it seems to come "out of the blue." But after the crisis passes, the person's life seems to return to its prior state. Figure 1 illustrates how, in this type of subjective experience, the postdistressed self is not fundamentally changed.

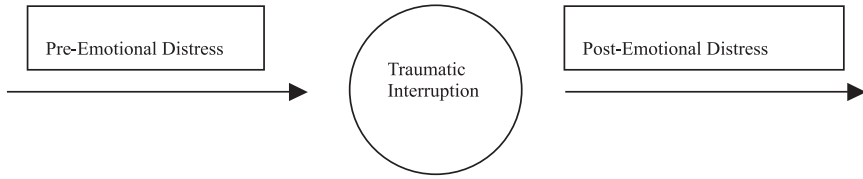


FIGURE 1 Life narrative in relation to a “traumatic interruption” experience.

A “traumatic interruption” experience is categorized by feelings of confusion, loss of control, and anxiety. The emotional crisis feels foreign to the person’s usual sense of self. For example, in the narrative *Holiday of Darkness*, Endler (1982) says, “Depression had turned life around for me. From being on top of the world in the fall, I suddenly felt useless, inept, sad, and anxious in the spring” (p. 12). Unlike an experience of “revelation/purposeful suffering,” in which the writer turns a negative experience into a positive one, in a “traumatic interruption” narrative, the writer’s life is negatively affected by his or her experience of emotional distress.

Types of Subjective Experience of Emotional Distress: “Revelation/Purposeful Suffering”

In this type of experience, a person’s life is interrupted by an emotional crisis, but the experience is positive in the sense that it becomes a catalyst for a personal revelation or breakthrough. For example, in *Out of the Depths*, Boisen (1960) describes his emotional distress as

terrible beyond the power of words to express. And yet I do not regard these experiences as “break-downs.” If I am right in believing that through them difficult problems have been solved for me and solved right, and if through them help and strength have come to me, am I not justified in such a view? (p. 139)

Those who have a “revelation/purposeful suffering” experience of emotional distress do not return to their predistressed self; instead, the insights they have gained lead to a reconstruction of self, and the life narrative may take an entirely different turn. The originating occurrence, or the emotional distress as a whole, profoundly changes the person’s outlook on life, concept of themselves, and direction of the postdistress narrative. For example, in *A Mind That Found Itself*, Beers (1908) describes how, prior to his breakdown, he was preparing for a career in the business world and would never have considered doing advocacy work on behalf of mental patients.

Beers traces the origins of his emotional distress back to the death of his older brother, who suddenly passed away as the result of a previously undiagnosed brain

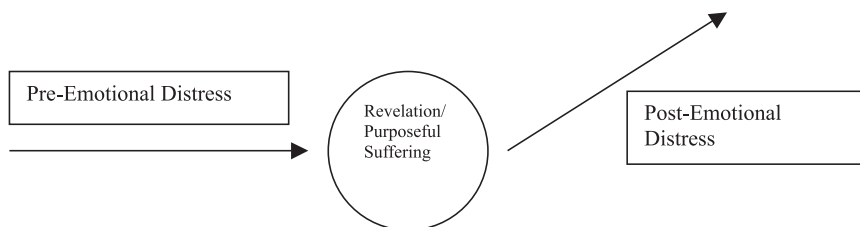


FIGURE 2 Life narrative in relation to a “revelation/purposeful suffering” experience.

tumor. Before his death, Beers’s brother suffered from epileptic seizures, and Beers became obsessed with the fear that he too would start having them and fall victim to his brother’s fate. The turning point that radically changes the direction of Beers’s life is his suicide attempt and subsequent hospitalizations in which he witnessed and experienced physical abuse of patients. While in the hospital, he decides that it is his duty to expose the horrific conditions of the state mental hospitals, and he begins a lifelong crusade for mental health reforms and advocacy of patients’ rights. As a result of his experience of emotional distress, Beers’s life narrative changed significantly, and he took on a new role as a writer, advocate, and public speaker, eventually founding the National Mental Hygiene Association. Figure 2 illustrates how the “revelation/purposeful suffering” experience changes the directionality of the person’s life narrative.

