Meanings of madness: a literature review

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This literature review focuses on how people make sense of mental illness. The study explores the process of meaning making by people experiencing mental ‘dis-order’ as it is influenced by the context of their environments, available cultural explanations and the nature of their mental states at that time. It is proposed that people experiencing psychological trauma attempt to regain a sense of order by imposing a narrative structure on these disconcerting experiences. The sharing of these personal stories with others results in meanings being shaped and refined through dialogue and across time. Socially agreed meanings, however, can have a political dimension and it is argued that personal meanings embedded in narratives of mental pain are often suppressed and categorized to fit dominant cultural or biomedical explanations. Implications for mental health nursing are discussed.

Keywords: meaning, mental health nursing, mental health, narrative, service users

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I cannot manage without another, I cannot become myself without another; I must find myself in another by finding another in myself (Bakhtin & Emmerson 1984, p. 287).

Introduction

The nature of mental health and illness has been discussed and theorized for centuries, across disciplines and cultures. As humans, we struggle to create order out of chaos; our fear of the unknown and irrational leads us to construct accounts or stories which help us to make sense of the world and our experiences within it. Many writers have discussed the human impulse to create order and meaning through imposing a narrative structure on diverse experiences (Riessman 1993, Sandelowski 1994, Polkinghorne 1996). Mishler (1986, p. 67) states that ‘telling stories is one of the most significant ways individuals construct and express meaning’. Our meanings are articulated through language which ‘is our means of ordering, classifying and manipulating the world’ (Spender 1985, p. 3) and we share our stories and meanings with others to know that we are not alone. We constantly negotiate and redefine our meanings and realities across time through communication and dialogue with others (Garfinkel 1967, Bakhtin 1981). Various influences impact on how our stories are told and interpreted, such as: personality (Bruner 1987), attitudes/beliefs/culture (Hinton & Levkoff 1999), gender (Crowe 1996, Busfield 1996), cognition (Sparkes 1994, Strand 1997), mood (White & Epston 1990, Polkinghorne 1996), social context and relationships (Sarason & Duck 2000). The dynamic interplay of these forces affects how individuals construct their identities and beliefs and also influences how these expressed identities are interpreted and accommodated by their social environments. This quest for personal meaning in a social world is inevitably influenced by cultural and political forces (Saris 1995).

Mental illness represents ‘a crisis of meaning’ (Roberts 2000, p. 435) for people undergoing these experiences, for
families and for carers. People with mental health problems experience phenomena which are disconcerting to them and/or their environments, and they often struggle to make sense of their experiences of altered mental states in order to gain psychological equilibrium (Kleinman 1988, Smale 2000). Crossley (2000) states that through telling stories about their experiences of trauma, people attempt to ‘reconfigure’ a sense of order, meaningfulness and coherent identity. As Champ (1999, p. 117) puts it:

I desperately needed to understand what psychosis was and extract some kind of meaning from the experience.

I could only do that by telling it over many times.

Narratives in mental health nursing research

As mental health nurses, we spend our working lives in a context of story telling. People bring to us their stories of how their lives came to be as they are. By attending to the stories of people in our care, we gain a fuller sense of the unique experience of mental illness for people as it is shaped by their cultures, mental states, and their past and present situations. So, how have versions of the reality of mental distress been represented in the nursing literature? A search was conducted using CINAHL and MEDLINE databases using the following key words: narrative; story; mental illness; mental health nursing; and service users. The most striking feature of this search was the scarcity of service users’ interpretations of their experiences of mental health problems in nursing literature. The few accounts which appear to render service users’ interpretations of their difficulties most faithfully tend to come from other disciplines, such as sociology and anthropology. Many of the studies found were conducted in America and Canada. Surprisingly little nursing research in Britain and Ireland has focused on service users’ understandings of mental illness, as conveyed to nurses. Therefore, this literature review will consider what has been written on people’s interpretations of their mental distress in this study, including: mental illness; mental distress; mental pain; madness. This is to reflect the diversity of interpretations of this phenomenon among those who are experiencing mental health problems and those hoping to help them. No one term is privileged over another because all are equally meaningful (or meaningless), depending on the perceptions and experiences of individuals.

