

## The Person with Schizophrenia as a Person II: Approaches to the Subjective and Complex

JOHN S. STRAUSS

In the mental health field, the attention given to the subjective side of a person's experience is grossly inadequate. The best way to reflect the subjectivity of a person may be by means of the subjectivity of another. To take account of both subjective experience and objective measures in the course of mental disorders, a new concept is needed. This may be the person's story.

Our field, reeling from the previous excesses of subjective reports and impressions, has now swung far to the other side, all but discounting subjectivity in scientific and academic work. In the belief that the subjective in all its aspects is an essential part of our data, this report, departing from current norms both in content and form, attempts to re-enter the sphere of subjectivity. All the author requests is a reader willing to consider.

In the process of doing research interviews, conducting rounds and seeing patients in other contexts, it is increasingly striking to me how little I recognise in these people many of the key concepts that dominate the ways we as mental health professionals work. The things patients talk about and the way they talk do not seem to reflect our concepts, or at the very least, our concepts seem to reflect only such a very narrow range of what is going on in these people.

Actually there are two problems. The first is reflected by a *Far Side* cartoon showing some scientific-looking people landing on the shores of an island and the islanders in their huts hurrying to hide their television sets and video-cassette recorders. The islanders are calling out to each other the warning, "Anthropologists! Anthropologists!" Like these anthropologists, we have many unrecognised ways not to see things, and many sources in the way we work that contribute to our not noticing even some of the most obvious phenomena that are right in front of us.

The second problem is the tendency to focus on only one issue or one perspective. This problem as it occurs in children was best delineated by Piaget (1947) in his experiment with two water glasses of different diameters. One glass is filled part way; the other is empty. In response to the question of what will happen if the water is poured from the narrow glass to the broad one, the young child will indicate how high the water will go, usually expecting it to

be at the same level as it was in the narrow glass. When the water is poured from the narrow to the broad glass, the child is asked what happened. The response is often an amazed, "There is less water!". Repetition of the demonstration and repeated questions fail to shake the child's belief that the water goes up and down in amount depending on which glass it is in. Piaget hypothesises that the child is attending only to one dimension, namely height of water, and not to the diameter of the glass. In this focus on only one dimension, it is impossible for the child to obtain the notion of volume. Although we have all solved this problem in looking at water in glasses, I think we struggle with very much the same kind of issue in thinking about severe mental disorders, being essentially able to focus only on one dimension or one perspective at a time. Hence certain more complex concepts remain elusive.

I first became dimly aware of these problems of considering the person while carrying out prognostic studies in association with Carpenter and Bartko (Strauss & Carpenter, 1974). We showed that, in contrast to the common belief that 'diagnosis is prognosis', prognosis in schizophrenia does not only involve the 'natural history' of the disorder, the diagnosis being expected to predict outcome, but is far more complex. Previous social relations predicted future social relations as well as future levels of symptoms. Previous history of work function predicted future level of work function as well as having a smaller but still significant predictive ability for predicting later symptom severity and need for hospitalisation. It was clear to us even then that focusing only on disease concepts was not adequate to understanding prognosis, and hence probably not adequate to understanding the true nature of disorder. In fact, measures of social functioning and presumably environmental factors as well (for example, the availability of work) are importantly involved in trajectory of disorder and recovery processes.

Although interactions among social factors, work functioning, and illness were suggested by our data, we did not notice at that time that the person as a person might also be important.

A turning point for me came during a much later follow-up study. In response to our various questions about how treatment, symptoms, social relationships, and work affected how she was doing, one of the subjects inquired why I didn't ask her what she did to help herself. After that we did begin to ask people systematically about their own efforts, and Breier and I wrote two reports on the way people with schizophrenia attempt to control their symptoms and how they utilise social relationships in the processes of recovery (Breier & Strauss, 1983, 1984). More recently, Davidson and I have written about stages in reconstructing a sense of self described by one person I saw in follow-up interviews (Davidson & Strauss, 1992). In that situation, just after a psychotic episode, the woman described how the simple acts of deciding to turn on a radio, then actually turning on the radio, and then finding that she was effective in getting the music that she had chosen were an important experience in regaining a sense of efficacy which had been lost during psychosis.

