2015

Narratives of Illness, Difference, and Personhood

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Chapter 9
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Abstract Narratives help us weave the tale of who we are and of how we fit (or don't) into the world around us. Thus, a search for meaning—an enduring "root metaphor" for one's identity and existence, and a way of coping with challenges to that metaphor—is central to the narrative perspective. The question for a clinician is not simply: "Is this client mentally ill" or "With which mental illness should the client be diagnosed." Rather, it is: "What is this person's understanding of the nature of his or her experience, and the meaning of that experience for identity and sense of self? What does it mean, for this person, to be mentally ill? To think of oneself, or be thought of by others, as mentally ill?" Using narrative theory, the chapter examines how ideas and attitudes about mental disorder are shaped by cultural values and stereotypes, and how the experience of trauma can shatter the narrative of self and world. Placing the question of illness, differentness, and personhood within a social justice perspective, it challenges clinicians to consider how the vocabulary of illness is used to frame experience and, in many cases, to minimize, marginalize, or discount the individual's own lived experience.

Keywords Constructivist · Intentionality · Particularity · Phenomenality · Referentiality · Root metaphor · Temporality · Trajectory

Introduction: Why This Matters

Human beings are storied creatures. As we live our lives from start to finish, within the bounds of what both memory and interpretation will allow, we weave the tale of who we are as persons and of how we fit (or do not) into the world around us. These stories both emerge from and serve to craft our sense of ourselves, the world, and ourselves in the world. The term that is commonly used for the construction of these stories and their role in our development and identity is *narrative*. For those who

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B. Probst (ed.), *Critical Thinking in Clinical Assessment and Diagnosis*,
Essential Clinical Social Work Series, DOI 10.1007/978-3-319-17774-8_9

suffer from what we consensually refer to (though with a good deal of subjectivity and variation, as we shall see) as a "mental disorder," a psychiatric diagnosis can have a significant impact, not only on the course of treatment that is indicated but on the very sense of self—the sense of one's own personhood. What does it mean to be mentally ill? To think of oneself, or be thought of by others, as mentally ill? And how does this impact the story of who I am in the world?

In this chapter, we will consider the nature and function of narrative and the implications of a narrative understanding of mental illness for the social and cultural worlds in which we live. We will explore what this means for the sense of self of persons identified by themselves or others as mentally ill. We will consider the multiple ways that this term may be used by individuals, families, institutions, and society. As social workers are interested in justice for the clients with whom we work, it is essential for us to be aware of the ways in which constructs like "mental illness" may be used, not only to understand and support people who are suffering in a particular kind of way, but also how the term "mental illness" may be used in subtle and not so subtle ways as a weapon of oppression and marginalization (Wakefield 2013). We need to understand that the words we use to frame our own experience or that of others may serve to minimize, marginalize, or, in some other way, further discount the lived experience of the persons with whom we work. We need to understand the responsibility that comes with the role of diagnostician that we take on in our practice.

Guiding Questions

1. What is narrative, and what does it mean to consider the nature of lived experience through a narrative lens?
2. Is mental illness a condition that an individual experiences? Or is it an attribute of the person's self—an aspect of identity?
3. What is the impact of culture (in all its many layers and manifestations) on our understanding of mental illness, and how is the label of mental illness used in the social environment?
4. How can a narrative understanding of the nature of mental illness, and an openness to the ever-unfolding narrative of our clients, inform our approach as social workers?

Background

Narrative and narrative psychology belong under the general rubric of constructivist theory. Constructivist theory is based on the notion that what is observed is conditioned upon the observer and that the development of a sense of identity and self has both psychological and sociological dimensions (Crossley 2003; Kelley 1996). White and Epston (1990) pioneered a particular form of narrative therapy as a

means of helping individuals deconstruct and reconstruct the ways in which they crafted the stories of their personal lives by selective attention to certain details along with the subjugation of other details. This approach highlights the central role of language and story (inherently both psychological and sociological) in the constitution of the self in the social world (Crossley 2003).

In other words, when we tell the story of who we are or how some aspect of our lives has unfolded, we invariably craft and interpret that story by selecting certain details of experience that both shape and illustrate our understanding of our experience. This selection is inevitably limited and, as we will see, is influenced by the seemingly countless individuals and happenings that have contributed to our sense of self.

Consider, for example, a client named Robin who tells you, her social worker, that she began a new job a couple of weeks earlier. When you ask Robin how the job is going, she replies that she is miserable! She goes on to say that on that day, she was given a task to complete that was terribly complicated. She had never been asked to do anything like that before. She found it very confusing, was rushing to meet the deadline given to her by her boss, and felt overwhelmed to the point of tears. In fact, she is thinking of quitting her job the next morning, or not even going to work at all. She is certain she will never be able to handle the job. She does not even know why they hired her in the first place. In response, you empathize with how difficult the day was for her, of course, and how overwhelmed she is feeling. You go on to ask Robin how she was feeling about the job prior to the frustrating events of the day. She reports that, generally speaking, she has really liked the work she has been doing. She has a pleasant and supportive boss and friendly coworkers. She actually felt quite proud of herself for getting the job since it is really a step up from her former job, both in responsibilities and salary.

