On Narrative: Psychopathology Informing Philosophy

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In “Whole Life Narratives and the Self” David Lumsden (2013) has provided us with a clear review of the debate over narrative and personal identity and has staked out his own position in that debate. Arguing against neo-Lockean views of an atomistic self, he defends a narrative component in personal identity. Specifically, he argues that personal identity or self involves “a bundle of narrative threads” (p. 1), but does not require the grand unity of a master narrative—a whole life narrative. It follows for him that the understanding—and treatment—of fragmented psychiatric states does not require whole life narratives. In his analysis, he is both defending a philosophical position regarding narrative and personal identity and exploring its application to psychopathology.

The editorial pages of PPP state that “PPP seeks to: (a) enhance the effectiveness of psychiatrists, clinical psychologists, and other mental health care workers as practitioners, teachers, and researchers by illuminating the philosophical issues embedded in these activities; and (b) advance philosophical theory by making the phenomena of psychiatry and clinical psychology more accessible to philosophers.” Although the stated goal of PPP is that philosophy will inform psychiatry and psychiatry will inform philosophy, it is fair to say that the pages of PPP are mostly filled with efforts at the first goal—various efforts to do philosophy of psychiatry. One could easily conclude that psychiatrists have more to learn from philosophy than philosophers from psychiatry.

The paper under discussion follows the above pattern. So do most of the articles cited and discussed in the paper, and so do my own publications on narrative and psychopathology (Phillips 1999, 2003a, 2003b). In this commentary, I would like to reverse direction and suggest what psychopathology and psychiatric experience might offer philosophy. Narrative is a good topic for this exercise, and I submit that narrative theorists have something to learn from psychopathology.

My argument is straightforward. There is a debate over the role of narrative in personal identity. One side argues that personal identity has and must have a narrative dimension. The other side argues that narrative is a fictive device that may be imposed on real life from the outside, but has nothing to do with life as actually lived. Philosophers, historians, and literary critics debate both sides of this question; neither side is able to persuade the other. The question I am raising is whether psychopathological experience should have a voice in this debate. That is, in this paper I will not use narrative theory to explain psychopathology; rather, I will let psychopathol-
ogy have a voice in the debate over narrative and personal identity. Which side of the debate will psychopathology support? In this debate, can philosophers step back from teaching psychiatry and learn something from psychiatry? Or in still other words, if the critics of narrative identity are not convinced by analysis of ordinary experience that life has a narrative dimension, would they be more convinced by the extraordinary experience of psychopathology?

**The Debate Over Narrative and Personal Identity**

Before we embark on the contributions of psychopathology to narrative theory, we need to quickly review the issues at stake in the debate over narrative. Lumsden has already summarized the debate, and developed his particular point regarding whole-life narratives. I add a few notes to his summary.


In the face of all this doubt concerning the reality claims of narrative, it is of interest that the strongest defense of narrative’s connection to the real world has come from three philosophers—Paul Ricoeur (1984, 1985, 1988, 1992), David Carr (1986), and Alasdair MacIntyre (1981). Just as Nietzsche (1974) hovers in the background of anti-narrativist theorizing, so does Heidegger (1996/1927) on the other side, with his analysis of temporality and the intertwining of the three temporal modes, provide a philosophic backdrop to these arguments for narrative reference. Heidegger’s insight was that human being is in the deepest sense historical. His student Gadamer (1960/1975) added the insight that the historicity of human existence is experienced linguistically.

Others may be included on the side of narrative. Jerome Bruner (1990/2002) has argued for the role of cultural narratives as an appropriate subject matter for the discipline of psychology. Roy Schafer (1992) has performed a similar role in the field of psychoanalysis. McHugh and Slavney (1998) have brought the narrative dimension into the field of psychiatry. Arthur Kleinman (1988) has worked extensively on illness narratives in the field of general medicine. Hardcastle and Flanagan (1999) and Kennett and Matthews (2003) have employed narrative theory to understand dissociative disorders. Phillips (1999, 2003a, 2003b) has brought narrative theory to the area of general psychopathology. Finally, Marya Schechtman (2005) offered a defense of narrative within the Lockean tradition.

To move this discussion forward, it might be useful to look at a representative statement from each side of the debate. For the pro-narrativist position, I invoke a literary scholar, Peter Brooks:

Our lives are ceaselessly intertwined with narrative, with the stories that we tell and hear told, those we dream or imagine or would like to tell, all of which are reworked in that story of our own lives that we narrate to ourselves in an episodic, sometimes semi-conscious, but virtually uninterrupted monologue. We live immersed in narrative, recounting and reassessing the meaning of our past actions, anticipating the outcome of our future projects, situating ourselves at the intersection of several stories not yet completed. (1984, 3)

Contrast that with this statement of historian Hayden White:

What I have sought to suggest is that this value attached to narrativity in the representation of real events arises out of a desire to have real events display the coherence, integrity, fullness, and closure of an
image of life that is and can only be imaginary. The notion that sequences of real events possess the formal attributes of the stories we tell about imaginary events could only have its origin in wishes, day-dreams, reveries. Does the world really present itself to perception in the form of well-made stories, with central subjects, proper beginnings, middles, and ends, and a coherence that permits us to see “the end” in every beginning? Or does it present itself more in the forms that the annals and chronicle suggest, either as mere sequence without beginning or end or as sequences of beginnings that only terminate and never conclude? And does the world, even the social world, ever really come to us as already narrativized, already “speaking itself” from beyond the horizon of our capacity to make scientific sense of it? (White 1987, 24–5)

The reader will have his or her own reaction as to which of the two statements more accurately reflects how we live our lives. I am on the narrativist side of the debate. In support of that position, I want to address a couple of the author’s arguments before proceeding to the case histories and the voice of psychopathology.