Types of Subjective Experience of Emotional Distress: “Continuity”

In this type of subjective experience, there is no significant interruption or break in the person’s life narrative and therefore no distinction between a pre- and postdistressed self. For example, in her narrative *An Unquiet Mind*, Jamison (1995) says, “For as long as I can remember I was frighteningly, although often wonderfully, beholden to moods” (p. 4). Over the course of her life, Jamison goes through countless cycles of mania and depression, but there is no critical turning point or moment when she considers herself completely recovered. Even at the end of her narrative, she notes that she expects more cycles of mania and depression in her future and has investigated all her treatment options for when those times come. In spite of acknowledging these ongoing struggles, Jamison also inspires and provides hope for others struggling to regain control over their lives in the face of emotional turmoil.

Because there is no significant interruption in the life narrative or any discernable turning point of recovery, the person may not consider his or her periods of emotional distress to be indicative of “mental illness.” For example, in *The Diary of Vaslav Nijinsky*, Nijinsky (1999) acknowledges that “I know I will be told I am insane because I speak of things that I do not understand. I know that I under-

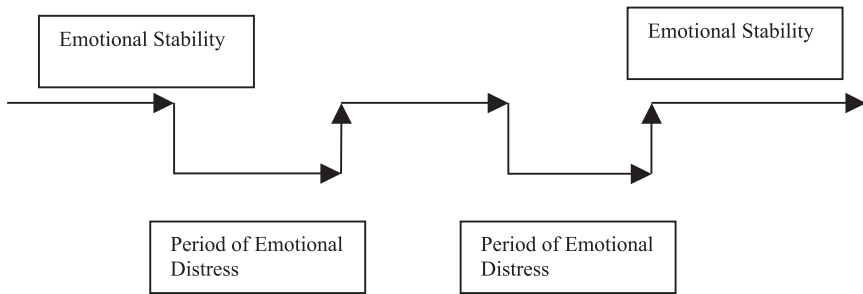


FIGURE 3 Life narrative in relation to a “continuity” experience.

stand” (p. 224). He considers himself to be enlightened and on a higher level of understanding about God and the workings of the world. By writing his narrative, Nijinsky hopes to impart his knowledge to all people, and he says that “I write because God commands me to” (p. 29). He is well aware, however, that his writings about God may lead others to assume that he is insane:

I know everyone will say that Nijinsky has gone mad, but I don’t care, for I have already behaved as if I were a madman at home ... People like eccentrics, and they will therefore leave me alone, saying that I am a mad clown. (p. 11)

Alternatively, a person may embrace his or her diagnosis as a part of identity, thus integrating his or her emotional distress into a continuous life narrative. For example, in her narrative *Thinking in Pictures*, Grandin (1995) regards her diagnosis of autism as an essential part of her identity: “If I could snap my fingers and be nonautistic, I would not. Autism is part of what I am” (p. 60). Figure 3 illustrates how, despite some periods of emotional distress in the person’s life narrative, there are no significant breaks in the overall progression of a “continuity” narrative.

Narratives of emotional distress can be further categorized in terms of their purpose and meaning. Following are summaries of three general types of emotional distress narratives, which we have named the “psychiatric oppression,” “psychiatric empowerment,” and “healing” narratives. Because these types reflect writers’ often complex purposes, a given narrative may fit within more than one of these categories or shift from one to another at different points in the story.

Types of Emotional Distress Narrative: “Psychiatric Oppression”

We have defined “psychiatric oppression” as the feeling of being in some way abused, mistreated, coerced, or denied human rights by mental health professionals; by a diagnosis or label of mental illness; by a hospital or institution; or

by treatments such as medication, electroconvulsive therapy (ECT), hydrotherapy, or restraint. For example, in *A Mind That Found Itself*, Beers (1908) says, "When my vocal cords were bound as with a chain, by delusions, my doctor had tried to induce me to speak. Now, when I was at last willing to talk, he would scarcely condescend to listen" (p. 92). Through the creation of their narratives, writers of psychiatric oppression accounts strive to regain their narrative voices after the right to narrate their own stories was taken away by the psychiatric establishment. The texts in our study that were categorized as "psychiatric oppression" narratives were Ward's (1946) *The Snake Pit*, Nijinsky's (1999) *The Diary of Vaslav Nijinsky*, Beers's (1908) *A Mind That Found Itself*, and Boisen's (1960) *Out of the Depths*.