Gradually, the scope of the notion of the person in relationship to mental disorder has been more and more compelling, and confusing. For example, more recently it was striking – but no longer surprising – when I saw in a research interview a young man in hospital for schizophrenia and heard his response to one of the questions I asked. This 28-year-old man had had the first onset of his schizophrenia ten years previously. He had spent three years in the hospital, and then from the period between seven and five years before my interview had been able to manage outside the hospital. However, five years before the interview he had been readmitted to hospital and had remained there since. As part of our interviews, we try to delineate the various general levels of illness at several times in the past. We then determine levels of social relations and work functioning, symptoms, and hospitalisation during those times and plot a time line of course of disorder. This line is generated by rating scales of established reliability. In this particular study, we also inquire about the worst year the person has had since becoming ill. I expected that when I asked that question of this young man he would say that it was one of the times when his functioning scores were lowest, his symptoms highest, and when he was in the hospital. He said that the worst year was about six years ago, a time when by our scores he was doing fairly well and was not in the hospital. He said that he had been living with his mother and then finally had been kicked out

of her house and was living in an apartment. About two weeks after leaving her house, he called home. She answered the telephone. He started talking, but when she heard his voice, she said, “You have the wrong number”, and hung up. He said that was the worst year of his life. My heart sank as he told this story. It was not difficult to understand what he meant, but the worst year according to him and the worst year according to our rating scales were very different. Who was right?

Perhaps rather than choosing between the two – his subjective experience and our ‘objective’ measures – rather than choosing between height and diameter of water in the glass, the question might better be: “How do we reconceptualise the issue? How do we integrate these perspectives? What is the concept of volume for which we search?”

A very likely candidate for the concept we need may be the person's ‘story’. The individual story can in fact reflect both the subjective and the more objective description. For example, early in our work we described what appear to be phrases in the recovery process. One of these phrases we called ‘woodshedding’ (Strauss *et al*, 1985). This is a plateau stage; the name we gave it comes from the practice of jazz musicians to retire to the shelter and privacy of the ‘woodshed’ when they are trying a new style of music. After they have ironed out the worst problems, they then reappear in public. We have noticed that many of the subjects in our study have had periods that have looked like fairly long plateaus which many have taken initially as reflecting burn-out. In fact, if one follows the subjects long enough, this plateau period often is followed by a rather sudden change to improvement. One subject in a follow-along study we were conducting described the subjective experience of feeling that she needed to have a time of “unconditional love” in which she lived with her parents and had no responsibility following a period in the hospital. Although I thought when I was interviewing her during that period that this would be bad for her (but being only a research interviewer, said nothing), on subsequent follow-up it appeared to have given her a respite, a time to accumulate skills and self-esteem that served her extremely well in her subsequent rapid and considerable improvement. Such a woodshedding phase is a kind of mini-story, a kind of narrative of a small segment in the lives of some patients that brings together objective and subjective aspects and ties them into time, a longitudinal chain that arises in the past and extends to the future.

In preparing this report, my original purpose had been to describe further the values of seeing the story as a scientific centre for understanding the course

of mental disorders without ignoring huge amounts of data. I was also going to describe the relevant literature in detail and try to deal with problems of the definition of the story, problems that it has as a basis for a science of humans and of mental disorder. But as I was working on these, it seemed important to fall back even further to pick up a thread of a still more basic problem that needed to be resolved before the notion of story could be further developed. This problem was the gross inadequacy, in the mental health field, of our attention to the subjective side of a person's experience. As mentioned elsewhere (Strauss, 1992), another turning point in thinking for me had been when I (finally) followed the suggestion of a friend to read one of the works of Goethe. But as I started reading it I felt rather insulted by this naive story of a young man with severe Oedipal problems. Reading on, however, I became disgusted with myself always analysing everything in the story. Giving up my psychoanalytic interpretations, I set to enjoying the beauty and depth of the narrative. It appeared to me then, and does now, that although such interpretations may have certain values, they are extremely limited for reflecting the depth and richness of human experience. Rather, they end again by dealing with certain aspects of a situation, but ignoring many other extremely important dimensions. There is this deeper, richer, perhaps more human aspect of experience which in our field is so often neglected, especially in our theories.

But how does one characterise this subjective side of the person? Recently, Dr Cindi Palman and I have been trying to explore further the nature of change in some of the patients seen in a follow-along study. We started by reviewing the research records, including the narrative summaries, of one subject whom I had seen in a total of 12 research interviews over four years. We both wrote about the change process in this person and were appalled with the shallowness of our description. Even though the research interviews are broad in coverage and have extended open-ended sections, there appeared to have been something about the way in which the data were collected and recorded that all but prevented Dr Palman and even me, who had done the interviews, from being able to write anything that nearly approximated this woman's experience. It struck us furthermore how little the psychiatric format – present illness, past history, family history, etc. – allows for noticing or recording the person's experience. From such a format, it is in fact almost impossible for the person to be discoverable.

Feeling both shocked and disillusioned by this experience, we then attempted to find how the

situation might be improved and turned to writing about change in ourselves. In one piece, for example, (following some concrete descriptions of recent experiences) Dr Palman wrote the following (published here with Dr Palman's permission).

