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LIVING WITHIN DARKNESS: PSYCHIATRIC SURVIVORS AND THE PROTECTION OF MYTHICAL LANGUAGE

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Misbirth is possible from the mythological womb as well as from the physiological: there can be adhesions, malformations, arrestations, etc. We call them neuroses and psychoses. Hence we find today, after some five hundred years of the systematic dismemberment and rejection of the mythological organ of our species, all the sad young men, for whom life is a problem.

Joseph Campbell (1951/1995, p. 59)

Introduction

The person diagnosed with schizophrenia experiences the world from a uniquely separate, often estranged locale, where the consensual reality is not only foreign but frequently dystonic, frightening, even abhorrent. In *The Divided Self: An Existential Study in Sanity and Madness*, R.D. Laing describes an especially horrifying and dramatic shift from schizoid to psychotic experience in terms of the changes within an individually created "false-self" system:

The self, as we said, tries to be outside everything. All being is *there*, none is *here*. This finally comes even to the position that everything the patient *is* is felt to be "not-me". He rejects all that he is, as a mere mirror of alien reality. This total rejection of his being makes "him", his "true" self, a mere vanishing point.

"He" can't be real, substantial; he can have no actual identity, or actual personality. Everything he is comes by definition, therefore, under the scope of his false-self system. This may go beyond actions and words and extend to thoughts, ideas, even memories and phantasies. This false-self system is the breeding ground of paranoid fears . . . the "self" has disavowed participation in it, the false-self system becomes enemy-occupied territory, felt to be controlled and directed by an alien, hostile and destructive agency. As for the self, it exists in a vacuum. But this vacuum becomes encapsulated, albeit at first perhaps in moments in a relatively benign and protective way. (1959/1965, p. 168)

He then illustrates this by quoting one of his patients, who said, "I felt as though I were in a bottle. I could feel that everything was outside and couldn't touch me." Laing (1959/1965) continues:

But this turns into a nightmare. The walls of the bottle become a prison excluding the self from everything while, contrariwise, the self is persecuted as never before even within the confines of its own prison. The end result is thus at least as terrible as the state against which it was originally a defence. (pp. 168–169)

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Can this psychotic individual garnish meaning from universal archetypal messages and truths, or use myths, as Doty (1986) says, to "facilitate communal expressions of joy, fear and hatred" or "project" the "possible selves one might become" (pp. 164–165)? The author believes that not only can those diagnosed with various forms of psychosis (who are also identified in this paper as "psychiatric survivors," "patients" and "clients") enter into the shared experience of myths, but that they are often more privy than the non-psychotic to mythology's profoundly ancient tones, and can be said to metaphorically live inside mythical or myth-like arenas. Case examples will follow illustrating evidence to support this perspective. The author will explore the idea that psychotic individuals can actually utilize distinctly mythical language as a bridge toward communicating with the non-psychotic and as a protective, defensive structure potentially analogous to the coping mechanisms and defensive modalities of people who are not identified as psychiatric patients or survivors.

The reader is asked to be mindful of the multi-layered, potential consequences and power of psychiatric labels and diagnoses. Although psychiatric language will be used in this paper to indicate concepts generally thought to have consistent meanings, as accepted by the professional mental health industry, it is important to reflect upon Thomas Szasz's statement:

> It is a fundamental characteristic of the language of psychiatry that imperative sentences habitually masquerade in it as indicative ones. This is invariably the case when the communicative situation involves third parties—that is, persons other than the psychiatrist and the patient. For example, the statement "John Doe is psychotic" is ostensibly indicative and informative. Actually, however, it is promotive and prescriptive, and may be translated . . . "Mrs. John Doe does not like the way her husband is acting. Dr. James Smith believes that men preoccupied with jealousy are mentally ill and potentially dangerous. Hence, both Mrs. Doe and Dr. Smith want Mr. Doe to be confined to a hospital." Clearly, however, these indicative sentences do not have nearly the same promotive impact as does the much shorter assertion that "John Doe is psychotic." (1974, pp. 120–121)

This suggests that there is not only an inherent but a potentially volatile and even damaging power within psychiatric terminology and labeling used by social service professionals. From the psychiatric survivor's experience and perspective, this language may manifest to promote harm instead of help, to undermine rather than heal.