A review of the literature suggests that the meanings people accrue from their experiences are contextually mediated and heavily influenced by the process of making meaning, as Saris (1995, p. 39) explains:

A narrative of a chronic condition is not simply a story of personal experience. It is, rather, deeply embedded within various institutional structures that influence its production as a story.

Accordingly, this literature review will focus on the following two inter-related themes:

- the process involved in constructing the meaning of mental distress (namely how people make sense of their experiences); and
- the understandings people reach about the nature and meaning of their experiences of mental distress (namely what sense people make of their experiences).

The process of meaning making

For the purpose of this literature review, the process of meaning making (i.e. how people make sense of their experiences) is examined under various subheadings: the nature of meaning and the organizing power of narratives; biographical disruption and incoherent narratives; and psychosis – cognitive dysfunction or meaning making?

The nature of meaning and the organizing power of narratives

It is useful to begin with a consideration of the nature of meaning in this context. Current postmodern approaches to the concepts of individual meaning and identity are moving away from ‘...the humanist concepts of the self as a neat, coherent package to a more complex idea of the self as fragmented and non-unitary’ (Bloom 1995, p. 122). Meaning is seen as arbitrary, shifting, context dependent (McAllister 2001), and changing with time as new experiences are interpreted in the light of past experiences and anticipation of the future (Ricoeur 1991):

The realm of meaning is not static: it is enlarged by the new experiences it is continuously configuring as well as by its own refiguring process which is carried out
through reflection and recollection (Polkinghorne 1988, p. 15).

Expressing and negotiating meaning through language is similarly complex; poststructuralists claim that language is ‘slippery’ and words have no intrinsic meaning except in their relationship to each other (Barthes 1972, Derrida 1973). In this context of meaning and identity flux, we construct a comforting ‘narrative of self’ about ourselves (Sparkes 1994). As Bruner (1987, p. 13) states:

...there is no such thing psychologically as ‘life itself’. At very least, it is a selective achievement of memory recall; beyond that, recounting one’s life is an interpretive feat.

Sarbin (1986) contends that humans always seek to impose structure on the flow of experience and that they do so by using narrative structures, which he calls the ‘organizing principle for human action’. Polkinghorne (1996, p. 300) has also commented on the organizing properties of narratives:

Narrative is able to fulfill the need for personal unity because of its capacity to draw together disparate life actions and happenings into a coherent whole.

Biographical disruption and incoherent narratives

Sandelowski (1994, p. 29) defines psychic health as ‘having a coherent narrative account of life, one that configures a person’s existence into a unity’. In this context, illness trauma is seen as ‘biographical disruption’ (Sandelowski 1994) or ‘narrative wreckage’ (Frank 1995). Waitzkin & Magana (1997, p. 811), in their analysis of narratives of people who manifest physical symptoms following psychological trauma, describe a similar process:

Extreme stress (torture, rape, witnessing deaths of relatives, forced migration, etc.) is processed psychologically as a terrible, largely incoherent narrative of events too awful to hold in consciousness. Culture patterns the psychologic and somatic expression of the terrible narrative.

The aim of therapy, according to Waitzkin & Magana (1997), is to empower people to express more coherent narratives of their prior traumatic experiences.

The range of meanings that are available to people with mental health problems is a powerful contextual feature in the process of meaning making. If meanings are created and shared through dialogue and personal stories, then people with mental health problems are often silenced. As stated by Sayce (2000, p. 31):

Until a language is created, people do not know what, ‘literally’ to say. If all they hear is that having weird thoughts means you could be crazy, and that mentally ill people are hopeless and dangerous, they will probably say nothing. But when they hear or read of other people’s strange experiences, it can enable them not only to speak of their own, but also to think them. Without a language, thought itself is silenced and truncated.