Writers of a psychiatric oppression narrative seek to protest psychiatric abuse, raise social awareness about these abuses, or challenge psychiatric authority. Beers (1908), Ward (1946), and Boisen (1960), who all had hospital experiences, give evidence of the widespread abuse of mental patients in institutions and help to raise the public's awareness of this problem. Beers and Ward each write with the narrative purpose we called "reformation," but their criticisms of mental hospitals are presented in different forms. Beers uses his narrative as a platform to explicitly criticize the mental health system and calls for the public to join him in reforming America's psychiatric hospitals. Ward's call for psychiatric reform is implicit in her account of the fictional Juniper Hill Hospital, a place where doctors and attendants do not listen to or try to understand their patients, physical treatments are given for psychological problems, and patients live in overcrowded and understaffed conditions that are hardly conducive to achieving emotional stability. Ward does not present a plan of action for reforms the way Beers does; instead, she uses a fictional storytelling method to dramatize the horrors of the mental hospital, which in turn elicits shock, fear, and indignation from her readers. Ward seems implicitly to hope that her readers will take action against the deplorable state of affairs within state mental hospitals as a consequence of reading her book.

Boisen, like Beers, explicitly criticizes mistreatment at the hands of attendants and doctors during his time in psychiatric hospitals. He depicts the mental hospital as a frightening and sometimes dangerous place where patients' rights are ignored and where they are frequently abused by the staff. In a haunting passage, Boisen (1960) describes the mental hospital as

a place of weeping and gnashing of teeth where the light is gone and the loved ones cut away, whereas those in control are industriously engaged in suppressing the symptoms which might lead to recovery ... Over the door I would write, "Lasciate ogni speranza, voi ch'entrate" [All hope abandon, ye who enter here] ... This is indeed a place of lost souls and the methods of treatment are nil. It is just a great prison which they call a "hospital." (pp. 113–114)

Boisen is also critical of the psychiatric system for not addressing the psychological and spiritual difficulties that he saw as being at the heart of his emotional distress.

Nijinsky (1999) did not spend time in a hospital or receive psychiatric treatment until after he wrote his diary, but he still feels oppressed and threatened by psychiatric authorities. Throughout the diary, Nijinsky expresses his fear that he will be labeled “insane” and committed to an asylum. Simply the threat of being diagnosed with a mental illness and being forced to undergo treatment were enough for him to feel psychiatrically oppressed.

Types of Emotional Distress Narrative: “Psychiatric Empowerment”

Writers using this narrative type have generally positive feelings about mental health professionals and the treatment they receive. The writer may even advocate for the type of treatment that was effective in his or her recovery. Writers may feel empowered by their diagnosis of “mental illness” because they can better educate themselves about the potential causes and treatment options available. Unlike writers of the “psychiatric oppression” type, writers of the “psychiatric empowerment” type feel that their treatment—whether psychotherapy, medication, or ECT—was their salvation from emotional distress. For example, in *An Unquiet Mind*, Jamison (1995) says,

I cannot imagine leading a normal life without taking lithium and having had the benefits of psychotherapy ... Psychotherapy is a sanctuary; it is a battleground; it is a place I have been psychotic, neurotic, elated, confused, and despairing beyond belief. But, always, it is where I have believed—or have learned to believe—that I might someday be able to contend with all of this. (pp. 88–89)

In his narrative, *Holiday of Darkness*, Endler (1982) explains that he was initially reluctant to undergo ECT for his depression, but in retrospect regards this psychiatric intervention as a key turning point in his recovery process. After a series of ECT treatments, Endler notes the profound change in his mood: “A miracle happened in two weeks. I had gone from feeling like an emotional cripple to feeling well” (p. 75). One of Endler’s purposes in writing *Holiday of Darkness* is to help portray the controversial psychiatric procedure in a more positive light; he lauds “ECT [as] the most reliable, effective, and convenient technique for alleviating disabling and/or intense depression” (p. 64).