Although it is beyond the purview of this paper to intensively address these concepts, it is important to acknowledge them. In any discussion utilizing a language system where assumptions are made about others which may be distinct from the way those individuals see themselves, these assumptions require ongoing consideration. This is particularly important in an examination of universality within mythical language, where, the author believes, those labeled as psychotic have the same right as non-psychotics to participate in and benefit from shared symbolic realms.

Moreover, as has been suggested, psychotic individuals may be deeply living within these realms in ways we frequently don't attempt fully enough to understand. Therefore, it is inadequate to use a reductionistic approach which accepts the linguistics of psychopathology as the only way to describe those labeled by the same language as mentally ill. The inherent hierarchy of our society's still generally accepted, pathological and paternalistic model of mental health/mental illness not only doesn't consider (as the reader is being asked to do) the potential wisdom, defensive prowess and capacity for healing which dwell within the seriously emotionally "disturbed," but has, historically, not respected the psychotic as equal to the non-psychotic. Instead, the traditional model suggests, even today, that madness is an experience to be dreaded, avoided, feared and looked down upon, and one can see why: psychotic people are not only seen as "crazy," but weaker than the rest of society's members, and are often still judged (by the layperson and even some mental health professionals) to be violent, dangerous, incapable of forming meaningful connections or relationships, etc.

It is fortunate that psychiatric survivors have organized a consumer empowerment movement which includes groups like "The Stigma Busters," a California-based gathering of survivors who do theatre presentations (and have videotapes of these available for public use) aimed at "de-bunking" the stigma surrounding severe psychological pain and crisis. The nationwide patient advocacy and clients' rights movement is gaining in numbers and, the author hopes, collective strength. The assumptions behind diagnoses and the damaging stigma which consciously

and unconsciously surface in association with almost any discussion of madness cannot be avoided. Like the struggles to alter other internalized forms of societally reinforced discrimination, these messages and beliefs need to be continuously uncovered, exposed and discussed, in order to promote the creation of a more progressive and realistic value system in our culture, which joins rather than separates people from each other. The reader is encouraged to do this not only for its function in combatting discrimination, but also as it relates to a more effective consideration of the themes delineated herein.

Discussion

Many historical debates have ensued and literatures arisen questioning whether or not the mentally ill are indeed "closer" to spiritual and psychological truth. Among the numerous examples of writing which address these questions, one of the most famous and controversial may be Marge Piercy's novel *Woman on the Edge of Time* (1976). Piercy suggests that a psychiatrically hospitalized woman, diagnosed with schizophrenia, who has overt symptoms of paranoid psychosis and a fixed delusional system, is actually a misunderstood, spiritually gifted and psychologically enlightened person who has contact with an advanced, futuristic civilization. The psychosocial assessment at the end of the text is terrifyingly consistent with typical mental status reports made by the psychiatric profession.

In "Schizophrenia—The Inward Journey" Campbell cites his discovery of John Weir Perry, M.D., of San Francisco, and the reprint of Perry's 1962 paper on schizophrenia in the *Annals of the New York Academy of Sciences*:

> To my considerable amazement I learned, on reading it, that the imagery of schizophrenia fantasy perfectly matches that of the mythological hero journey, which I had outlined and elucidated, back in 1949, in *The Hero with a Thousand Faces*. (1972/1993, p. 202)

Campbell describes the process of "the wonders of the inward schizophrenic plunge," in the stages of "splitting" or beginning of the "regressus," "drop-off" and "regression backward in time and biologically as well" (p. 218), the challenge of a

. . . terrific task ahead with dangers to be met and mastered; but also a presentiment of invisible helpful presences that may guide or help one through. These are the gods, the guardian daemons or angels: innate powers of the psyche, fit to meet and to master the torturing, swallowing, or shattering negative forces (1972/1993, p. 220)

and, finally, "a terrible rapture, a culminating overwhelming crisis—or even a series of such culminations, more than can be borne" (p. 220). Campbell (1972/1993) parallels mythical hero journeys with the stories of the psychiatric client, who is "the hero chosen for a destiny" (p. 218) stating:

> The patient (let us now call him that) has united what remains of his consciousness with the consciousness of all things, the rocks, the trees, the whole world of nature, out of which we all have come. He is in accord with that which has indeed existed forever: as we all are, actually, at root, and therein at peace—once again, as stated in the (*Bhagavad*) *Gita*: "When one completely withdraws the senses from their objects, like a tortoise drawing in its limbs, then is one's wisdom firmly fixed. In that serenity is surcease of all sorrow." In short, my friends, what I find that I am saying is that our schizophrenic patient is actually experiencing inadvertently that same beatific ocean deep which the yogi and saint are even striving to enjoy: except that, whereas they are swimming in it, he is drowning. (pp. 219–220)

In our society, individuals often psychologically ask themselves to bring together irreconcilable or paradoxical experiences: as young children we are grandiose and simultaneously helpless, and as adults we are existentially aware of living until we die, often questioning a greater purpose, and how to make peace with the knowledge that we are always grandiose to a certain degree, and, in fact, helpless to prevent certain suffering, or our deaths. These irreconcilable differences are unable to be bridged without a level of splitting off from the self, or disassociative presentation. Psychotic individuals, as has been noted, take this splitting off to a further level. It has been remarked that many people would go "insane" if they rationally considered on a daily basis that we live in a world of massive poverty and violence, with the

threatening yet real possibility of instantaneous and complete nuclear destruction.

It is curious, considering the objective and consensual truth of these premises, why more people don't become psychotic. Instead people seem to be managing appropriately disassociative techniques as a defensive posture against the feelings of terror and helplessness associated with these concepts. If differences exist in people's ability to manage these levels of awareness, it logically follows that some people are more disassociated, or closer to psychosis, than others. Why, then does Campbell suggest that the psychotic person is "drowning"? Why is the psychotic person not seeking an alternative to the pain of irreconcilable differences to a greater degree than the average, non-psychotic person? Even as he appears to be empathic to the experience of psychosis, drawing parallels (as is his thesis) with heroic experience, Campbell also judges the psychotic, in an extension of his metaphor, as unable to swim. It is the author's belief that the psychotic is not drowning, but swimming differently than does the non-psychotic.

In *The Divided Self*, Laing (1959/1965) says that in psychosis,

> The "true" self, being no longer anchored to the mortal body, becomes "phantasticized", volatilized into a changeable phantom of the individual's own imagining. By the same token, isolated as is the self as a defence against the dangers from without which are felt as a threat to its identity, it loses what precarious identity it already has. Moreover, the withdrawal from reality results in the "self's" own impoverishment. Its omnipotence is based on impotence. Its freedom operates in a vacuum. Its activity is without life. The self becomes desiccated and dead. (p. 141)

This is an even more serious suggestion than Campbell's: here the psychotic person is not only drowning, he, his "self" is dead. There is in this argument a subtle reinforcement of the pathological model's contention that the psychotic is manifesting an inherent weakness, sickness or ineptitude. Laing as a medical doctor would be expected to accept the traditional model to at least a limited degree, yet he is considered one of the radical thinkers of western psychiatry. For example, in the preface to the Pelican edition of *The Divided Self*, he states,

> Psychiatry could be, and some psychiatrists are, on the side of transcendence, of genuine freedom, and of true human growth. But psychiatry can so easily be a technique of brainwashing, of inducing behaviour that is adjusted, by (preferably) non-injurious torture. In the best places, where staitjackets are abolished, doors are unlocked, leucotomies largely forgotten, these can be replaced by more subtle lobotomies and tranquilizers that place the bars of Bedlam and the locked doors *inside* the patient. Thus I would wish to emphasize that our "normal" "adjusted" state is too often the abdication of ecstasy, the betrayal of our true potentialities, that many of us are only too successful in acquiring a false self to adapt to false realities. (1959/1965, p. 12)

This seems to support the idea that we all are living in varying degrees of defensive disassociation, using a "false self to adapt to false realities" or avoid "true" realities. However, Laing seems to suggest that psychotic people, in their experience of death of the self, may not have the same "true potentialities" as the non-psychotic. How can they, if they are, in fact, "dead"? Therefore, both Campbell in his initially supportive and empowering conceptualization of the psychotic as heroic and Laing in what is considered one of the illustrations of radical thinking about psychiatry, ultimately identify the psychotic as unable to succeed, as failing to thrive, drowning and dead. Laing (1959/1965) himself, in his conclusion of *The Divided Self*, makes the claim that there is something meaningful, poignant and hidden which can be discovered within the psychotic if only the professional, therapeutic practitioner tries to find it. He describes the case of a woman:

> Her existence was depicted in images of utterly barren, arid desolation. This existential death, this death-in-life was her prevailing mode of being-in-the-world. In this death there was no hope, no future, no possibility. Everything had happened. There was no pleasure, no source of possible satisfaction or possible gratification, for the world was as empty and dead as she was. She was utterly pointless and worthless. She could not believe in the possibility of love anywhere. (p. 205)

Myths identify heroes having loss and trauma but usually they have some closure to their distress, achieving a sense of accomplishment following the terrible crises to which Campbell alludes. In the case of the woman above, Laing (1959/1965) concludes,

> Yet . . . she did value herself if only in a phantom way. There was a belief (however psychotic a belief it was, it was still a form of faith in something of great value in herself) that there was something of great worth deeply lost or buried inside her, as yet undiscovered by herself or by anyone. If one could go deep into the depth of the dark earth one would discover "the bright gold", or if one could get fathoms down one would discover "the pearl at the bottom of the sea." (p. 205)

This is not the only time that Laing himself uses or quotes patients' use of mythical language which describes the kind of voyaging experienced by heroes explored by Campbell. In many cases, as is evident here, there is an allusion to entering the otherworld, underworld or hell, that underlies many artistic, psychological and literary expressions and metaphors of psychosis and how it has been perceived. After venturing into the depths of these mythical places like the otherworld, upon returning the heroic archetype is renewed, or clearer about some significant truth, whether outward or inward. Laing (1959/1965) quotes Jung's statement "that the schizophrenic ceases to be schizophrenic when he meets someone by whom he feels understood. When this happens most of the bizarrerie which is taken as the 'signs' of the 'disease' simply evaporates" (p. 165). In another example of mythical journeying by a mental patient, Laing tells the story of James, one of the other nine case examples of schizoid or psychotic patients illustrated in *The Divided Self*:

> In his dream world James experienced himself as even more alone in a desolate world than in his waking existence, for example:

1. I found myself in a village. I realize it has been deserted: it is in ruins; there is no life in it . . ..
2. . . . I was standing in the middle of a barren landscape. It was absolutely flat. There was no life in sight. The grass was hardly growing. My feet were stuck in mud . . ..

3. . . . I was in a lonely place of rocks and sand. I had fled there from something; now I was trying to get back to somewhere but I didn't know which way to go . . .. (pp. 141–142)

These expressions, as viewed by Campbell, are further illustrations of the hero's journey, as described through the stages of psychotic regression. James's world of desolation is analogous to the land which all heroes venture into and attempt to pass through, perhaps conquer. Yet, in Laing's comments, James's potential for conquering is not accentuated, nor is the woman's who is described above. Her pearl is seen with hope and positive regard only to the degree that it is real in a psychotic context, inferior when compared with the non-psychotic's capacities for health.

James and the woman have glimmers of hope, it is true; and if only they are communicated with in their language, they "cease to be schizophrenic" for the time during which this communication takes place. Yet, again, it is intimated here that once one is psychotic, there is a death of self which overwhelms the possibility of learning from lessons, or experiencing growth in the way the non-psychotic can, a "striving to progress upward," as Caldecott (1993) describes it (p. 49). Why even in the most positive description of the psychotic hero's possible striving toward the unreachable do both Campbell and Laing imply that the concept of the psychotic's sickness will prevail, and that he, unlike the heroes of myth to whom he is compared, will not succeed, live through the crises intact or resurrect from the otherworld? Why isn't the analogy taken to that extra step, and why is there no true hope for the psychotic to be healed, to heal himself, even to be considered as whole within his own psychosis?