First, let me highlight a tendency for anti-narrativists to focus on events and for narrativists to focus on meaning. This very likely reflects a split between the analytic and Continental styles in philosophy. Certain words are ambiguous in this discussion. ‘Memory’ can mean a Lockean memory event or a Heideggerian ‘openness’ toward the past. ‘Action’ can mean an atomistic event or intelligent activity, as with MacIntyre. When Hayden White describes a lived life as more like a chronicle than a story, he is arguing that a lived life is a series of isolated events rather than a web of meaning-related activities.

Lumsden (2013, 2) embraces the latter position in entitling a section: “a narrative is incomplete; in contrast to a life, which is complete,” and then writing about the incompleteness of narratives: “this is one way of expressing a point that seems obvious to many, that although a narrative can be about a life there is a fundamental difference between the narrative and the life it describes” (2). This point is in fact dramatically unobvious. The notion that a life is complete while a narrative is incomplete is true only if a life is defined as a series of events, or, say, like a glass of water—complete if filled to the top but incomplete if only half full. In contrast, a human life, described as a meaningful narrative unity, could be said to be complete even with millions of irrelevant details left out of the narrative account.

A second clarification, which I have addressed before, is that the narrative dimension of ordinary life, is a pre-reflective, background phenomenon. The average person does not go around rehearsing his life narrative. The author, defending the notion that narratives are ‘discontinuous’ with life, quotes Lamarque (2004, 404): “Narratives are stories that only exist when they are told. Without narration there is no narrative.” I argue that exactly the opposite is the case. Lived narratives are mostly not narrated. My life, for instance, contains multiple, interrelated, often-conflicting narratives of my professional career. I generally do not think about them; I live them. If something challenges one of them, or if, say, I have to upgrade my CV, I might attend to one or another of the narrative strands, but they do not wait for that formal ‘narration’ to come into existence. Lumsden is, in fact, ambiguous on this point. He argues at one point for the discontinuity of narrative and life, and later for “narrative threads that are tightly connected with experiences” (2013, 5).

A third clarification is that the anti-narrativists tend at times to wage their arguments against a narrativist straw man. The claim here would be that narratives are aesthetically structured fictive creations; lives are always messy and never have the clean, aesthetic structure of fictive narratives; lives therefore do not have an essential narrative dimension. Alasdair MacIntyre is the best antidote to this tendency because he articulates so well the qualities of lived narrative as well as its differences from fictive narrative.

It is now becoming clear that we render the actions of others intelligible in this way because action itself has a basically historical character. It is because we all live out narratives in our lives and because we understand our own lives in terms of the narratives that we live out that the form of narrative is appropriate for understanding the actions of others. Stories are lived before they are told—except in the case of fiction. (1981, 211–2).
In describing the uniqueness of lived, enacted narratives, MacIntyre emphasizes that personal narratives are multiple, complex, and interconnected. My life is a congeries of narratives, some fairly developed and others partial, tentative, and fragmented. Any single narrative thread may be embedded in several others. I am a participant in the narratives of others, and they in mine. Regarding the issue of creativity, I am the author (or partial author) of some, and a willing (or unwilling) inheritor of others. “We enter upon a stage which we did not design and we find ourselves part of an action that was not of our making. Each of us being a main character in his own drama plays subordinate parts in the dramas of others, and each drama constrains the others” (1981, 213). Finally, responding to Mink, MacIntyre writes:

This [enacted narrative] has of course been denied in recent debates. Louis O. Mink, quarrelling with Barbara Hardy's view, has asserted: 'Stories are not lived but told. Life has no beginnings, middles, or ends; there are meetings, but the start of an affair belongs to the story we tell ourselves later, and there are partings, but final partings are only in the story. There are hopes, plans, battles and ideas, but only in retrospective stories are hopes unfulfilled, plans miscarried, battles decisive, and ideas seminal. Only in the story is it America which Columbus discoveries and only in the story is the kingdom lost for want of a nail.' (Mink 1974, 557–8)

What are we to say to this? Certainly we must agree that it is only retrospectively that hopes can be characterized as unfulfilled or battles as decisive and so on. But we so characterize them in life as much as in art. And to someone who says that in life there are no endings, or that final partings take place only in stories, one is tempted to reply, ‘But have you never heard of death?’ Homer did not have to tell the tale of Hector before Andromache could lament unfulfilled hope and final parting. There are countless Hectors and countless Andromaches whose lives embodied the form of their Homeric namesakes, but who never came to the attention of any poet (MacIntyre 1981, 212).

**Case Histories**

I begin this discussion with a series of case histories. This will allow us to engage the inquiry with concrete examples of psychopathology, as opposed to relying on solely on generalities.