The prevailing themes of peoples’ life stories can also influence mental health and the interpretation of new experiences, as Roberts (2000, p. 433) explains:

Some [people] grow up with life-denying meanings and are hostage to toxic stories that adversely define and constrain their identity and self image.

Polkinghorne (1996) studied narratives of people who adopted the role of victim in their experiences of mental illness. Polkinghorne states that construction of a victimic identity may help people to make sense of feelings of hopelessness and helplessness and that by helping people to construct a more positive, empowering narrative, mental health can be improved. McIntosh & McKeeganey (2000) carried out a sociological study using interviews with 70 recovering drug addicts. They describe the process involved in addicts constructing ‘a narrative of recovery’ and a non-addict identity. This approach is the focus of narrative therapy where adherence to negative internalized stories is challenged and ‘toxic’ stories are deconstructed. In narrative therapy, people are supported in ‘authoring’ or ‘reauthoring’ their own lives (White & Epston 1990, Polkinghorne 1996).

Psychosis – cognitive dysfunction or meaning making?

The experience of psychosis adds further complexity to the process of formulating, expressing and negotiating meaning. Lockwood (1984) claims that cognitive function can affect a person’s perception of mental status. Moreover, Strand (1997, p. 325) refers to the ‘impact of mental constructions as a primary context dictating the nature of reality’. This obviously has implications for how people construct and articulate meaning and how likely it will be that their meanings will be either misinterpreted or articulated for them. Leudar & Thomas (2000, p. 6) claim that people who try to make sense of verbal hallucinations are ‘caught between the rocks of mystification and pathologization’. In recent years there has been increased interest in discovering the meaning of ‘mad’ or ‘crazy’ talk (Swartz & Swartz 1987, Szasz 1993). Psycholinguistic and sociolinguistic approaches aim to extend the understanding of psychotic discourse by exploring cognitive and social processes influencing language and communication (Silverman 1974, Thomas & Fraser 1994).

Roberts (1991) advances the argument, suggesting that rather than a destruction of meaning, or cognitive dysfunction, delusions are methods of sense making; that delusions represent the individual’s way of attributing meaning to unaccountable, unpredictable, anomalous experience
(Roberts 1991, p. 19). He supports the assertion of Lansky (1977, p. 21), that a delusion is restitutive, ‘ameliorating anxieties by altering the construction of reality’. Carr (1988) conducted a survey using a sample group of 200 people in relation to the coping strategies they used in dealing with their ‘symptoms’ of schizophrenia. In discussing his findings, Carr (1988, p. 351) states:

In some respects, it could also be suggested that delusions themselves represent coping devices in which the schizophrenic patient attempts to master a frightening and bewildering subjective state by imposing meaning or forcing an explanation upon experiences which would otherwise be meaningless or inexplicable.

It could be argued therefore that delusions represent the ‘stories’ produced as a result of using narrative processes to structure this ‘frightening and bewildering subjective state’. Cox & Theilgaard (1987) argue that progression from psychosis to sanity involves recovery of the ‘real’ life story in which the psychotic experience has been processed and integrated from the standpoint of ‘sanity’. This is supported by a service user’s perspective (Champ 1999, p. 126):

Ultimately, even a paranoid delusion is a miraculous thing, testimony to the infinite wonder that is the human mind. Learning to integrate such bizarre phenomena into my life and still find meaning has enriched my life, for all its hardships.

Context of meaning making

Peoples’ life circumstances and contexts will also influence their experiences and interpretations of mental pain. The context of meaning making is explored under the subheadings below.