Campbell (1972/1993) describes more specifically the analogy between the archetypal hero and what the author has termed the psychotic hero as follows:

> The usual pattern is, first, of a break away or departure from the local social order and context; next, a long, deep retreat inward and backward, backward, as it were, in time, and inward, deep into the psyche; a chaotic series of encounters there, darkly terrifying experiences, and presently (if the victim is fortunate) encounters of a centering kind, fulfilling, harmonizing, giving new courage; and then, finally, in such fortunate cases, a return journey of rebirth to life. And that is the universal formula also of the

mythological hero journey, which I, in my own published work, had described as: 1) separation, 2) initiation, and 3) return (p. 202)

What happens to the psychotic hero who is not fortunate, as Campbell describes him? We are told that he drowns, dies, ceases to have a self. What if the psychotic hero is in the stage of return and the psychiatric professional ceases to speak to him in the unique language suggested by Jung and quoted by Laing? What if the counselor sees the psychotic hero to be sufficiently "fortunate" to succeed in the stage of return? If the social service professional sees himself as equal or metaphorically analogous to what Campbell terms "a presentiment of invisible helpful presences that may guide or help one through," and is therefore not invisible, but visible and essential, perhaps a different viewpoint or even outcome could be acknowledged, both by the psychiatric client and the psychiatric practitioner.

Campbell (1972/1993) himself states,

It was Dr. Perry's thesis in his paper that in certain cases the best thing is to let the schizophrenic process run its course, not to abort the psychosis by administering shock treatments and the like, but, on the contrary, to help the process of disintegration and reintegration along. However, if a doctor is to be helpful in this way, he has to understand the image language in mythology. He has himself to understand what the fragmentary signs and signals signify that his patient, totally out of touch with rationally oriented manners of thought and communication, is trying to bring forth in order to establish some kind of contact. Interpreted from this point of view, a schizophrenic breakdown is an inward and backward journey to recover something missed or lost, and to restore, thereby, a vital balance. So let the voyager go. He has tipped over and is sinking, perhaps drowning; yet, as in the old legend of Gilgamesh and his long, deep dive to the bottom of the cosmic sea to pluck the watercress of immortality, there is the one green value of his life down there. Don't cut him off from it: help him through. (p. 203)

This sounds more hopeful and supportive of the possibility that psychotic individuals can be reached and have the inner potential and wish to be healed,

even the capacity to go on living with a new self, without what was previously suggested to be a built-in, predictable and complete self-death or drowning. Perhaps they live with a self which is transformed precisely because of the self-death or drowning, and is resurrected, like the hero who survives travel through the underworld, is metamorphosed and lives again. However, Campbell constructs limitations on this apparently and initially hopeful outlook. He informs us that some psychotics are able to be helped, are closer to heroic potential, are more appropriately analogous to shamans, and others—they are the ones who drown and do not "survive" to tell the tale.

Citing an article by a Dr. Silverman, who, like Mircea Eliade and Campbell himself, considers the analogy between the psychotic and the shaman, Campbell (1972/1993) describes Silverman's distinction between the "essential" and "paranoid" schizophrenic:

It is in essential schizophrenia alone that analogies appear with what I have termed "the shaman crisis." In essential schizophrenia, the characteristic pattern is of withdrawal from the impacts of experience in the outside world. There is a narrowing of concern and focus. The object world falls back and away and invasions from the unconscious overtake and overwhelm one. In paranoid schizophrenia, on the other hand, the person remains alert and extremely sensitive to the world and its events, interpreting all, however, in terms of his own projected fantasies, fears and terrors, and with a sense of being in danger from assaults. (pp. 206–207)

He continues,

This, states, Dr. Silverman, is not the type of schizophrenia that leads to the sorts of inward experience that are analogous to those of shamanism. "It is as if the paranoid schizophrenic," he explains, "unable to comprehend or tolerate the stark terrors of his inner world, prematurely directs his attention to the outside world. In this type of abortive crisis solution, the inner chaos is not, so to speak, worked through, *or* is not capable of being worked through." (p. 207)

Campbell concludes by describing the essential schizophrenic as different from the shaman, who re-

turns from a trance to rational consciousness via his being at one with his culture's symbolism:

> Whereas, in contrast, in the case of a modern psychotic patient, there is a radical break-off and no effective association at all with the symbol system of his culture. The established symbol system here provides no help at all to the poor lost schizophrenic, terrified by the figments of his own imagination, to which he is a total stranger; whereas, in the case of the primitive shaman, there is between his outward life and his inward a fundamental accord. (pp. 207–208)

Campbell informs us in quoting Silverman that the paranoid schizophrenic is more tragic a figure than the essential schizophrenic; he is incapable of moving past crisis to enter the stage of return, is essentially stuck in a phase of terror, and, is seen, in effect, as unreachable. When compared to the shaman, even the essential schizophrenic, who is seen as more capable of completing the stage of return than his paranoid counterpart, is described as the "poor, lost schizophrenic."