**Case #1**

Mr. Jones is a middle-aged man in the midst of a serious depression. He describes a common array of depressive symptoms and accompanies them with statements such as: ‘my life is a failure . . . everything I've tried has failed, and I'm now 55 and have nothing to show for it, and nothing to live for.’ With further conversation he is ready to detail the life failings: failed marriage, professional disappointments, and poor relationships with his children. Of course, his negative judgment on his life is at least in part a product of his depression, and one of the goals of treatment is certainly to help him to achieve a more balanced view of his life. In the circular manner of psychiatric treatment, an altered view will relieve the depression, and at the same time relieving the depression will alter the view.

**Case #2**

This is, again, a case of depression. Tom, in his early 30s, has been able to secure his dream job, one that he has spent years preparing for, and on which he has placed all his hopes for a future of satisfactory work and financial security. In the first several weeks on the job, he discovers gradually and with increasing panic that he cannot tolerate the pressure of the work (pressure, by the way, that is quite real). Finally, feeling on the verge of a complete breakdown, he resigns his position. His mood state now shifts from the overwhelming anxiety he experienced on the job to one of failure and depression, as well as anxiety about an uncertain future. His statements are as you might expect: “I spent my life trying to get to that point, I had my opportunity, and I couldn't do it. I've failed, I feel inadequate and guilty, and I hate myself—and I don't know where to go from here.”

**Case #3**

My third case is Virginia Harris, a 40 year-old woman who carries a diagnosis of borderline personality disorder. The product of a troubled childhood, with parental divorce, shifting residences, and inadequate parenting on both sides, Virginia showed signs of being a troubled individual from at least her early adolescence. Her symptom ar-
ray was marked by on and off drug and alcohol abuse, a several-year period of an eating disorder, periods of depression, at times with suicidality and brief hospitalizations, and, finally and predictably, turbulent personal relationships. With all these problem areas she also had her strengths. She was an intelligent young woman with a determination to turn her life around. With many interruptions en route, she tried to be compliant with treatment and made a valiant effort to continue her education. Predictably, her efforts to make a coherent narrative of her life made for a rather jagged and fragmented history, with life plans started, restarted, failed, and reversed, and always persistently restarted once again. Through all of this, she maintained a realistic sense of slow but gradual progress over time.

**CASE #4**

My fourth example is Patricia Deegan, whose real name I am using because she is a public figure. Deegan is a clinical psychologist and a leading figure in the Recovery movement. She also suffers from schizophrenia and has written about her personal experiences. I will let her speak for herself.

The following quotations are cobbled together from three lectures. I never did get to the Arctic as a child. Instead, the silence I imagined in my childhood was shattered when, at the age of 17, I experienced the onslaught of distressing voices, or what clinicians call auditory hallucinations. I remember exactly where I was when the distressing voices started. I was a passenger in the front seat of a car that was going down a highway with a lot of curves on it. As each new curve loomed in front of me, a voice would hiss, ‘Watch out. It’s coming.’ My stomach would clench, a terror would come over me, the car would round the curve and approach the next one. Again a voice would curse, ‘Killing. Spilling. Watch out it’s coming.’ I remember looking around to see where these voices were coming from, but I could not see who was speaking the words. However, I did notice that everyone else in the car seemed unperturbed, as if they were just listening to the radio. Soon after, I began to notice that instead of being upset by these terrible voices, all the people in the car were glancing sideways at me with their lips turned up in barely disguised snarls. Were they part of it? Were they part of what was coming? What was coming? What did the voices mean? I yelled for the driver to pull over to the side of the highway, stumbled out of the car and vomited as the voices laughed at me.

Following two weeks of such torment, I was locked in a psychiatric institution and diagnosed with schizophrenia. After a brief interview with a psychiatrist, I was taken to a room and injected with an antipsychotic drug called haloperidol. When I awoke from that drug-induced stupor, I could barely recognize myself. My tongue was thick. My vision was blurred. Saliva drooled and leaked down my face. The medication made it hard to swallow, so food spilled and soiled my shirt. I began to smell of last night’s supper. Just weeks before I had been a strong athlete who excelled in sports. Now I was in a chemical straightjacket. I moved stiffly and slowly, as if some old woman had crawled into my body and my bones were nothing but arthritic crutches, propping me up against the wall of a mental institution.

Drugged on haloperidol I could not feel anything. I did not care about anything. I could not smile or laugh or cry or think. In the distance I could still hear the auditory hallucinations, but they had lost their power to grab my inners and shake me to attention. They drummed like a dull ache in the background and were easy to ignore. Everything and everyone else were also easy to ignore, because I cared about nothing and felt nothing. I had been muted. I had become the muted body. I had been silenced—erased and disappeared under the tyranny of those small green pills.