Cultural context

The process of integrating ‘bizarre phenomena’ and ‘finding meaning’ is inevitably bound up with dominant cultural interpretations and responses to these phenomena. According to Wittgenstein (1968), cultures and groups agree shared meanings of language for social and political purposes. Crowe (1998, p. 341) comments:

Cultures determine what meaning is attributed to experiences and actions by imposing structures of categorization based on normative criteria. The individual’s sense of reality is thus determined by the internalization of these cultural constructions which occur through the medium of language and ensure continued adherence to the established social order.

People with mental health problems often look to dominant cultural meanings for explanations of their distress. Even if explanations are not actively sought by the individual, the surrounding culture may impose meanings in terms of responses to behaviour identified as ‘madness’. As stated by Sayce (2000, p. 3):

A complex set of material and cultural conditions is likely to be significant in determining how a person defines its ‘mad’ and how accommodating it is towards them: for instance, whether and how it defines ‘perfection’ of mind and body and their opposites, on what basis it distributes resources and what other cultural preoccupations it links to madness.

Mental distress has been interpreted through time and across cultures as: possession by evil spirits; punishment for past wrongs (Robbins 1986); mystical experiences; spiritual imbalance (Fernando 1991); biochemical imbalances (Lieberman 1999); faulty genes (Gottesman 1999); feeble mindedness; lack of self-control; social deviance (Sayce 2000); product of damaging interpersonal/social environment (Albee & Ryan 1998); learned behaviour (Seligman et al. 1980); faulty thinking (Strand 1997); or the result of past traumatic experiences (Herman 1994). Levine & Levine (1970) argue that in socially conservative times, explanations of mental illness in terms of an individual’s internal make up are more prevalent, whereas in times of social/political reform, explanations which suggest the influence of the social environment on causation of mental illness are more prevalent.

Gender

In relation to the ‘gendering’ of mental illness, Busfield (1996, p. 117) states:

Since gender is such a key feature of social relations and a major dimension of social difference, gender inevitably features in the constructions of mental disorder.

Crowe (1998) argues that meanings which are privileged in a given culture will reflect the dominant interests of power. Much postmodern feminist writing asserts the belief that language is ‘phallocentric’ and cannot adequately help women to reflect on or articulate their experiences (Harden 2000). This point is also evident in Crowe’s (1996) article on self-mutilation where she argues that self-mutilation is used as a form of symbolism or expression of mental pain where words and language have failed. Other writers have also commented on the communication/signifying aspects of self-mutilation: ‘the language of injury’ (Babiker & Arnold 1997). As Mason (1996), in describing the context of her agoraphobia, states: ‘like most women, I had learned to eat my anger, not to let it show’. Ritsher et al. (1997) used a survey to explore the issues in the lives of 59 men and 107 women experiencing ‘severe mental illness’. They found that these women did not see their mental illness as...
central to their identities but that personal relationships were fundamental in their lives. The authors concluded that ‘women’s experience of living with severe mental illness is considerably different from that of men’ (Ritsher et al. 1997, p. 1281). Riessman (1992) suggests that women’s experiences have become a focus for medicalization because of women’s social roles and their subordinate relationship to the male-dominated biomedical culture. Sayce (2000) claims that the inclusion by the Diagnostic & Statistical Manual of Mental Disorders of premenstrual disorder into its criteria subjugated other experiences/meanings of mental distress among women into a ‘syndrome’ and ‘made half a million more women pathological at a stroke’ (American Psychiatric Association 1994, p. 110).

Race/ethnicity

Similarly, racial and cultural identities are seen as inherent in the formulation and expression of meaning (Fernando 1991, Sandelowski 1994, Hinton & Levkoff 1999). Just as patriarchal gender relations can constrain female meanings, so Western assumptions about normality can silence the expression of ethnic minorities. Crowe (2000) claims that colonized cultures experience a loss of identity as they are forced to adopt the dominant culture’s meanings. Clarke (1998, p. 536) discusses the situation of Irish emigrants who ‘emigrate to the country of their oppressors’. Clarke (1998, p. 561) claims that feelings of inferiority and dispossession among the Irish in Britain, as well as stereotypes, may account for the higher rate of Irish people diagnosed with schizophrenia in Britain:

For many, immigrant status in Britain exacerbates feelings of diminished self-worth, thus helping bring about debility in the form of psychological distress. Amongst British psychiatrists the tendency to find a diagnosis for this distress using the standard indices of illness must be high.