When you ask her to reflect on how she has handled such challenging work assignments in the past, particularly when the work is new to her, Robin reports that she seems to have always found a way to get the job done. She says that she has is a hard worker who can figure things out when she puts her mind to it. And she has never had the experience of a boss being really unhappy with the work she has done. She has asked questions when she needs to and has usually gotten the support she needs to do her work. She even goes on to tell you about a seemingly impossible task in a previous job that she was able to tackle all on her own, and how her boss was so proud of her for what she had done. As you reflect back to her what she has said about her overall positive experience of the job so far, and her history of competence and success in the work place, you begin to see the expression on her face changes. “What might all of this positive experience have to say to you about the kind of day you had today” you ask her? Robin pauses and suggests that maybe it was just a really bad day and that she will likely adjust to the new work and responsibilities as she has done in the past. From a narrative perspective, we might say something like this. In order for the client to tell herself the story that her new job is bad, overwhelming, and beyond her abilities, she has to subjugate or ignore all the positive experiences she has had since starting the job as well as her history of success in the workplace. She does not do this purposefully or

consciously, of course. The power of the unpleasant experience and story of the day simply takes over and gets in the way of her telling a more balanced story of the events. The narrative approach helps her to balance out the story in her mind in a way that is richer and more adaptive while still being realistic.

Crossley (2000, 2003) states that narrative is built upon the notion that human consciousness is constructed by the ordering of events in a meaningful way. Two constitutive dimensions of this, he suggests, are time/temporality and relationships/connections. That is to say, the meaning of all human events is structured by their placement in time and over the course of time, as well as by their relationship or connection to other events that make up the life narrative of the subject.

Some social constructivist perspectives are criticized for portraying daily, lived experience as overly disordered, chaotic, and random. In contrast, Crossley states, the narrative approach attends to the more orderly sense of daily existence that we structure along the lines of meaningfulness and anticipated trajectories. To illustrate this, Crossley uses the example of trauma and the disruption it causes to the survivor's sense of self and his or her expected course of experience. This is similar to the notion that trauma shatters the assumptive world of the survivor (Janoff-Bulman 1992). Through the experience of the rupture of trauma, or the development of a mental illness that may change the anticipated course of our life, we realize the profound orderliness that that we had come to expect from the narrative of our experience. But beyond this, it is through the process of narrative and story making that we reconstitute a sense of meaning and order both in ourselves and in the world around us.

Sarbin (1986) introduces his work on narrative with the premise that all human conduct is framed by the structure of a story and that such stories provide the vehicle for the interpretation of inter- and intrapersonal interactions and intentionalities. Calling upon the work of Pepper (1942), Sarbin offers the notion of the *root metaphor* as a framework for understanding the function of narrative.

> [Pepper] demonstrated how the root metaphor provides the framework for the construing of occurrences in the natural and man-made worlds. The root metaphor constrains the kinds of philosophical or scientific models to be applied either to the task of observing and classifying or to the task of interpreting and explaining. (p. 4)

In other words, the root metaphor conditions the way we think about experience and the meaning it has in the overall narrative of our life. To this end, narrative makes use of *emplotment* to organize events and the observations of experience into coherent and relatable units of meaning. It is the way in which human beings "impose structure on the flow of experience" (p. 9).

Narrative, Meaning Making, and the Search for Meaning

Arguably the foremost thinker of the twentieth century with respect to the role of meaning making was Frankl (1946/1984). Based on his experience of life in a Nazi concentration camp, Frankl's development of logotherapy aimed to address what he

saw as the existential importance of making meaning of suffering and adversity as a way of accessing inner resources that could lead to survival and transformation. Frankl writes:

> We must never forget that we may also find meaning in life even when confronted with a hopeless situation, when facing a fate that cannot be changed. For what then matters is to bear witness to the uniquely human potential at its best, which is to transform a personal tragedy into a triumph, to turn one's predicament into a human achievement… In some way, suffering ceases to be suffering at the moment it finds a meaning, such as the meaning of sacrifice. (p. 135)

Numerous theoreticians and researchers have since added to the literature regarding meaning making and the search for meaning in human experience, as well as to the understanding of the human person as a meaning-making creature. As far back as the eighteenth century, Kant (1787/1965) argued that the human person seeks to bring order to the world based on distinct criteria that structure our experience. This all has important ramifications for our understanding of what is means to be diagnosed (or to diagnose someone else, for that matter) and to live with a mental illness.