Upon examining these constructions, the reader is again left with the impression that schizophrenics are to be pitied and, barring their being able to be categorized as essential versus paranoid, there is little, if any, hope for them to approach psychological healing. This is an apparent embracing of the pathological and paternalistic model's view of mental illness in general, and psychotic process in particular: these tragic, lost individuals deserve our sympathy and are probably (if categorized as paranoid) without much hope for personal change or growth.

The assumption that these individuals, being somehow "sick" or deficient, need help from "normal" people, is troublesome. To address this, the author here applies a "wellness model," a view of potential psychological healing: in general, all people strive to feel well within and without, and seek ways to improve themselves over time as they age. Therefore, dependent upon individual wishes and circumstances, all people, including those labeled psychotic, have the potential for psychological and emotional growth.

We are informed above that the psychotic person is estranged from "the figments of his own imagination," while in the shaman's case, "there is between his outward life and his inward a fundamental accord." Although to an outside observer there may not be an obvious relationship of accord between the psychotic's inner and outer lives (a grave assumption at best, and difficult to prove), perhaps there is a relationship of accord between the psychotic and his own imagination, and even between his inner and outer lives. Perhaps the psychotic is at one with a special, uniquely configured, internal and mythical symbolism which keeps him sane enough for himself, if not sane enough for societal standards. Possibly he would be even less sane without this special internal relationship.

Therefore, the therapeutic practitioner's goal may not be to assist the psychotic client in gradually seeing his defensive structure as something to turn away from in horror in order to become more like others who do not live as he does (changing the psychosis from ego-syntonic into ego-dystonic). Instead, it may be to assist him in deciding if he wants to live and relate with others, having the choice of living within his own imaginings and the common world. In this way, he may be more capable of thriving in consensual reality's economic and social realms without having to abandon his defensive structure, unless (if realistic) that becomes the mutually agreed upon therapeutic goal. Non-psychotic individuals in therapy often strive and learn to replace defensive coping strategies that are no longer useful with new techniques more relevant to their current lives, but they are not expected to relinquish these patterns if no harm comes from them and/or they are still successful in helping the individuals function within society. This therapeutic approach, using the wellness model, can be extended to include the psychotic community. Here we can apply Campbell's sentiment without his limitations: the therapist "has to understand the image language in mythology" to "let the voyager go," not "cut him off" but "help him through."

Case Examples and Remarks

Two clients with long-term, severe psychiatric histories will now be presented. Both clients were on the author's caseload during her employment as a psychiatric social worker in an outpatient day treatment program in New York City. Both clients carry the diagnosis of Chronic, Undifferentiated Schizophrenia, and both have a history of alcohol abuse.

Client A

"A" was born in Jamaica during the Second World War. He is the second youngest of five children and comes from an intact, supportive family. There may have been some alcoholism in the extended family, but this is not clear, and none is known to be present in his immediate family. "A" came to the United States with his eldest sister when he was 20, married and had a son. His other siblings also came to the United States and the family remained in close communication with each other.

Throughout his early 20's, while successfully employed as a draftsman, "A" began to drink beer to cope with feelings of anxiety around his marriage. For reasons he can't recall, he began to experience paranoid symptoms, and was unable to complete his tasks at work. Soon "A" and his wife realized he was "more than just troubled" and sought help. "A" had a brief inpatient stay in a psychiatric facility, was discharged, and returned home. He presented as more withdrawn, confused and disinterested in daily activities. Over time, his symptoms worsened, and his wife asked him for a divorce.

"A" had several other psychiatric hospitalizations and spent some time in institutional care. While he was institutionalized, his latency age son was killed in a hit-and-run car accident. The driver was intoxicated with alcohol. "A" is confused about how old his son was when he died, but recalls feeling helpless due to being "locked up" when it happened. "A" withdrew from his family and became quite depressed. Upon discharge, he lived for an extended period of time with his eldest sister, then moved into a mental health residential facility. He still lives there and consistently stays with one of his siblings during the weekend.