It is widely assumed that anti-psychotic drugs are helpful because they suppress psychosis and restore one to a more familiar sense of self. In my experience, antipsychotic drugs at these high dosage levels were not helpful. Haloperidol did not return me to a non-psychotic, more familiar self. Rather, it delivered me into a negation of myself, an absence, a silenced echo of my former self. Haloperidol replaced me with the drugged-me. And worst of all, the professionals kept telling me how good this medication was for me. They kept telling me I would have to take this medicine for the rest of my life. They said I should be grateful modern psychiatry had a medicine that could so quickly restore my functioning. The psychiatrist said my hallucinations and delusions were gone. The symptoms were abating he said. I was more in control and I was stabilizing he said. From my perspective, however, things appeared quite different. I did not feel better. The so-called hallucinations were still there although they were no longer a bother to the people around me. I was not more in control but rather, I felt controlled by the medication. I was not stabilizing. Rather I was becoming a shadow of my former self, unable to think or feel. I was not beginning to function. Instead, I was learning to play the game in order to get discharged from that institution as soon as possible. I...
was not grateful for this medicine. I was not grateful for this help. As far as I was concerned, this help was not help. (Deegan 2005, available from: http://www.patdeegan.com/pat-deegan/lectures/silence)

We found ourselves undergoing that dehumanizing transformation from being a person to being an illness: ‘a schizophrenic’, ‘a multiple’, ‘a bi-polar’. Our personhood and sense of self continued to atrophy as we were coached by professionals to learn to say, ‘I am a schizophrenic’; ‘I am a bi-polar’; ‘I am a multiple’. And each time we repeated this dehumanizing litany our sense of being a person was diminished as ‘the disease’ loomed as an all powerful ‘It’, a wholly Other entity, an ‘in-itself’ that we were taught we were powerless over.

Professionals said we were making progress because we learned to equate our very selves with our illness. They said it was progress because we learned to say ‘I am a schizophrenic’. But we felt no progress in this. We felt time was standing still. The self we had been seemed to fade farther and farther away, like a dream that belonged to somebody else. The future seemed bleak and empty and promised nothing but more suffering. And the present became an endless succession of moments marked by the next cigarette and the next.

So much of what we were suffering from was overlooked. The context of our lives were largely ignored. The professionals who worked with us had studied the science of physical objects, not human science. They did not understand what the neurologist Oliver Sacks so clearly articulates: “To restore the human subject at the center—the suffering, afflicted, fighting, human subject—we must deepen a case history to a narrative or tale; only then do we have a ‘who’ as well as a ‘what’, a real person, a patient, in relations to disease—in relations to the physical . . . the study of disease and identity cannot be disjoined . . . (stories) bring us to the very intersection of mechanism and life, to the relation of physiological processes to biography.” But no one asked for our stories. Instead they thought our biographies as schizophrenics had been already been written nearly a century before by Kraepelin and Bleuler. Yet much of what we were going through were simply human experiences—experiences such as loss and grief and shock and fear and loneliness. One by one our friends, relatives and perhaps even families left us. One by one the professionals in our lives moved on and it became too difficult to trust anyone. One by one our dreams and hopes were crushed. We seemed to lose everything. We felt abandoned in our ever-deepening winter.

The weeks, the months or the years began to pass us by. Now our aging was no longer marked by the milestones of a year’s accomplishments but rather by the numbing pain of successive failures. We tried and failed and tried and failed until it hurt too much to try anymore. Now when we left the hospital it was not a question of would we come back, but simply a question of when would we return. In a last, desperate attempt to protect ourselves we gave up. We gave up trying to get well. Giving up was a solution for us. It numbed the pain. We were willing to sacrifice enormous parts of ourselves in order to say ‘I don’t care’. Our personhood continued to atrophy through this adaptive strategy of not caring anymore. And so we sat in chairs and smoked and drank coffee and smoked some more. It was a high price to pay for survival. We just gave up. And winter settled in upon us like a long cold anguish (Deegan 1996, available from: http://www.patdeegan.com/pat-deegan/lectures/silence)

Early on in my recovery, I experienced an important turning point. It occurred when I was eighteen years old. My psychiatrist told me I had chronic schizophrenia and I would never be well. He said I would be sick for the rest of my life and the best I could do was avoid stress and cope. Something in me fought back against his prognosis of doom. And as I stood outside his office, I remember rejecting the chronic mental patient life-plan and thinking, “I will become Dr. Deegan, and then I will change the mental health system so no ever gets hurt in it again.” That became my survivor’s mission. That became the project around which I organized my recovery.

My goal was not entirely altruistic. From my vantage point, at 18 years old, becoming a psychologist was attractive, in part because it meant I would be powerful and rich. And, even more importantly, I thought being a psychologist meant I would be certifiably sane. I really thought psychiatrists and psychologists were utterly sane and that by becoming a card-carrying member of that elite establishment, I would once and for all put psychosis behind me and never be a mental patient again. I really thought you had to be completely well in order to help other people. And so I figured I would become a doctor, and my job would be to help “them”. However, in time, I learned my vocation was not to help them. Rather, I learned that I was one of them. My vocation was not to reach down, from some exalted and lofty place, to help the poor unfortunates. Rather, my vocation was to reach across and to share my hope for recovery with others, as they shared their hope with me. (Deegan 2004, available from: http://www.patdeegan.com/pat-deegan/lectures/silence)