Many writers have explored the theme and experience of stigma (Goffman 1963, Pointon & Davies 1997). Sayce (2000) states that people who experience mental illness have also internalized societal stereotypes of ‘madness’, especially the notion of mental illness as a moral failing. This has obvious implications for how people make sense of their experiences, and many people in mental distress feel shame when they are diagnosed as ‘mad’.

Biomedical context

Much medical research in psychiatry concentrates on purely biochemical explanations for mental disorder (for examples see Keshavan 1999 and Lieberman 1999). As Crick (1994, p. 3) concludes: ‘the you that is you...is in fact no more than the behaviour of a vast assembly of nerve cells and their associated molecules. Some people find it helpful to attribute a specific medical/psychiatric diagnosis to their experiences of mental distress, as a biochemical explanation can relieve a person of feelings of guilt and self-blame (Lindlow 1996). Peters et al. (1998) interviewed 68 people who were experiencing physical symptoms for which no physical cause could be found. The researchers found that this sample group used medical frames of reference to create a ‘self-protective narrative’. This is illustrated by the following assertion (Peters et al. 1998, p. 563):

I have clinical depression. It’s not normal depression, it is, in fact the clinical type. The doctor explained it to me quite well actually. It’s between the neurones, in these synapses. Something goes awry and that happens in clinical depression. Everything that hurts – I know that it’s because of the brain cells not quite working.

In addition, a number of other studies show that people incorporate biomedical explanations into their meanings of mental distress (Hinton & Levkoff 1999, Karp 1992). Brown et al. (1996, p. 1578) comment that ‘clients’ descriptions of their problems are already storied along psychiatric lines’.

A contrasting view of the biochemical explanation is expressed by Fisher (1999, p. 131) who finds it ‘dehumanizing’:

When I think that I am a group of chemical reactions each with its own scheme and plan, I feel dehumanized and powerless. I feel that I am thinking, feeling and acting at the whim of those chemicals, not through any effort or responsibility of my own...Another problem with this mechanical view is that it removes people from their unique histories, relationships, classes and culture. Yet these have been shown to be some of the most important variables, both in the aetiology of and recovery from mental illness.

Other service users (Wurtzel 1996, Perkins 1999) argue that they find it valid to incorporate biomedical explanations into their meanings of mental distress. As Perkins (1999, p. 143) states:

To assume some genetic or organic contribution is not to be determinist. It is simply one of the many variables that influence the complex array of human behaviour and experience.
argues: and transformed into mental illness. Stoppard (1997, p. 22) (1998) claims that mental distress becomes pathologized therefore highlighted. In this biomedical model, Davidson meta-narrative to shape public opinion and attitudes is also constructs what society can expect as normal behaviour’ (Crowe 2000, p. 584). The power of the psychiatric meta-narrative to shape public opinion and attitudes is therefore highlighted. In this biomedical model, Davidson (1998) claims that mental distress becomes pathologized and transformed into mental illness. Stoppard (1997, p. 22) argues:

This reification of the disorder is supported by a process of circular reasoning which begins by considering individual experiences in isolation from other aspects of their lives. These detached experiences are then re-conceptualized as ‘symptoms’ of underlying (and observable) disorder, one that can be detected only by means of the very experiences on which the initial diagnosis was based.