The writers of the “psychiatric empowerment” narrative type may also use their own experiences to inspire, encourage, and give hope to others in a similar state of emotional distress. Accounts of this type tell stories about overcoming external obstacles and personal demons on the journey to emotional healing. The “empowerment” narrative stands as a testament to the perseverance of the human spirit and

the possibility of hope even in the most dire of circumstances. People who are struggling with their own emotional distress may use the “empowerment” narrative as a model for how to regain control over their own lives by taking an active role in the recovery process. To those readers who have lost their narrative voice or ability to tell their own life story due to personal trauma or external oppression, the writer of an “empowerment” narrative may serve as their representative voice. The narratives from our study that fit into the “empowerment” type were Endler’s (1982) *Holiday of Darkness*, Jamison’s (1995) *An Unquiet Mind*, Grandin’s (1995) *Thinking in Pictures*, Manning’s (1994) *Undercurrents*, Knauth’s (1975) *A Season in Hell*, and Custance’s (1952) *Wisdom, Madness and Folly*.

Types of Emotional Distress Narrative: “Healing Narrative”

Another narrative type that emerged from the analysis of our data was the “healing narrative.” In such an account, writing is itself therapeutic, as part of the individual’s emotional healing process. Hawkins (1999) notes that the “act of writing in some way seems to facilitate recovery: the healing of the whole person” (p. 129). For example, Manning’s (1994) narrative, *Undercurrents*, is organized by diary entries, and she uses her journal to reflect on her experiences while they are occurring and in retrospect when she constructs her narrative. Through the process of emotional healing, the writer often expresses a sense of deeper understanding of what he or she truly values or what is most important in his or her life. The narratives from this study that fit into this type were Manning’s *Undercurrents*, Knauth’s (1975) *A Season in Hell*, and Boisen’s (1960) *Out of the Depths*. The “healing narrative” has a sense of finality or a resolution to the problems the person dealt with during his or her period of emotional distress. This sense of resolution is often facilitated by the writing itself. For example, in *A Season in Hell*, Knauth says that writing gave him the opportunity to “review the course of my illness, to absorb what I had learned about depression, to find a place for this extraordinary experience within the context of my life” (p. 85).

DISCUSSION

Limitations of this Study and Suggestions for Future Research

One limitation of this study was that we formally analyzed only 10 madness narratives. A larger sample might yield refinements to the categories and perhaps even additional narrative types. Given the paucity of research in psychology on narratives of emotional distress, however, this study does provide a clear foundation on which future research can build. One example of a possible additional narrative type of subjective experience that may exist could be called a “deterioration” experience. The “deterioration” narrative resembles a “traumatic interruption” plotline, except that

the postdistressed self takes a downward trajectory rather than an upward one. The narrative analyzed in this study that most closely resembles this new type is *The Diary of Vaslav Nijinsky* (Nijinsky, 1999), in which the writer's narrative clarity and coherence deteriorate through the course of the diaries. Figure 4 illustrates this possible additional narrative type that may be found in further studies.

A subgenre of the first-person narrative of emotional distress is the account written by a family member of a person diagnosed with a mental illness. Like the different subjective experiences of the writers analyzed in this study, family members' lives are affected in varying ways by a loved one's psychological difficulties. A future study might analyze family members' subjective experiences and compare them with the types of narrative presentation found in this study. Another subgenre of interest for such a comparison are narratives written jointly by the person diagnosed with mental illness and his or her therapist. Does the presence of the clinician's narrative voice affect the patient's choice of narrative presentation?

This study focused on the construction of emotional distress narratives in terms of overall structure, narrative voice, and purpose. Future research might focus on a more fine-grained analysis of syntax, punctuation, and paragraph structure to see how these relate to the subjective experience being presented. How do these elements of literary style embody the overall narrative structure and voice of the writer? For example, a "free-floating" narrative voice may be conveyed by a writer's choice to make few paragraph breaks or omit periods at the ends of sentences to convey the fluidity of his or her thought patterns.