“But I am stuck in the present, and if change is happening, it is quite invisible and unfelt by me. I do know that change can be undone; that it is fragile and takes much nurturing to hold fast. I don't believe the world we live in is adaptable to these qualities of change. We allow months for something that may take years, whether it's building a career or getting over the loss of someone you love. And as the world flies by rapidly and a new car is made in hours, and someone is shot every minute, it appears to be an unforgiving and unknowable world to those of us who change ever so slowly that we drift backwards on the tide.”

Without intending it, I think Dr Palman had written profoundly about the subjective experience of a kind of woodshedding. Although these writings seemed to be a step towards reaching into some of the depth of feeling and experience, still, we were writing only about ourselves. How does one write about a patient? We decided that we would try writing about each other. That way, when each of us saw what the other was writing, we could at least say whether or not he or she had captured our subjective experience and say for example, “No, you don't have it at all right; that's not how it is for me at all.” In this effort to patch together a particular approach to a science of subjectivity, we at least could check out what the other one was writing with our own experiences. What we found was that when one person wrote about his or her own experience of the other, it often seemed to be extremely accurate. When he or she attempted to describe the other's subjective experience from a more distant perspective, however, the description was usually wrong. This was a strange paradox indeed, that when a person was writing about him- or herself, he or she was most accurately writing about the other, and when he or she was trying to write about the other, it usually missed widely. Perhaps this was a psychological instance of the sociological concept of ‘intersubjectivity’, where the subjectivity of one of us was the best way to reflect the subjectivity of the other. Among other things, what this experience suggested was the active role of the observer. When the observer tries in one way or another to do away with him- or herself and be more ‘objective’, the subjectivity of the other person disappears. How much we are taught in the mental health field to reduce our observer subjectivity to a very narrow range, if such subjectivity is viewed as acceptable at all.

Where to take such observations? The arts have learned much from the mental health field, but now

perhaps it is time for the reverse to take place. The following are some examples. In the last few years, I have had the opportunity of joining a writing workshop. In this workshop, in which 14 people participated with an outstanding teacher, one aspect of the experience particularly amazing to me was noticing that when people wrote about their own private experience, describing it in depth, they had the most power to communicate with the others in the group, even if the others had not had that experience. Thus, for example, when one woman wrote about the experience of waiting with her husband for their daughter who was taking drugs to come home, all of us in the room were spellbound, even though none of us had had that experience. This is so similar to the apparent paradox experienced when Dr Palman and I were trying to write about the nature of change.

Another example of the mental health field possibly needing to learn from art was an experience I had in an acting class which I started recently. The teacher, who is excellent, repeats time and again: "The life is in the details. Life is specific, not general. There is nothing general about life." He has demonstrated this in many ways and is helping us to learn it. In one instance in the class, the non-verbal aspect of such specifics of 'life' was illustrated. Two of the students were doing a scene from *The Philadelphia Story* in which there is a rather coy encounter between two of the leads. The two actors repeated their lines, engaging each other with a kind of seductive banter. But there was absolutely no feeling, no sense of 'real' in what was happening. The teacher told them to try it again, removing the table they had placed between them and getting closer together. That helped a little, but not much. He then said to the woman, "While you're talking, fix his lapel." They started again, and she did so. The transformation was almost magical. Her eyes lit up as she looked up into his face and her voice softened. He reacted strongly to her. Can we afford to ignore this kind of specificity in our field attempting to understand human functioning and its aberrations?

What is there about being a person that is relevant to mental disorders like schizophrenia and to their treatment? First, as the cartoon of the anthropologists suggests, a broad model for understanding mental disorders is required. Such a model must be able to include without distortion, for example, the kinds of statement made by so many with severe mental disorders who have improved that a caring person has been the most crucial aspect of the recovery. Or that work, or having a job, was the most crucial thing for them. Such phenomena are cited by patients as important at least as often as

medication and psychotherapy, although medication and psychotherapy are also often given significant credit. We must also include in this breadth in far more adequate ways the subjective as well as the descriptive in evolving a science of mental disorders. For the person whose mother told him he had the wrong number, that experience may well have been at least as important a phenomenon and as accurate in identifying his worst year as a measure of an extended period in hospital.

Secondly, it may be possible that the story, with its capacity to combine subjective and objective aspects of experience in a temporal context, may be the optimal organising structure for a science of psychiatry. The literature on the use of narrative in related fields suggests many of the problems as well as the strengths of such a possibility (e.g. Dilthey, 1894; Allport, 1942; Giorgi, 1970; Geertz, 1974; Mischler, 1986; Strauss, 1987, 1989; Estroff, 1989; Chesla, 1989); but if we continue to ignore the complex centrality of subjective and objective factors to our own work, I doubt that it is possible to understand the nature of mental disorders such as schizophrenia or to develop optimal treatment.

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John S. Strauss, MD, *Professor of Psychiatry, Yale University School of Medicine, Department of Psychiatry, 34 Park Street, New Haven, CT 06519, USA*