Narrative, Meaning and Trauma As in the case of Frankl (1946/1984), meaning is commonly sought in the context of trauma, loss, and suffering. Indeed, the psychological consequences of trauma can be conditioned by the meaning ascribed to the event by individuals, families, and communities (Fullerton 2004). Neimeyer (2005) notes that human beings understand loss in the context of narratives that are thematized in such ways as to offer us a sense of the *why's* of our experience. Trauma, however, can shatter the themes by which we understand our world and incite us to renegotiate our systems of meaning.

This notion is central to the work of Janoff-Bulman (1992, 2006) who suggests that human beings possess a conceptual system of assumptions about the world and the way it works. These assumptions are hierarchically organized such that our most basic assumptions are also the most general and the least open to change. Janoff-Bulman (1992) proposes that most people share three basic assumptions. First, the world is benevolent. This belief may be held even in the face of contradictory evidence because the fundamental point of reference is one's personal experience of the world and the people in one's life, and most people's experience has been predominantly positive. Second, the world is meaningful. The notion that the world makes sense emerges from our desire to find congruity among ourselves, other people, and the events that happen to us. We tend to look to culturally endorsed rules like justice and personal control, for example, to understand this. Third, the self is worthy. Most of the time, most people perceive themselves as good, capable, and moral, even if this requires some degree of compartmentalization or rationalization.

Janoff-Bulman (1992) suggests that the origins of these assumptions are to be found in the earliest periods of human development in relationship to what has been variously conceived of as our emerging sense of basic trust (Erikson 1968), the sufficiency of the holding environment (Winnicott 1965), the positive nature of our

attachment to our primary caregivers (Bowlby 1969, 1973), or the organization of our earliest perceptions and experiences into what Stern (1985) calls representations of interactions that have been generalized (RIGS).

According the Janoff-Bulman's (1985, 1992, 2006; Janoff-Bulman and Frantz 1997) thinking, the experience of trauma shatters the fundamental assumptions on which we have built our sense of the world. Consequently, the process of recovery from trauma requires a renegotiation or rebuilding of our assumptions in order to reestablish our sense of equilibrium. This is an intuitive rather than a deliberate process that allows us to regain our ability to perceive benevolence and meaning in the world, as well as our own sense of self-worth.

Janoff-Bulman (1992) highlights three strategies by which traumatized individuals accomplish this. First, comparison to others allows us to focus on those whom we perceive to be worse off than us, thereby providing us with some sense of reassurance with respect to our own experience and position in the world. Second, the interpretation of one's role in the victimization (often entailing self-blame) allows us to restore the notion that we, in fact, had some sort of control over the situation. This, she notes, may be characterological ("There is something wrong with me, not the world") or behavioral ("I did something I should not have done or misjudged the situation in some way"). Third, individuals search for some benefit from the trauma they have endured or a sense of the purpose for which this might have happened to them. This effort to find deeper meaning in the experience (e.g. lessons that have been learned, a deepened sense of altruism, a validation of justice or fairness) enables us to continue perceiving the world as a place that makes sense.

Utilizing social work's traditional emphasis on the strengths perspective combined with a narrative constructivist view, Norman (2000) encourages clinicians to create a supportive, listening environment in which clients can begin to tell the story of their trauma, all the while listening for and identifying signs of strength, survivorship, and resilience. Whether clients have been traumatically impacted by a single event or prolonged exposure, whether they have been traumatized in adulthood after a history of relatively healthy psychological functioning or bear the enduring scars of a traumatic childhood, helping them to reframe their stories in light of these positive elements can facilitate clients' growth and allow for the creation of useful metaphors that can help them find meaning in past as well as future experience.

Narrative and culture The effort to make meaning of our experience extends beyond the realm of the individual and the interpersonal into the social and cultural worlds in which we are immersed (Neimeyer 2005). Here too, human beings seek validation of their interpretation of experience as they express it in culturally endorsed ways.

Bruner (1986, 1990, 1991, 2004) has been a key contributor to the understanding of the role of narrative in organizing human experience and the recursive relationship between intentionality, action, and interpretation. In a seminal essay on narrative, Bruner (1991) argues that narrative is a cultural product that aids in the organization of our sense of reality. He proposes that narrative has ten features:

- Diachronicity: the unfolding of events over time
- Particularity: the relationship of narrative to *specific* events
- Intentional state entailment: the influence of narrative characters' beliefs, desires, theories, and values
- Hermeneutic composability: the human capacity to tell and interpret stories *as* stories
- Canonicity and breach: the notion that what makes a story worth telling is the way in which it constitutes a break from that which is routinely expected
- Referentiality: the relationship between the contents of the story and its resemblance to our consensual sense of what is possible in reality
- Genericness: the ability of a narrative to be identified with a certain genre
- Normativeness: the implication of the narrative about the way in which one ought to behave or what one ought to do
- Context sensitivity and negotiability: the relationship between the roles of the author or story and the reader/listener with respect to context and interpretation of the narrative
- Narrative accrual: the notion that stories build on one another and flow from one to the other

Bruner further develops his thought about the matrix that gives rise to narrative in his understanding of the reflexive relationship between narrative and culture. Beginning with the premise that life in time is necessarily cast within and described by a narrative structure, Bruner notes that life is not only expressed in narrative form, but that narrative comes to structure the expectations and parameters within which life can be experienced (Bruner 2004). This is importantly and more broadly set on the stage of culture where the relationships between individual and communal narratives are shaped. Thus, Bruner suggests, culture provides us with the canon within which our narratives are formed and so conditions the range of meanings and possible worlds accounted for in our stories (Bruner 1986, 2004). Bruner (1990) writes:

> …by virtue of participation in culture, meaning is rendered *public* and *shared*. Our culturally adapted way of life depends upon shared meanings and shared concepts and depends as well upon shared modes of discourse for negotiating differences in meaning and interpretation. (p. 12–13)

Howard (1991) agrees and suggests that narrative is a way of knowing within the context of culture and cross-cultural society. Culture can be seen as communal consensus regarding a system of meaning that informs the way individuals within groups make sense of lived experience. "Thus, a culture can be thought of as a community of individuals who see the world in a particular manner—who share particular interpretations as central to the meaning of their lives and actions" (p. 190). Such meanings may fall into the domains of science, religion, politics, morality, and others. Furthermore, individuals may participate in any number of subcultures that make up a larger social framework and may take on a variety of roles within these subcultures. It is also possible for there to be conflicting messages

that are delivered by the subcultures to which one belongs. All these factors contribute to the way in which people make meaning of their experience in the world.

This is particularly important in the context of social work practice as we attend to the ways in which differences between our clients and us impact our understanding of their experience. We must always maintain a curiosity that wonders how the world, or life, looks and feels from the perspective of the client. This is always shaped by the many aspects of diversity that inform our experience: race, ethnicity, gender, age, socioeconomic status, sexual orientation, ability, family structure, social history, etc.

Saleeby (1994) details the significance of attending to the intersection of the meaning systems of the client, the worker, and the culture in which they are embedded. This perspective takes seriously the impact of the social and political environment, and can provide a vehicle for the client and worker to name and challenge structures that may oppress the client as well as the community. This is particularly important when considering issues of diagnosis and the stigma that, for so many, is attached to the idea of mental illness.

Building on the work of Bruner (1986), Josselson (1995) suggests that Bruner has brought legitimacy to the study of narrative as a means of understanding human knowing. This narrative perspective gives a privileged place to the human experience of the observer or teller who is embedded in the matrix of society and culture. Josselson writes: "Narratives are not records of facts, of how things were, but of a meaning-making system that makes sense out of the chaotic mass of perceptions and experiences of a life" (1995, p. 33). This perspective is essential when we consider the nature of diagnosis. Particularly compared to the exercise of diagnosing according to the fixed criteria of the DSM, the narrative perspective draws our attention to the lived experience of the individual in the context of society and culture, and seeks to understand the meaning of that experience on these multiple levels.

The Impact of Culture and Dimensions of Diversity: A Narrative Tapestry

As we consider social work practice with the mentally ill, these insights compel us to reflect further on the multiple cultures and subcultures to which our clients belong. We must ask ourselves what the multi-layered cultural and social system reflects to the client about the meaning of mental illness and of being mentally ill. Even before receiving a diagnosis, the client has been raised and immersed in a particular cultural milieu and has absorbed its outlook. Following a diagnosis, the client may well find him or herself to be the object of the culture's narrative about mental illness and the mentally ill. Clients are likely to internalize these messages as they strive to make sense of their experience and to reconfigure their sense of self and the narrative of their past and anticipated future in light of a mental illness. This

interaction between the individual and the social environment is the birthplace of stigma, both *externalized* stigma projected by others and *internalized* stigma absorbed into the person's sense of self.

We have noted that the nature of narrative development is recursive. That is to say, individual and communal narratives shape, challenge, and reinforce each other. We are influenced by the dominant narratives of the cultures in which we are immersed. We, in turn, to a greater or lesser extent impact the narratives of our culture(s). This may occur in spheres ranging from the closest circle of family and friends, to the broadest social and cultural arenas within which we live. Those who are marginalized and oppressed, however, may experience severe barriers to their ability to influence the narrative of the wider culture, particularly with respect to an experience like mental illness. This may be true, for example, of the homeless, those who do not share the language of the dominant culture, and the poor, as well as racial, ethnic, and sexual minorities. These individuals—who, because of their marginalized status, often feel invisible and unheard—may well find this is only exacerbated by a diagnosis of mental illness.