Diagnosis and labelling

Psychiatric diagnoses are not objective, scientific renderings of truth, but constructions of life experiences inextricably linked to the social and political context. Harper (1994) studied the use of the term ‘paranoia’ by utilizing discourse analysis of interviews with five mental health professionals. Findings demonstrate these social and political forces at work as the mental health professionals justified their use of the term/diagnosis of ‘paranoia’. Harper’s examination of their accounts shows how this group of mental health professionals exploited the range and ambiguity of diagnostic definitions in order to give ‘scientific’ credibility to their own subjective personal and professional attitudes and interpretations. Many service users have commented that ‘non-compliance’ with psychiatry’s dominant meanings and treatment is taken as further evidence of ‘mental illness’, in that ‘being defiant can become a disorder as the practice of diagnosis veers into the absurd’ (Sayce 2000, p. 110). Barker et al. (1999, p. 8) comment strongly: …we should never forget how the bestowal of a psychiatric label can so usurp the person’s sense of identity that all subsequent distress (relapse) is reconstituted as a function of that diagnosis.

The psychiatric meta-narrative is often also adopted by ‘patients’ to structure and explain their experiences of mental distress. Some people find that ‘having a name’ for their experiences provides a sense of order and enables them to reconstruct their lives incorporating the diagnosis, as McIntosh (1996, p. 72) reflects in relation to her diagnosis of manic depression:

On a positive note, at least when I did learn of my diagnosis I was able to begin coming to terms with my illness and dealing with it on a constructive basis...I discovered a common identity and a camaraderie with fellow MDs, which enhanced my life tremendously. Peters et al. (1998, p. 563) articulate the discomfort of not having a name for disconcerting experiences:

Not having a label, I think that’s the real problem so I can put it in a box and go ‘yeah it’s that, I’ve got that now I can get on with me life’. I can’t deal with the unknown.

The vulnerability of the self-concept of people in mental distress and the impetus to account for disconcerting experience is so overwhelming that there is a risk that biomedical explanations are privileged over individuals’ personal contextual meaning for their experiences. Champ (1999, pp. 115–116) poignantly expresses the horror of this position from the perspective of an individual in mental distress searching for meaning: Prior to developing schizophrenia, the workings of my mind had been unquestioned. Suddenly I was being told...
by a psychiatrist that I could not always trust my own thoughts and senses. I felt that my own mind had betrayed me. How could I ever trust it? Self had become a traitor and was working against my own good... Trying to decide what was normal or sane was like negotiating a foreign city without a map... That search for normalcy was doubly confusing as each health professional I encountered would tend to see indicators of my progress differently.

While the biomedical interpretation of people's mental health problems may be useful, biochemical influence is one of the many variables which affect human behaviour, perceptions and experience. It has been argued that unquestioning acceptance of the biomedical account as the only explanation can lead to passivity and the stultifying of further attempts to find personal meaning in human suffering. Roberts (2000, p. 438) suggests that psychiatry's 'narrative of chronicity' forces people into 'exchanging the precarious and uncertain struggle for health with acceptance of meanings that will forever constrain the individual's hope and potential'. However, as Sayce (2000, p. 111) argues, there is a need for some conceptual map, some frame of reference from which individuals in mental distress and those hoping to help them can gain some guidance:

- The DSM is open to considerable question as a reliable and acceptable categorization system, but we do need a language, a set of categories, to describe different experiences. The most promising are those rooted in user/survivors' own articulations of their experiences.

- The authors of this literature review argue that the meanings which sustain people are achieved through dialogue, through articulating and hearing individual stories and by reflecting on our own and others' versions of reality.

Service users' understandings of their mental health problems

Representing the voice of the service user

The recent focus on user participation and patients' narratives has led to a greater proliferation of people's accounts of their physical illness experiences appearing in nursing journals. However, searches demonstrate a lack of nursing research in Britain and Ireland in relation to the interpretations that people make of their experiences of mental distress. The narrative accounts reviewed showed variation in their focus, some conveying as faithfully as possible the person's account of pain or distress where 'the data speaks for itself' (Running 1997, p. 118, Myers 1994, Smale 2000). More commonly, in other narrative studies, there is a stronger authorial presence trying to make sense of these experiences. The 'sense making' in these accounts is usually performed by researchers who identify 'themes' which are indicative of a particular way of experiencing illness (Pejler et al. 1993, Chaftetz 1996). While all research involves researcher interpretation and some degree of personal bias, Running (1997, p. 117) warns:

- Practising nurses must work at resisting the temptation to assign themes, categories, metaphors, models or theories to unique individuals.