"A" came to day treatment in 1993 and was assigned a student social work intern, under the author's supervision. "A" was disheveled, unclean, distant, and spoke in generally mono-syllabic and almost inaudible tones. He also spoke very little, and only when asked a direct question, never initiating any contact nor volunteering information about himself. However, when asked something he was always cooperative and cordial in his responses.

Over time, the student found "A" quite paranoid, and we witnessed him increasingly isolating himself from others on a daily basis. He attended milieu groups but never spoke during them unless called upon by a facilitator. His answers to questions were consistent with his verbal behavior with the student social worker. "A" was also isolated at his home, never participated in activities with residential peers, and infrequently attended to his personal hygiene.

"A" began to come to program smelling of alcohol, but denied consuming any. When he first arrived at the program, he gave written consent to random urinalysis as part of an agreed upon treatment contract, due to agency protocol and his history as a M.I.C.A. (Mentally Ill, Chemically Addicted) client. Eventually one of the random screenings was positive for alcohol, and "A" showed a new side of his personality: when gently confronted about his usage by the intern, he became enraged, verbally agitated and paranoid.

After the subsequent results were again negative, "A" returned to his former presentation. During supervision, the student and the author began exploring ways to reach "A," because the student found traditional techniques unsuccessful in helping to therapeutically engage him. We discovered his interest in artwork due to his participation in several art groups. All of "A"'s drawings used a unique style which included a combination of drafting techniques, English words, fragmented images of his body, dates, codes, directional descriptions and maps, among other devices. The author suggested to the student that she encourage "A" to draw with her, during their individual meetings. She agreed, "A" accepted the idea, and he was able to use his art images to gradually increase his verbalizations to her. He drew between three and twenty images a day beyond their scheduled meetings, and would leave these drawings with her, frequently "revising" them in ways mysterious to us both. His revisions involved changing what he eventually termed symbols into other subtly different images.

"A" began to explicitly describe two worlds of which he claimed to have a special awareness. One world was Jamaica and other nations "of the east," life with health, his child, his mind the way it was before his problems began, etc. The other world, "the western world," was America, pain, separation, the death of his marriage and his young son. One day at the program he noticed a poster with illustrations of human emotions expressed with words and accompanying faces. He adapted these into his personal images, and began to translate the feelings into the corresponding two worlds in his diagrams. He described himself as being in the middle of all the worlds and directions, yet separated and unable to be joined with

anyone or anything. When he first came to the program, he was often seen laughing, smiling and talking to himself and responding to what appeared to be auditory hallucinations. This lessened over time as he began to use his drawings to talk with the student.

As her internship drew to a close, the student and the author decided that the best plan for "A" would be for his case to be transferred to the author. "A" had papered the student's entire office wall with his most important images, which he selected. They brought those to the author's office and the images were hung on her office walls to help make for a smooth transition. "A" already knew the author well, in her role as his backup counselor in the student's absence. He readily accepted the transfer, and expressed gratitude for the decision.

During the following 2 years, "A" experienced some changes in his medication regimen. Risperidone, the newest medication given, did not give him the physical side effects he experienced from former medications, and he was grateful for this. Whenever the author met with "A," she encouraged him to freely express his psychotic process, magical beliefs and continue his symbolic drawings. The conversation initially surrounded an elaborate discussion of the apparently delusional nature of the drawings. The author never suggested that his process was unusual, but unique, and joined with his delusional system, always speaking using "A"'s special terms.

"A" became increasingly verbal and demonstrated a growing personal involvement during individual meetings, in milieu groups and during art therapy groups. He was briefly assigned an art therapy intern who worked in tandem with the author to help "A" continue to comfortably express himself. His images of the worlds began to shift and he started to talk about feelings rather than disassociating while drawing. "A" actually started to tell personal stories about his past. His hygiene improved, he changed his clothes, participated in activities at home, and was unrecognizable when compared to the person he was when he first came to the agency.