Case #5

The final example is Linda Bishop, whose course stands in stark contrast with Patricia Deegan’s, and whose story was chronicled in The New Yorker in May, 2011, by journalist Rachel Aviv (Aviv 2011). Linda’s formal psychiatric history began in
1999 when, as a 43-year-old divorced mother of a 13-year-old daughter, she left home in the middle of the night, abandoning her daughter and leaving a note saying that she was going to meet the governor. She spent the next 9 years in a nomadic existence, much of the time homeless, often in jails and mental hospitals. In 2005, she was arrested for a minor incident, spent a year and a half in jail before being found incompetent to stand trial, and then spent almost a year in New Hampshire Hospital. In the hospital, she refused all treatment and medication, and was finally discharged in 2006. The hospital staff were unable to make a discharge plan because Linda refused to state in the application forms for assisted living that she suffered from mental illness. After her discharge, she wandered for several days and finally settled into an abandoned farm house in Dover, New Hampshire. She lived there for several months, surviving on an apple orchard, and finally died of starvation and exposure in early 2007.

Linda’s history is notable for the late onset of her illness, her persistent and varying delusions, and her dramatic refusal to recognize her psychotic illness. The latter has been called denial of illness, lack of insight, and currently carries a name borrowed from neurology, anosognosia. It is, of course, the anosognosia that prevented conventional psychiatric treatment. Her pattern was one of hospital admissions, efforts by hospital staff to convince her to accept treatment, and her ultimate refusal to agree or comply with those recommendations.

Her copious journal entries and letters, as well as hospital records and interviews with friends and family, allowed the journalist to capture a minimal picture of her inner life. Much of the material involves her changing paranoid delusions: For example, driving to Canada with her 13-year-old daughter to avoid the Chinese Mafia, then, when back from that trip, leaving to inform the authorities in Concord that the government was behind John F. Kennedy, Jr.’s plane crash. In The New York Post, “Homeless ‘Angel’ a Blessing at Ground zero,” described how Linda patrolled the perimeter of the site, waving an American flag, greeting visitors, and giving impromptu tours. (Montero, 2001)

At other times, as when staying with her sister and taking medication, she was able to take some distance from her delusions. As Aviv (2011) wrote:

In 2003, she entered a supported-housing program in Manchester, New Hampshire, and told her caseworker that she wanted to ‘live like an adult again’. She was upset that her illness had alienated her daughter and friends. Joan [Linda’s sister] told me that ‘Linda would talk analytically about how it had felt to be delusional. It wasn’t as if she felt she was being chased by government agents. In her mind, they were as real as I am right now’.

During her long hospitalization at New Hampshire Hospital, Linda would not attend therapy groups but was active in supports groups called Inner Strength, Loss and Recovery, and Lifestyle Choices.

According to worksheets she filled out at one group, ‘freedom’ was her only long-term goal. Her short-term goal included ‘get clothes’, ‘depart from evil’, ‘put pressure on the guilty’, and ‘laugh more’.

When Linda finally ended up in the abandoned farm house, she was initially exhilarated at having her own house and plot of land, and she wrote about starting a new life. The latter was organized around her delusional fantasies that a man whom she had known briefly 10 years earlier (and to whom, while in the hospital, she was convinced she was married), was coming to join her in the house, where they would live happily together. When Steve did not show up by Christmas, Linda began to doubt that he was coming. She wrote in her journal:

So maybe the fact that I haven’t seen him is a good sign? . . . I just hope God does want us to be together—everything seems to assure that—but who knows if it all fits. Certainly my death at this point does not seem beneficial to God’s plans as perceived by me.

In the ensuing, days she vacillated in her intentions. At one point she decided to leave the house and make her way back to the assisted-housing program in Manchester where she had lived in 2003. But she felt too weak to make the trip and decided to stay, writing: “So I’ll wait and continue to pray since God knows where I am.”
Psychopathology and Narrative

It is now, finally, the moment to allow the confrontation of psychopathology and narrative theory. I divide this confrontation into two sections: First, the general confrontation with the anti-narrativists, and second the confrontation with the modified position of David Lumsden, who finds a place for ‘narrative threads’ in lived experience but rejects the notion of whole life narratives.

Regarding the first confrontation, who are the disputants? The author quotes Lamarque (2004, 404)—“Narratives are stories that only exist when they are told. Without narration there is no narrative”—and Mink (1974, 123)—“stories are not lived but told. Life has no beginnings, middles, and ends”—and he references the neo-Lockeans. I have already quoted White (1987, 24-5)—“What I have sought to suggest is that this value attached to narrativity in the representation of real events arises out of a desire to have real events display the coherence, integrity, fullness, and closure of an image of life that is and can only be imaginary”—and have mentioned others. Here is Roland Barthes (cited in White 1987, p. 35):

Claims concerning the ‘realism’ of narrative are therefore to be discounted. . . . The function of narrative is not to ‘represent,’ it is to constitute a spectacle. . . . Narrative does not show, does not imitate. . . . ‘What takes place’ in a narrative is from the referential (reality) point of view literally nothing, ‘what happens’ is language alone, the adventure of language, the unceasing celebration of its coming.