As was discussed with respect to the work of Bruner (1986, 2004), we frame our experience in the language and constructs that are available to us. In other words, the social and cultural vocabularies that we have learned both shape our understanding of our experience and provide the parameters within which we can communicate about it. A clear example of this phenomenon is found in the cultural concepts of distress discussed in the DSM–5 (American Psychiatric Association 2013). For example, the experience of *ataque de nervios* (an attack of nerves) is encountered among many Latino clients as a culturally understood if upsetting manifestation of anxiety and distress. Similarly, *ghost sickness* may be manifested by members of some Native American communities as a consequence of the work of witches or other evil powers. Within their cultural contexts, these conditions have a significance that would be understood differently (or not at all) by those outside the culture.

Examples of culture-based understandings of mental illness and mental distress abound. In Quechua-speaking rural communities in southern Peru, for example, mental illness, or what is referred to as "madness," is considered a social and family phenomenon that is manifested in a disturbance of behavior around food and eating. Here, where the sharing of food has deep relational significance for the family, a disruption in the ability to partake in the meal is a key sign of mental illness. Similarly, the act of feeding and the provision of food is viewed as an essential aspect of care for the person who is mentally ill (Orr 2013). Additionally, culture has a great bearing on the process of many individuals in their struggle to accept a mental health diagnosis. Culture may serve both as a facilitator and as a barrier to this kind of acceptance (Mizock and Russinova 2013; Sosulski et al. 2010).

In order to work ethically with our clients and to connect empathically with their experience, social workers must always reflect on the meaning of mental illness in cultural context. This requires having a familiarity with the kinds of symptoms or forms of emotional expression that are endorsed and those that are pathologized in a given cultural and social situation. This distinction influences both the experience of

the client who internalizes such messages and the way in which the environment responds to the individual.

For example, consider how a phenomenon such as grief is viewed in your culture. Following the death of a loved one, what is considered an "appropriate" amount of time to grieve? What are the common ways that grief is expressed in your culture? How do others respond to those who are grieving? At what point would a person's grief come to be viewed as "dysfunctional" or problematic? All of these questions serve to reflect the notion that grief is both a personal and a social/cultural experience. The meaning of grief is conveyed to us through a social and cultural narrative that helps us make sense of that experience. When an individual's experience or manifestation of grief falls outside of this culturally endorsed narrative, we come to think of this as a "problem"—something that deviates from what is acceptable and thus needs to be addressed.

Members of the mental health community, including social workers, have a unique voice in shaping the social narrative around issues of mental illness and psychopathology. Consider, for example, the origins of the term *hysteria*. The word hysteria comes from the ancient Greek term for *womb* or *uterus*. This reflected the Greek notion that symptoms of hysteria were caused by a medical issue in the uterus. Thus, hysteria was an illness experienced exclusively by women. Over time, this medical connotation gave way to a more psychological understanding of hysteria as a neurotic disorder marked by symptoms of anxiety with somatic manifestations such as fainting and paralysis (Freud and Breuer 1985/2004). It was continued to be viewed, however, as a condition related to the uterus, and thus, diagnosed only in women. In social and cultural narrative, the term has come to take on a negative connotation that led to its use as a gender-biased form of dismissal or marginalization.

Currently, the debate about cultural narratives of mental illness continues. With the publication of the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association 2013), there has been much discussion of the broader significance of changes to a manual that is already a product of a social and cultural discourse about mental illness. Horwitz and Wakefield (2007), for example, have posed the challenging question of whether or not the psychiatric establishment has come to pathologize the experience of ordinary sadness. If this is so, is it a reflection of a culture that has grown increasingly intolerant of the experience of emotional discomfort or of a medical and pharmaceutical industry that is invested in classifying the experience as a disorder for which they can provide costly treatment? In other words, if you are experiencing troubling feelings in your mind and body, and there is a medicine that might allow you not to have to feel those feelings, does this mean you have a disorder? Given what is known about the recursive nature of narrative development, the great likelihood that it is both and that each of these factors serves to reinforce the other.

All of this has clear implications for our understanding of the nature and experience of mental illness as well as for the work of assessment and diagnosis in which we engage as social workers. Social workers are continually "walking the tightrope" between diagnostic and environmental approaches to an understanding

of mental illness (Probst 2013). It is imperative for us, at all times, to maintain an awareness of the socially constructed nature of the concept of mental illness—a concept that simultaneously shapes both the ways in which we receive the experience of our clients and our understanding of mental illness itself. Narrative theory is well suited to this approach (Fisher and Freshwater 2014). A narrative perspective must ask not only, "Is my client mentally ill" or "With which mental illness should be client be diagnosed" but "What is my client's understanding, both of the nature of their experience, and the meaning of this for their identity and sense of self?" This is a question to which we now turn our attention.