Another important avenue for future study is to compare narratives of emotional distress to narratives of physical illness, such as cancer, rheumatoid arthritis, or AIDS, to see if there are similarities in structure despite differences in the nature of the trauma. In the case of physical illness, there is typically a clear distinction between the person's sense of self and the part of the body that is deemed broken or damaged. The "traumatic interruption" subjective experience identified in emotional distress narratives is similar to some experiences reported by sufferers of physical illness in the sense that the preinterruption self is felt to be the same as the postinterruption self. Thus, this "traumatic interruption" category may be applicable to some physical illness narratives. But do writers of physical illness narratives have "revelation/purposeful suffering" experiences, where the fundamental sense

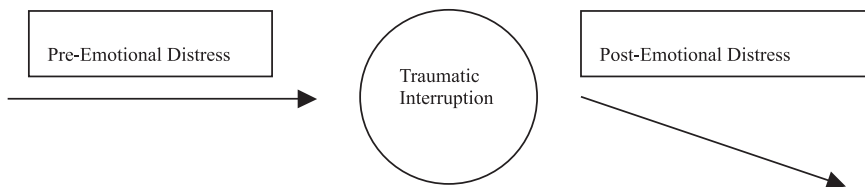


FIGURE 4 Life narrative in relation to a "traumatic interruption" experience with a negative outcome.

of self is changed by the illness experience? Furthermore, the “continuity” experience identified as characteristic of some emotional distress narratives might not fit the experience of physical illness because such experiences are largely negative and most likely result in a traumatic interruption of the person’s life narrative. “Revelation/purposeful suffering” experiences, on the other hand, might be found in some physical illness narratives where the experience serves as a catalyst for the person’s realization of some deeper meaning or higher purpose in his or her life.

There are varying definitions of “mental illness” across cultures, and it would be interesting to compare and contrast narratives from different regions of the world. Despite the fact that different societies have different names and classification systems for patterns of behavior labeled as mental illness, there might still be commonalities in the subjective experience of emotional distress, and there might be differences in narrative structure or voice. This might hold as well for different subcultures—that is, do African American narratives of emotional distress fit the same categories as those by European American writers?

CONCLUSIONS

The first-person narrative genre gives clinicians and lay persons alike a rare, inside view of what it is like to experience “mental illness.” The focus of this study was on writers’ subjective experiences and not on their particular labels of mental illness. For many writers, the narrative is a way of articulating their experience of “mental illness” in their own words, without the restrictions, assumptions, and stigma of psychiatric labels. Defining one’s own experiences and deciding how they fit (or do not fit) into the larger life narrative can be empowering. A narrative allows the writer to construct his or her sense of self in relation to whatever traumas or psychological problems he or she may have had. In the most basic sense, the act of writing one’s life narrative allows a person to reconstruct what events led up to his or her emotional distress and try to make sense of them. When the underlying meanings or causes of a psychological problem are better understood, the life narrative regains coherence or continuity, which may have been lost during the chaos of an emotional crisis.

Further studies of first-person narratives of emotional distress would advance the field of psychology. This narrative genre gives authority to the voices of the “mentally ill” and puts their accounts of personal suffering on an equal plane with the medical/psychiatric master narrative. Many consumer/survivor/ex-patient advocacy groups have already embraced the first-person narrative as a vehicle to counter the feelings of oppression and helplessness that people often feel as a result of their treatment (or mistreatment) in the mental health system.

Doctors and psychologists may find the diagnostic criteria of *DSM-IV-TR* (American Psychiatric Association, 2000) useful in their attempts to study and understand human behavior, but it is often the case that the people who are assigned these diagnostic labels do not feel that they are better understood. Instead, those la-

beled “mentally ill” often feel stripped of their individuality, and the uniqueness of their subjective experiences is lost in impersonal medical discourse. The “mentally ill” are left with the problem of trying to reconcile the meaning and place that their experiences of emotional distress have in their overall life narratives. When the traumatic experience is integrated back into the context of the rest of their lives, then emotional healing, personal growth, and a sense of recovery may be achieved. Many of the writers in this study used personal narratives as a way to achieve this integration, and for them, the act of writing was therapeutic. Others write their narratives after or during the recovery process to educate others about what it means to be “mentally ill,” to refute stigmas and stereotypes, to share treatment options that they found useful, or to set forth their own theories about “mental illness.” As psychologists, we have a great deal to learn from such works.