So, what is the response of psychopathology to this formidable array of anti-narrativists? We note immediately that all the spokesmen are forced by their circumstances to take a reflective review of their lives, and they all articulate this reflection in historical, narrative form (Linda Butler is an exception whom I will discuss below). They all exhibit in the strongest possible way that, to speak in Heideggerian terms, they live their lives temporally or historically, and that any effort to express this lived history will take a narrative form. As with Heidegger and MacIntyre, the histories interweave present, past, and future in very complex ways, and the narrative accounts reflect that. To underline the point yet one more time, the story we hear after the fact does not represent a narrative that only begins with the recitation; it reflects life experience that was lived through in the historical, narrative form in which it is now narrated.

Mr. Smith tells us that his life has been a failure, and he can flesh out that summary statement with relevant details. He describes early hopes and plans regarding his personal and professional life. He details what he considers his failures, and he parcels out shares of personal responsibility, bad luck, and blame of others. If I quoted him Galen Strawson (2008, 194) saying, “I have absolutely no sense of my life as a narrative with form, or indeed as a narrative without form” (obviously substituting ‘story’ for ‘narrative’ as needed), I can only imagine Mr. Smith responding with something like, “I don’t really know what you mean, I’ve just told you my story, and it’s a pretty awful one that leaves me feeling pretty desperate. If you say that my story is not about my life as I am living it, I’ll feel that one of us is nuts, and I hope it’s not me. I already feel bad enough.”

How about Tom? He has told his story of a major life dream realized and then lost in personal failure. In his frantic state he maintains good control of his tenses: The years of dreaming and planning, the moment of achievement, the period of developing failure—as viewed from the past perfect period of early dreams, the current perspective of recent failure and regret, a future perfect of looked-back-upon failure—and finally, glimmers of renewed hope for a future that will take a different form than the early dream.

We can challenge Tom with Louis Mink’s statement: “Stories are not lived but told. Life has no beginnings, middles, or ends; there are meetings, but the start of an affair belongs to the story we tell ourselves later, and there are partings, but final partings are only in the story. There are hopes, plans, battles and ideas, but only in retrospective stories are hopes unfulfilled, plans miscarried, battles decisive, and ideas seminal.” Won’t Tom object: “Wait a minute. What do you mean, life has no begin-
nings, middles, or ends. I just lived through that sequence. It began with my dreams, plans, and school. There was a middle period while I was on the job, at first doing well. And it had an end, a very precise one on the day I left the job. Why do you tell me that that sequence only happened when I told the story afterward. I lived it, Professor Mink. What makes it so hard to grasp that? It’s not a very pleasant story I lived through, but it’s really not very hard to understand that I did live through it. My hopes were not just ‘unfulfilled’ in retrospect. I lived through that ‘unfulfilling’ day by day as I was crashing.”

Ms. Harris, as we have already noted, is a bit of a mess. Her story, as she relates it, is a jumble of hopes, dreams, plans, failures, rehabs and hospitalizations, recurrences, good and bad periods, successful and unsuccessful therapeutic experiences, and so forth. As a fictive product, it is not very aesthetic. In her account, she readily moves from one period to another, and she has enough insight to be aware that even in the better periods, she was aware—at the time—of the dangers and probabilities of relapse trailing along in her shadow. The narrative she relates is a broken and fragmented one, with life stories that readily contradict one another. She would insist, as do our other witnesses, that she is describing her experiences as she has lived them, and not merely supplying a summary that makes the connections after the fact. If she gives an account of resolving to do one thing and then doing the opposite, that’s an accurate account of her experience as she lived it.

Regarding Patricia Deegan, as I have already indicated, she is a highly articulate narrator of her life experiences. She has obviously related her life story on many occasions, and her account has all the markings of a well-constructed, emotionally arresting narrative product. More than the other personal narratives related here, hers has the qualities of a well-wrought aesthetic product. Does that, however, make it only an after-the-fact narrative product and count against its authenticity as an accurate depiction of her lived experience?

Deegan describes her early experience of psychosis:

I remember looking around to see where these voices were coming from, but I could not see who was speaking the words. However, I did notice that everyone else in the car seemed unperturbed, as if they were just listening to the radio. Soon after, I began to notice that instead of being upset by these terrible voices, all the people in the car were glancing sideways at me with their lips turned up in barely disguised snarls. Were they part of it? Were they part of what was coming? What was coming? What did the voices mean? I yelled for the driver to pull over to the side of the highway, stumbled out of the car and vomited as the voices laughed at me.

And then later:
My tongue was thick. My vision was blurred. Saliva drooled and leaked down my face. The medication made it hard to swallow, so food spilled and soiled my shirt. I began to smell of last night’s supper. Just weeks before I had been a strong athlete who excelled in sports. Now I was in a chemical straightjacket. I moved stiffly and slowly, as if some old woman had crawled into my body and my bones were nothing but arthritic crutches, propping me up against the wall of a mental institution.

Deegan is effectively serving as a double narrator in these passages. She is describing her deeply troubling and chaotic experiences as they were happening in that present time of many years ago (at which time she would have been completely absorbed in her immediate suffering and have had no idea of what was in her future); at the same time, she is speaking from the present moment of giving the presentation, with full awareness of how things have turned out since the original experience. About the first narrative, I think she would insist: This is the way it was, this is how I experienced it. The chaotic experience did not come to life with my narrating of it now. And about the second narrative I can imagine her saying, I know my story, I have the condition, I cannot guarantee that I will not have an episode tomorrow. But I can tell you that I have learned how to take better of myself.