Diagnosis and the Self: Do I Have a Mental Illness? Or Am I Mentally Ill?

Since narrative both emerges from and continually shapes our appraisal of the meaning of our experience, it has an inevitable relationship to our sense of self and identity. The way in which we tell the story of our life gives dimension to our sense of self, the world, and our self in the world. When considering the nature of mental illness then, the question that arises for those struggling with such conditions is, "Do I have a mental illness? Or am I mentally ill?" As with other chronic and serious conditions affecting the health of our clients (e.g. cancer), individuals with mental illness come to think of their illness and themselves within the framework that society and culture sets for them (Bruner 1991, 2004). This shapes the range of possible versions or meanings available to them and may be quite limiting. It may also mean that these individuals struggle greatly to maintain a sense of self that is broader than the illness with which they live. For many, this entails a process of mourning the loss of the life that they might have imagined for themselves—not necessarily a life marked by any particularly grand accomplishments, but one free of the burdens that a mental illness may impose.

Narrative Practice with Diverse Populations

Social work practice is about encounter—which means encounter with the *other* (Ploesser and Mecherill 2011). This may be construed, of course in many ways, inasmuch as there are perhaps countless ways of being *other*. Narrative approaches to practice perhaps pay particular attention to this kind of encounter with the *other*. Our engagement with clients almost inevitably stands at the intersection of a variety of forms of otherness, since the likelihood of encountering a client who is "like me" in every readily identifiable way is more than remote (and even then there is still more otherness to discover!).

Whether we are focusing on difference in gender, race, ethnicity, sexual identity or preference, religious belief, socioeconomic status, family structure, physical or intellectual ability, or even mental health, we are continually interacting with clients

whose otherness may be more or less apparent to us. As often is the case in social work practice, the ways in which a client appears different may be more apparent to us than the ways in which we are similar. This may be particularly true when we work with clients who are marginalized or oppressed. When intersectionality, the compounding effects of the interaction of multiple categories of marginalization or oppression, is at play, our sense of the client's difference may be even greater (Murphy et al. 2009).

Of course, difference or otherness is likely to be a factor not only for us, but for the client as well. Relying on perceptions of our difference from them, clients may question our ability really to hear and understand the story of their experience. Together, clients and social workers may be drawn into the sometimes tempting fantasy that, in order to understand each other, we must be "similar" is some sort of apparent way. This, of course, is deceiving and dividing, and can undermine the development of a productive therapeutic alliance. In fact, both similarity and difference from our clients contain the possibility of many layers of meaning. What is more essential is our ability to convey an openness to the *other* in the experience of their otherness and to demonstrate to our clients the kind of curiosity that was discussed above.

Our encounter with otherness in the social worker/client relationship is an instance of the intersection of unique narrative worlds. For this reason, work with two clients will never be quite the same, even if we do grow through the process of accumulating knowledge as we become more familiar with some of the shared aspects of experience. Like our clients, we come to this work with our own narratives—our stories of ourselves, the world, and ourselves in the world. At its deepest level, our ability to work with our clients in all the many aspects of our mutual diversity is not dependent on the acquisition of the "facts and figures" about this or that client group. It is not about what I have learned about a "category" of person, though this kind of information can be somewhat helpful in a general way. Rather, it depends on our ability to be open to the client and the worlds of human experience, understanding, and even misunderstanding they (and we) bring into the consulting room. It depends on our ability to take seriously on a fundamental level their experience as they experience it, and to make ourselves available with whatever knowledge and skill we have so that together we can help the client come to a deeper, richer, and more life-giving sense of self. While it does not guarantee success with every client in every situation, it can go a long way to helping us bridge those gaps that we imagine keep us so far apart.

Conclusions

Just as Crossley (2000, 2003) suggested that the experience of trauma reveals the profound orderliness that we have come to expect from life, so too the diagnosis and experience of a mental illness calls into question profoundly important, but commonly taken for granted dimensions of our day-to-day existence. These include

the clarity of mind and stability of emotion that we associate with mental health. Similarly, the ability to study or work, to organize the business of daily life, and to experience mental and emotional leisure, and even the opportunity to participate in stable and reciprocal relationships may all be adversely impacted by mental illness.