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APPENDIX

ANALYSIS OF NARRATOR'S SUBJECTIVE EXPERIENCE OF EMOTIONAL DISTRESS

The following questions were used to generate information regarding subjective experience. Once each narrative was evaluated in terms of these questions, a profile describing the narrator's subjective experience was generated based on our analysis.

- Does the narrator identify a specific *cause/origin of his or her emotional distress*?* (*Terms in italics are defined below*)
 - Does the narrator explain the cause of his or her emotional distress? If so, how? *Situational? Environmental? Biological?* A combination?
 - Is the narrator diagnosed with a particular mental illness? Does the narrator accept or reject his or her diagnosis?
 - Does the narrator describe his or her emotional distress in terms different from medical/psychiatric terminology?
 - Are metaphors and/or symbolism used to describe the narrator's experiences? If so, what kinds?
 - Does the narrator experience his or her "mental illness" as something separate from themselves or as a part of themselves? Does that relation change throughout the narrative?
 - Does the narrator experience a change in productivity due to their emotional distress? If so, what type of change is it? Is the narrator unable to carry out everyday tasks like cleaning or cooking? Is the narrator unable to complete projects at work or school? Does the narrator show a decreased interest in hobbies/leisure activities? Is there an increase in the narrator's artistic creativity and production?
 - Does the narrator experience a change in his or her personal relationships due to their emotional distress? If so, what type of change is it? Does the narrator have an increased or decreased interest in spending time with friends and family? Does the narrator avoid or seek out social situations where he or she may interact with other people?
 - Does the narrator experience a *crisis/breakdown* due to their emotional distress?
 - What types of treatment, if any, are given to the narrator? How does the narrator evaluate the effectiveness of these treatments? Positively? Negatively?
 - Does the narrator recover from his or her emotional distress? If so, what methods of healing/treatment/coping were used?
 - Does the narrator experience a *turning point* in his or her recovery process?
 - Does the narrator identify an end point to his or her emotional distress?
 - Does the narrator find wisdom or a lesson learned at the end of his or her narrative?

Definitions of "Subjective Experience of Emotional Distress" Terms

- *Emotional distress*: Broadly defined as an extreme mental state in which a person experiences feelings of unrest, turmoil, suffering, and general sense of being out of control or not one's "normal" self. Periods of emotional distress may stem from or are exacerbated by conditions such as political oppression, poverty, an existential crisis, social injustice, racial or gender discrimination, and abusive relationships.

- *Cause/origin of emotional distress*: Time and/or circumstances when the emotional distress first began in the narrator's life.

- *Crisis/breakdown*: Point at which the narrator feels a loss of control over his or her own life; sometimes marked by a suicide attempt, feelings of hopelessness, desperation, fear, depression, and a loss of ability to function in the "normal" world.

- *Turning point*: An event or occurrence that becomes a catalyst for change in the narrator's life; it is often the climax of the story line. It is the point at which the narrator hits rock bottom and must face his or her problems to heal and recover, or when the narrator has a personal breakthrough/revelation and begins the healing process.

- *Situational*: Cause of the narrator's emotional distress is attributed (at least in part) to an isolated event that triggers the onset of the emotional crisis. The situation usually involves a traumatic event such as the death of someone close to the narrator, loss of a job, or any other occurrence that results in the onset of emotional distress.

- *Environmental*: Cause of the narrator's emotional distress is the culmination of negative influences from the individual's immediate social environment (home, family, work, etc.). These environmental influences in some way negatively affect the narrator's mental health. For example, if the narrator lives in a home where physical abuse is prevalent, this would be considered an environmental influence in the onset of his or her emotional distress.

- *Biological*: The narrator attributes the cause of the emotional distress as being physical/bodily. For example, the narrator explains the occurrence of depression in terms of a chemical imbalance of neurotransmitters.

Analysis of Narrative Structure

The following questions were used to generate information regarding narrative structure. Once each narrative was evaluated in terms of these questions, a profile describing its plot structure was generated based on our analysis.

- Is the narrative organized in *chronological sequence*?* (*Terms in italics are defined below.*) Or is it *Thematic*? Or is it a combination of the two?