In the final piece by Deegan, she provides a moving example of someone determined to change the narrative identity that has been imposed on her:

Early on in my recovery, I experienced an important turning point. It occurred when I was eighteen years old. My psychiatrist told me I had chronic schizophrenia and I would never be well. He said I would be sick for
the rest of my life and the best I could do was avoid stress and cope. Something in me fought back against his prognosis of doom. And as I stood outside his office, I remember rejecting the chronic mental patient life-plan and thinking, ‘I will become Dr. Deegan, and then I will change the mental health system so no one ever gets hurt in it again.’ That became my survivor’s mission. That became the project around which I organized my recovery.

The skeptical anti-narrativist may want to claim that this is all retrospective story telling, but it certainly has the flavor of someone taking control in vivo of the course of her personal identity.

Finally, Linda Bishop is different because she has lost the ability to narrate her life. She feels the need to make sense of her life and makes meager, often fragmented and delusional, attempts to give a coherent account of herself. In fact, anything close to a coherent narration of her life requires the agency of a third person, the journalist. She demonstrates the argument for narrative identity precisely because she makes us appreciate that without any coherent narrative identity, there’s not much identity. MacIntyre makes a relevant comment in talking about human action as intelligible:

When an occurrence is apparently the intended action of a human agent, but nonetheless we cannot so identify it, we are both intellectually and practically baffled. We do not know how to respond; we do not know how to explain; we do not even know how to characterize minimally as an intelligible action; our distinction between the humanly accountable and the merely natural seems to have broken down. And this kind of bafflement does indeed occur in a number of different kinds of situations . . . in our encounters with certain types of neurotic or psychotic patients (it is indeed the unintelligibility of such patients’ actions that leads to their being treated as patients; actions unintelligible to the agent as well as to everyone else are understood—rightly—as a kind of suffering. (1981, 210)

MacIntyre’s point is that human actions are not event-points in time; they are not the unconnected events of a chronicle as described by Hayden White. They are, in contrast, intelligible, interconnected actions, marked by meaning that can be interpreted and understood. Bishop’s actions lack these qualities, and for that reason we cannot make sense of them, and we can only ascribe to her a personal identity that is profoundly disturbed.

In her own way, Linda Bishop provides the strongest response to Mink, Lamarque, and the other anti-narrativists. If you want to claim that personal identity does not require some form of narrative unity, test your theory out on this poor woman. She will make no claims, except occasional incoherent and delusional ones, of narrative unity. You could certainly chronicle her activities à la Hayden White—one action after another.

**Psychopathology and Whole Life Narrative**

In “Whole Life Narratives and the Self,” Lumsden makes a fundamental distinction between what he calls narrative threads and whole life narratives. He argues that self and identity involve the first but do not ‘require’ the second. His use of the word ‘require’ is a little ambivalent. He states that, “An overarching narrative is not what is required to be a well-functioning person. What is more important is that she can access the appropriate narrative threads to deal with current circumstances” (Lumsden 2013, 9).

I, of course, want to let our voices of psychopathology speak to Lumsden’s argument; however, I wish first to make a theoretical point, namely, that I consider his argument conceptually incoherent—incoherent in the sense that it misunderstands the nature of lived narrative. To borrow once again the language of Alasdair MacIntyre, human action is intelligible action, action that is imbued with meaning. As such, it cannot be treated as disconnected event points. “There is no such thing as ‘behavior’, to be identified prior to and independently of intentions, beliefs, and settings” (MacIntyre 1981, 208). If the latter were possible, then you might isolate a chain of such points or behavior units, call it a ‘narrative thread,’ and keep it compartmentalized and disconnected from other compartmentalized threads. But that does not work if you understand action as intelligible action. Intelligible, narrative action will always spread as one theme suggests another. A narrative sequence will always be part of a larger sequence, and that part of a still larger one, finally reaching one or several master narratives of the person’s life. MacIntyre is himself primarily interested in Aristotelian virtue, how to lead a good life. With
virtue, as with anything else that involves one’s personality, it is impossible to discuss that without talking about the life as some kind of unity—and that means, of course, a whole life narrative.

What remains puzzling about Lumsden’s account is that he understands narrative connectedness so well, but then, rather arbitrarily and—in my opinion incoherently—limits it to ‘narrative threads.’ When he writes, “The view that is recommended here, in which it is narrative threads that are tightly connected with experiences, avoids any strong assumptions about the nature and reality of selves” (Lumsden 2013, 5), I have no idea what he means.

Although I take it as somewhat obvious—contra Lumsden—that I am able to reflect back on my life and view it as a whole life narrative—with all the fragmentation, breaks, subnarratives, and so on as described—I think that psychopathological experience brings this point home in a stronger manner. Let’s look again at the case examples.