As social workers, we must be attentive to the possible impact of all of this on the client's narrative of the self. "Do I have a mental illness, or am I mentally ill?" It is essential to note that some of these narratives, based solely in psychiatric conceptualizations of pathology, may serve to oppress and obscure rather than to liberate and clarify. Some clients may feel that diagnoses have been used to marginalize and blame them, or to dismiss their experience. I still recall the first time I heard a clinician, frustrated by the challenging and erratic moods and behaviors of a client, say dismissively, "She's just a borderline!" I recall, too, a most helpful supervisor who modeled a stance of compassion when she said, "I wonder what terrible things she has experienced in life that taught her that this is what she needs to do in order to have her needs met?" In all the years since that moment, the voice of that supervisor has reminded me to seek to understand the experience of the client—no matter how difficult that experience may be.

As social workers working to achieve justice with and for our clients, (Wakefield 2013) one of our responsibilities may be to help clients break open and challenge the dominant and dominating narratives that have come to shape their sense of identity—to call into question the cultural "givens" and facilitate a re-storying of clients' experience in a way that is nuanced, life affirming, and liberating. This is not to deny the problematic and disruptive aspects or impact of mental illness. Rather, it is to support mentally ill persons in developing a sense of self that is constituted by more than their mental illness. This is something that narrative is uniquely suited to do.

Application to the Case of Ray

How then, can we apply this narrative approach to the case of Ray? In this section, we will consider a number of aspects of Ray's experience and the ways in which they might impact his narrative of his life and experience. This kind of understanding is essential if one wishes to work with such a client from a narrative perspective.

First, it may be noted that Ray is similar to a great number of men who may be compelled at some point to present for treatment. I say "compelled" here, because often such clients will say that they might not have sought out treatment for themselves if the pain they were experiencing and the circumstances they were enduring had not made the need for help clear to them. So often, these men have been socialized to believe that strength and masculinity require emotional endurance and that they should be able to tolerate without difficulty whatever degree of adversity life may throw their way. For such men (and some women as well, of course), reaching out for help represents some form of weakness. Alternatively, some may

feel that requests for support should be confined to a specific group of people who may share a similar experience. (E.g. "A cop should only talk to a cop; a fireman should only talk to a fireman. No one else will understand.") It is important to acknowledge that both of these perspectives are, in fact, narratives. They are the kind of narratives that can exercise tremendous emotional authority in the lives of individuals and may make it difficult for some to receive the help they need.

Nonetheless, Ray does find himself in treatment. The distress he is experiencing in his daily living has prompted him to seek out some assistance. There are a number of aspects of Ray's story to which we might attend from a narrative perspective. Ray has a meaningful relationship to his Catholic identity. This has impacted his story in a number of ways. He is a man who believes that loyalty and trust are qualities of great importance in a person. (Note that although this may not seem like a "narrative," it constitutes part of the "story" that Ray tells himself about what it means to be a good person in the world. This is the narrative way of framing Ray's outlook.)

Ray believes that one must never "rat out" another person. This is part of the conflict that he has with his girlfriend, Cecilia. He feels that she has betrayed him to the priest from whom they sought counseling as a couple (something Ray was reluctant to do and agreed to only because he thought it meant they were going to work things out) by disclosing personal details and then "turning on him". It is also part of his conflict in disclosing the abuse he sustained by a priest when he was a boy. One might consider that this reluctance may also be connected to the kind of narrative about male strength that was discussed above. Ray should be strong enough not to be impacted by these events that, however painful, took place long ago.

Ray's narrative as an Irish Catholic has also informed his sense of guilt and the meaning guilt has for him. Ray continues to feel guilt over the three abortions Cecilia had at his request. Here, there is evidence of conflicting narratives. One lies at the heart of his guilt over the abortions. Another lies at the heart of his belief that they were necessary at the time. It is not uncommon to encounter clients who are struggling with two or more competing narratives in treatment. And it is often powerful and therapeutic to be able to "hear" or pick out those narratives and bring those competing claims to light for further exploration and resolution.

Ray's understanding of guilt has also impacted his feelings about not having been able to save a fourth child from a burning building. In this case, the guilt narrative leads Ray to highlight in his consciousness the loss of one child while subjugating or downplaying his rescue of three others. This was reinforced by the events of 9/11 that led to a shift in his narrative about the meaning of being a police officer. Where he once focused on the satisfaction he derived from "doing some good", he now feels that, "All I ever see are the worst things about people…". To make matters worse, in light of recent events, Ray's gun has been taken away and he has been reassigned to a post where he feels that all he can do is wait and watch while bad things happen—a passive stance that further confirms this shift in his narrative.

We may notice that there are ways in which both narratives contain aspects of "truth", but that many circumstances of life lead us to attend selectively to some

details more than others. In narratively base treatment, we work with clients to broaden these filters in order to help them see a broader (and hopefully more adaptive and healthy) array of narrative elements that are "also true" and just as true as the more limiting stories they have been telling themselves.