- Does the narrator write in the past or present tense?
- What is the form of the narrative? Stream of consciousness? Conversational? Didactic?
- What is the genre of the narrative? Diary? Memoir? Novel? Textbook? Letters?
- How is the plot structure organized? One continuous story line? Separate, seemingly unconnected thoughts? Flashbacks? An academic paper? Legal brief?
- What perspective does the narrator write from? 1st person? 3rd person?
- Does the narrative include a preface or have commentary from a medical/academic source?
- What event or period of time in the narrator's life does he or she choose to begin with in the narrative?
- Is there a turning point in the narrative that distinguishes the predistressed narrator from the postdistressed narrator?
- Who is the intended audience? Psychologists? People with "mental illness"? Hospital administrators? Family?

Definitions of "Narrative Structure" Terms

- *Chronological*: A plot that is structured by the passage of time. However, the plot does not have to unfold in uninterrupted chronological order. For example, flashbacks to an earlier time are common in a chronological plotline.
- *Thematic*: Plot is organized by groups of events that the narrator combines by a common theme. An example of a thematic plotline would be hospitalization, family life, therapy.

Analysis of Narrative Voice

The following questions were used to generate information regarding narrative voice. Once each narrative was evaluated in terms of these questions, a profile describing the narrator's voice was generated based on our analysis.

- Is there a clear distinction between the *distressed self* and the *nondistressed self*?* (*Terms in italics are defined below*)
 - Does the narrative voice change throughout the narrator's experience of his or her emotional distress? If so, how and when does it change? From pre- to postemotional distress? Vulnerable to Assertive?
 - Does the narrator identify themselves as a *victim*? *Survivor*? *Witness to suffering*?
 - Does the narrator see themselves as a *deviant*? Does he or she embrace or reject this label?

- Does the experience of emotional distress lead to a reconstruction of the narrator's concept of self?
- Is there a turning point in which the narrator is reintegrated into "normal" society? Does the narrative voice change as a result?

Definitions of Narrative Voice Terms

- *Distressed self*: A narrative voice in which the narrator adopts the schema of "being sick." This would include loss of productivity, fatigue, weakness, and depression.
- *Nondistressed self*: A type of narrative voice that is confident, authoritative, or emotionally stable.
- *Victim*: A narrative voice that is helpless, weak, and has experienced harm of some kind. The victim usually seeks sympathy and help from others to escape his or her troubles.
- *Survivor*: A narrative voice that is empowered and wiser from whatever trials and tribulations the narrator has experienced. The survivor often advocates for others who are going through the same problems the narrator once lived through. The narrator gives a message of hope through his or her own example of recovery.
- *Witness to suffering*: Type of narrative voice that remains neutral in the narrator's telling of his or her life story. The narrator reports the past events and feelings that he or she experienced during the period of emotional distress.
- *Deviant*: A type of narrator who is at the margins of "normal" society. He or she is rejected due to thoughts, feelings, or behavior that deviate from the norm of the society/culture in which the narrator lives.

Analysis of Purpose of the Narrative

The following questions were used to generate the data regarding narrative purpose. Once each narrative was evaluated in terms of these questions, a profile describing the narrative's purpose was generated based on our analysis.

- Is the narrative written to expose abuse/inadequate conditions of a psychiatric institution? Does the narrator call for reforms of these abuses?
- Is the narrative written to refute the stigmas and stereotypes of "mental illness"? To reveal the abuse/discrimination toward those labeled with a mental illness?
- Is the narrative written to create order out of a chaotic experience? To reconstruct the disrupted life story?
- Was the narrative written to recover the narrative voice after losing it during the period of emotional distress?

- Is the purpose of the narrative for the narrator to come out about their experience of “mental illness”?
- Is the narrative written to describe the narrator’s problems in living in terms different from those used by doctors and mental health professionals?
- Is the narrative written to propose an alternative viewpoint about the origins/ concept of “mental illness”?
- Does the narrator write to identify problems within the mental health system (whistle-blowing)? If so, what are they? Does the narrator experience abuse, neglect, or the loss of civil rights at the hands of those working in the mental health system such as nurses, doctors, or psychiatrists?
- Is the narrative written as a means by which the narrator self-analyzes him- or herself?
- Does the narrator assert his or her sanity either explicitly or implicitly within the narrative?
- Does the narrator write to share a divine message, religious experience, or revelation?

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