When Mr. Jones laments, “my life is a failure . . . everything I’ve tried has failed, and I’m now 55 and have nothing to show for it, and nothing to live for,” is he not working with a whole life narrative? He is, of course, speaking from the perspective of his depression, and he is leaving out millions of life details, including some that would suggest accomplishment, but so what? Even if he is providing an inaccurate narrative, is he not showing us that he is passing judgment on his life as a whole? The author can write, “What is more important is that she can access the appropriate narrative threads to deal with current circumstances” (Lumsden 2013, 9), but isn’t this patient screaming at us that the needed narrative is a different whole life narrative.

Certainly this patient’s narrative is in some measure a product of his depression. It may happen that with time and treatment he will alter his life narrative to a more balanced one that includes a mixture of successes and failures, as well as a less harsh judgment on what he is calling his failures. It may also happen that he may fall back into the depression and revert to the negative narrative. Whatever happens, he is telling us that he will have feelings about his life as a whole, and that with all the elisions, distortions, exaggerations, and lapses of memory, he needs a whole life narrative.

Similar comments are appropriate regarding the second patient, Tom. There is obviously much more to his life than the theme of achieving his dream job. This is indeed one narrative thread in his life. But it is a thread that stretches over much of his life and is for him a central whole life narrative. The narrative as it stands stretches into a future without much hope. His recovery will require major changes in his life narrative with possibilities for satisfaction in a future without his dream career. In this he exemplifies the future dimension of a whole life narrative. He may not be able to fill in the details, it will be a whole life narrative—now one that includes initial hopes and plans, a major setback, and adjustments for a future that is different from the one initially imagined.

Virginia Harris makes her own kind of case for a whole life narrative. She is acutely aware of the notion of a unified, coherent, meaningful life, with goals and plans that are realized over time. As we have already noted, she experiences this as something she longs for as unrealized, and at the same time she relishes every possibility of thinking of something as a life success. More than the others, and of course stimulated by the nature of her condition, she takes a somewhat additive attitude toward her life narratives: a success here, a failure there, how does it add up for the grand life-total.

Patricia Deegan speaks for herself. She offers us her life narrative, and what is it if not a whole life narrative: Promising childhood with appropriate hopes and plans for the future; catastrophic rupture with the onset of schizophrenia; prognosis of life as a limited, disabled person; resolution to reject the prognosis of disabling; chronic schizophrenia and rather to become a clinical psychologist and lead a productive life; and finally, into the present, her role in the Recovery movement as someone demonstrating that schizophrenia does not have to carry the verdict of disability that was forecast for her.

Linda Bishop offers us another perspective on the whole life narrative. I argued that she exemplified—through its absence—the components of narrative personal identity. Here I make the same argument regarding whole life narrative. It is clear that she has no whole life narrative, conscious or preconscious. She is able to give her life a sense of
unity only through imagined or delusional plans (I’ll go to the farm and begin a new life; Steve will join me there), somewhat more realistic but limited plans (I’ll keep track of the apple orchard and survive on apples through the winter), or religious thoughts (God knows where I am). For anything like a whole life narrative, we have to look to the journalist, who does provide us with the narrative of a life without any narrative unity. In doing this, the journalist demonstrates that a life without any experienced whole life unity is a life with a very shattered personality.

**CONCLUSION**

In this paper, I have made a special claim: Individuals suffering from psychiatric disorders can claim a unique status in the debate over the role of narrative in personal identity. Because the issue is of such importance to them, because they often cannot take for granted a personal identity that forms the background of their everyday activity, their voices should be heard. Their response to the philosopher pontificating from his easy chair that narrative is unrelated to personal identity might be: Just a minute, Herr Professor, I’ve spent a lifetime struggling to maintain a coherent story of myself—in action, not just in telling it to my grandchild on my knee. If in fact this is their response, then perhaps Herr Professor should listen to these people and acknowledge that they might have something to offer him in his lucubrations on narrative and life.

Finally, in concluding I wish to make two points. The first is that, although I am arguing that lived, narrative identity is essential to personal identity, I am not arguing that narrative identity is essential to personhood. Linda Bishop may not have anything close to a unified self, but we are not going to stop calling her a person—however uncertain we are about how to define personhood. That question is a larger one than the topic of this discussion, and I leave it for another time. In speaking about what defines personhood, we should not be confused by the author’s discussion of ‘the structure of a whole person.’ When he argues that “an overarching narrative is not what is required to be a well-functioning person” (Lumsden 2013, 9) the ‘well-functioning person’ he describes is not Linda Bishop, who is, precisely, not well-functioning. I could have made the same point more dramatically by presenting a person with significant dementia. Lumsden and I would probably agree that such a person does not have much of a personal identity, but neither of us would want to stop calling her a person.

The second point is that, in defending the notion of narrative personal identity, I am in no way endorsing so-called narrative therapy as the treatment of choice for individuals with identity problems. The issue of loss of personal identity in psychiatric disorders, and the issue of what therapeutic modality is appropriate for what condition, are completely separate. The assumption that because a psychiatric condition has a destructive effect on one’s sense of identity, the appropriate treatment is one of the narrative therapies, is completely naive. That would, for instance, dictate using narrative therapy for a fragmented schizophrenic. To take another example, it is possible that, in the cases of the first two patients, Mr. Smith and Tom, their fractured identities would benefit more from an antidepressant than from a formal narrative therapy. Judgments about the merits of formal narrative therapy are beyond the scope of this paper.

**REFERENCES**