- There are pitfalls inherent in regarding peoples' accounts and stories as 'text' for researcher interpretation, in that the 'categories' or 'theories' of researchers can be privileged over the personal meanings that people have for their experiences (Riessman 1993, Bailey 1996). For example, Crowe & Alavi (1999) interpreted the narrative of a woman experiencing psychosis using a poststructuralist feminist approach. How closely the researchers' interpretations concurred with the patient's is debatable. In narrative analysis, there is a risk that researchers may be responsible for suppressing the very meanings they are purporting to uncover through the analysis and may, in fact, be replicating 'expert professional' vs. 'passive patient' relationships of unequal power. Many writers, especially from the service users’ perspective, claim that the most valid sense making is performed by the person experiencing the phenomenon, often as a result of dialogue and story sharing with others who have had similar experiences (Read & Reynolds 1996, Barker et al. 1999).

User movements and story sharing

The impetus to find meaning through sharing stories with people who have had similar experiences has contributed to the rise in number of user movements. User movements among people with mental health problems began in the 1960s in a context where dominant social institutions were being challenged by antipsychiatry, feminist and civil rights movements (Busfield 1996). Among user groups there are strident voices challenging dominant psychiatric versions of other people's realities, as Wallcraft (1996, p. 191) asserts:

- For the past 10 years or so we have been finding a voice; coming together and realizing that, although our life stories are very different, there are common threads in our experiences of having been misheard, devalued, written off and damaged because of other people's fear of madness.

- The literature produced by users' movements is often in the form of people's stories of their mental distress and the sense they make of their experiences. In this context, the stories have the quality of an evangelical or moral quest; there is the sense that the person has come through their
experiences of mental pain (and often psychiatric treatment) and, being a ‘survivor’ of both the personal experience and the system, now must share that story with others. Groups such as Survivors Speak Out, and anthologies with titles such as Speaking our Minds (Read & Reynolds 1996) bear witness to the emphasis placed on articulating, sharing and asserting personal meanings. The validity of personal experiences is emphasized, as is the power of sharing stories (Wallcraft 1996, p. 191):

Sharing our stories finally gave us the courage to believe that we are not mad; we are angry…our distress and anger is often a reasonable and comprehensible response to real life situations which have robbed us of our power and taught us helplessness.

The search for personal meaning
The study thus far has examined meanings of madness as influenced by the context of the person’s environment, available cultural explanations and the nature of the person’s mental state at that time. It has also examined how these complex influences are interwoven into narratives. However, there is also the very personal existential question, ‘Why me? Why have I had this experience as opposed to anyone else?’ Often when people struggle for answers to these questions, they search for understandings in spiritual belief systems. The influence of spiritual/supernatural beliefs on people’s accounts of mental pain has been explored by Razali et al. (1996) and al-Krenawi 1999). In many societies and cultures, people often account for suffering as ‘the will of God’. Morrison & Thornton (1999) interviewed a sample group of African-Americans in the American South who were experiencing mental health problems. The researchers used a case study to show that this group of people used a spiritual framework to account for their distress. Carone & Barone (2001, p. 989) state that ‘religious beliefs provide order and understanding to an otherwise chaotic and unpredictable world’. Moreover, the experience of psychosis is often interpreted as a state of altered consciousness wherein there are hidden meanings, frequently spiritual in nature (Barker et al. 1999).