Another significant narrative that has shaped Ray's experience involves the story of himself as different from others (particularly peers), and as needing to defend himself. As a boy of eight or nine, Ray became aware of himself as smaller than and different in appearance from his neighborhood peers. It is also his understanding that these factors contributed to the bullying he experienced. All of this led to the development of his narrative that it is important for him to be tougher and stronger.

While this story or perspective may have served some adaptive purpose (though there certainly might have been other ways to manage the situation) in helping Ray deal with neighborhood bullies, it is also a narrative that has led to more significant troubles in his life. Ray has found himself getting into bar fights over perceived offenses. It has even led to some physical violence with Cecilia. Here again, we notice a conflict between two competing narratives. On the one hand, Ray has a story that tells of the importance of being tough and standing up for yourself—a story in which fighting becomes a means of self-expression, a language of sorts. On the other hand, Ray also has a story of growing up in a loving and peaceful household and of the prohibition against violence toward women. When these two stories come into conflict, Ray knew he needed help because "for the first time this violence had cost him something that really mattered…"

Powerfully intermingled with all of this is Ray's narrative as a survivor of sexual abuse at the hands of a priest when he was a child. From this experience emerge numerous narrative threads that have become so twisted as to form a knot that Ray has struggled mightily to cope with if not undo. Like that of so many survivors of abuse, Ray's narrative has been shrouded in secrecy born of shame. Like so many others he asks himself, "Why me?" "Was there something I did to bring this on? "Was there something I did to encourage it?" Given what we already know about Ray, it becomes apparent that this experience of great pain stands in conflict with some of the dominant narrative themes we have already touched on—themes of trust and betrayal of trust, the theme of being singled out or targeted for abuse, and the theme of guilt, this time over other victims, he feels he might have saved if he had come forward earlier.

Ray's story is a perfect example of the way in which, in narratively informed treatment, the multiple layers of story and meaning are interwoven to form a complex tapestry. For this reason, as was discussed, narrative treatment relies on our ability to listen carefully in a particular kind of way—to listen for the presence of stories and of systems of meaning. We listen for the ways in which those stories are challenged and reinforced, and for the ways in which our clients attend, unintentionally or unknowingly perhaps, to some aspects of the story while ignoring or downplaying others. We listen with great curiosity, wondering where the narrative unfolding will take us, and how the story may play out as we encourage our client to imagine and explore new plot lines that lead to new capacities and a new sense of self.

In this context of a trusting therapeutic relationship, we have the opportunity to play with and stretch the stories that clients tell themselves and tell us. With some prompting and support, the narrative that emerges from this kind of re-storying can be deeply rich even if is marked by great pain. In the telling and crafting of the story, in the powerful exchange that occurs when the story is not only told but heard, not only shared but received, we open up the possibility of discovering something greater than ourselves. In this, we find the possibility of crafting a narrative that takes us simultaneously beyond and deeper to understand ourselves more fully. That is narrative in practice.

Practical Exercises

Consider journaling about your own narrative with respect to some of these questions. You might wish to discuss your thoughts with someone you trust.

1. What are the dominant aspects of your narrative about yourself, the key aspects of the way you understand yourself?
2. Who and what factors have been most formative in the shaping of your own narrative of the person you are? Consider things like ethnicity, family structure, family expectations, and messages about you and your place in the world, gender, sexuality, and spirituality.
3. What has been your narrative of yourself as a social worker and helping professional? What personal experiences have led you into this profession? What is the story you are telling yourself about who you will be as a social worker, the kind of work that you will do, and the impact you will have on your clients?
4. Are there stories or narratives that you find particularly intriguing or compelling? What are the kinds of narratives you most wish to hear (or at least think you will)? Are there narratives that are (or that you imagine will be) too painful or frightening to hear?
5. Are you aware of any narratives that you have inherited from our culture, family, environment, that may be limiting to you, your clients, or your ability to be helpful to them?
   Try some of these prompts and see what they bring up in you and how you respond to them:
   (a) I think of myself as a person who…
   (b) Those who know me well would say that I…
   (c) I find it most difficult when…
   (d) I am at my best when…
   (e) The thing about myself I find most difficult to embrace is…
6. What did you learn from your culture, environment, or the media as you grew up about the mentally ill?
7. How do you understand the causes of mental illness? What thoughts, feelings, and fantasies do you have about those who suffer from mental illness?

8. If you have had the opportunity to work with clients, think back to your encounters and try "listening" from the vantage point of narrative. (You can, of course, practice this in your sessions going forward as well.) What stories do you hear the client telling about themselves and their experience of the world? Have those stories been helpful or unhelpful to them—or somewhere in between? How might a narrative approach impact the way you work with your client? (This can be done as an in-class exercise in pairs or small groups.)

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