Some people appear to favour personal explanations of recent psychosocial factors/stress and personality factors (Hay 1996, Angermeyer & Klusman 1998). Fisher (1999, p. 128), however, has moved beyond looking for specific causative factors:

I no longer search for the sickness in myself or in those I grew up with as an explanation for my woes. Instead I search for the strengths in myself and those close to me which propel me through my version of the suffering we all share but seldom face.

Other people see mental illness as a heightened sensitiv-

ity to the pain of being in the world and that their search for meaning is related to working through their experiences of emotional and existential pain. This process, for some, has resulted in personal growth. Champ (1999, p. 123) supports this view:

I have come to see that you do not simply patch up the self you were before developing schizophrenia, but you actually have to recreate a concept of who you are that integrates the experience of schizophrenia. Real recovery is far from a simple matter of accepting diagnosis and learning facts about the illness and medication. Instead, it is a deep searching and questioning, a journey through unfamiliar feelings, to embrace new concepts and a wider view of self. It is not an event but a process.

For many, I believe it is a life-long journey.

This personal searching and questioning can provoke wider contemplation as to the meaning of life (Clay 1999, p. 35):

Although we have been broken, we have tasted the narrow of reality. There is something to be learned here about the mystery of living itself, something important, both to those who have suffered and those who seek to help us. We must teach each other.

Implications for mental health nursing
Mental health nurses are ideally placed to ‘journey’ with and to learn from people experiencing mental distress. We are constantly in the presence of people who are trying to make sense of mental disorder through telling their stories. We strive to uphold the basic human right of each individual in our care to determine meaning for himself/herself. As participants in the biomedical model, however, we often ‘categorize’ and reconstruct the service users’ narrative to suit dominant explanations that suppress the attempts of people to find personal meaning in their experiences of mental pain. Richards et al. (1996, p. 6, Available at: http://www.mk.dmu.ac.uk/~brown/pubs/racism.htm) in their study of 30 psychiatric nursing students’ constructions of hypothetical narratives, found that technical, esoteric medical language is part of nursing discourse and thinking and, as such, stunts mutual understanding between nurses and people in mental health care:

They are part of the implicit assumptions and taken-for-granteds which characterize practitioners’ constructions of the ‘patient’ as one who is sick, unable to provide an explanation for their own behaviour, or whose actions lack meaning. Thus, practitioners compensate for this perceived deficit, attempting to create reason and logic with their inevitable cultural overtones.

There have been recent calls for mental health nurses to reflect on their personal constructions of mental health
problems and to help people in care to articulate their own understanding of their difficulties (Brown et al. 1996, Smale 2000). Attending to stories – our own nursing stories and the stories of people in our care – can help us to better appreciate the complexity of mental disorder and the many unique ways we can help individuals to achieve coherent and sustaining personal meanings. As Aranda & Street (2001, p. 792) explain:

As people tell their stories, they start to hear their life anew through the hearer; they fabricate, explain and elaborate, exaggerate, minimize, silence themselves and give themselves away.

As mental health nurses, we participate in this process of creating meaning. Our role as ‘hearer’ is fundamental in relation to what we interpret, construct and reflect back to people in our care. As hearers, we can enable people to recognize and consider their life positions, perceptions and motivations. We can help people to identify narratives that are constraining, as well as support them in their endeavour to develop new perspectives. Through supporting people in the formulation and articulation of their own stories, we help them to achieve narrative coherence; a way of accommodating disconcerting experiences into the context of their life histories. As Champ (1999, p. 123) comments:

I think the best professionals involved in my care have walked alongside me, opening themselves to the mystery that is schizophrenia. They have gained my trust, sharing and supporting my inner search for meaning and understanding of self in relation to illness.

The message for nurses from people in our care seems to be that rather than resorting to pre-existing generalizing frameworks to ease our discomfort in the face of the mystery of madness, we should become more humble. We should acknowledge that mystery and share, rather than direct the individual’s quest for meaning.

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