One day "A" started drawing people who were whole instead of fragmented, and began to join the lines on his diagrams. He told the author that the worlds had "come to peace with each other" and that he, no longer permanently in the center and without hope of contact, could now "be reached." Subsequently, after each individual meeting, "A" and the author would touch the lines that had joined in his last "revised" drawing.

"A" maintains magical beliefs in himself and his body which are complex and numerous. He claims to have predicted when his son was born that the child would die prematurely. "A" also describes very personal physical symptoms he experienced when his wife was pregnant, and says these indicated to him that she would need a caesarian section. The surgery made him feel inadequate as a man, due to his belief that the procedure is "unnatural" and reflected his inability to "have my wife bear a child the normal way." Over time he speaks less of this and more about the pain of losing his son. Recently, he processed an outstanding law suit against the drunken driver who killed his child and won the case, and also began the process of applying for citizenship.

Last year "A" joined a weekly, intensive, multi-creative arts therapy group facilitated by a drama therapist which uses a model of mythology and life journey symbols to approach healing. "A" will continue his membership in this group for a total involvement of approximately 1 year. He says he wants to stay out of the "pit" (his symbolic place of terror and suffering, where he describes having been "stuck") in the journey path and seeks improved and consistent ways to visit the "water forest" (his symbolic place of joy, prosperity and fecundity).

In June 1996, the author nominated "A" for an agency-wide achievement award for demonstrated growth and progress. He was given the award at the agency's annual ceremony, witnessed by his siblings and an audience of hundreds. "A"'s middle sister informed the author that when the family looks at him now, they recognize the person he was "before all the pain entered his life." They attribute the change in his circumstances to "something inside him bigger than the psychosis," therapy, and "the grace of God."

"A" has not relinquished his personal symbolic language but uses it when he chooses or needs to, and lives in consensual reality most of the time, by his own report. He wants to go back to school to study further drafting techniques and may evaluate the possibility of gainful employment in his future.

According to Campbell, "A" would have been identified as a drowning man, and, due to his severe paranoia, judged unlikely to improve. The author and his family perceived his right to maintain his own symbolic language, a metaphoric system which provided a much needed defense against apparently insurmountable inner anguish. His unique verbal and literary form, uncensored by psychiatric professionals, adapted itself over the course of his healing pro-

cess to become closer to a universally archetypal mythical language, including images of darkness (the "pit") and fluidity or growth (the "water forest"). In her Nobel lecture, Toni Morrison (1996) highlights the value and strength of accepting all forms of expression in an uncomplicated approach to language, versus the danger of censorship:

> Be it grand or slender, burrowing, blasting, or refusing to sanctify, whether it laughs out loud or is a cry without an alphabet, the choice word, the chosen silence, unmolested language surges toward knowledge, not its destruction. But who does not know of literature banned because it is interrogative, discredited because it is critical, erased because alternate? (p. 202)

Laing suggests that clients like "A" are forever separate from the practitioner, and even if they can be "reached," there will exist within them a constant variable which cannot be understood by a non-psychotic person:

> The kernel of the schizophrenic's experience of himself must remain incomprehensible to us. As long as we are sane and he is insane, it will remain so. But comprehension as an effort to reach and grasp him, while remaining within our own world and judging him by our own categories whereby he inevitably falls short, is not what the schizophrenic either wants or requires. We have to recognize all the time his distinctiveness and differentness, his separateness and loneliness and despair. (p. 38)

Laing here advises that the practitioner respects the client's right to be in despair, experiencing his own scenario of separateness, etc. This is a known, effective way to approach the healing realm, but the author has shown that it is not always true that the client "remain(s) incomprehensible," since in "A"'s case, much of his language became comprehensible to the author (in her "sanity"), while she simultaneously respected his right to separateness and despair.

Client B

"B" was born in the southern United States in the late 1950's. He graduated from high school and attended a university for at least 2 years before dropping out for mysterious reasons, likely related to emo-

tional distress and possibly psychiatric symptoms. "B" and his records provide little or no information about his parents, family and background. He describes a close personal friend with whom he grew up and attended school, and also a special fondness for the friend's mother.

"B" came to New York City after leaving college, but it is not clear exactly why or when he made this decision and carried out his plans. When "B" came to New York he found himself unable to manage financially and also began to intermittently drink alcohol. He became homeless, suffered numerous emotional and physical traumas, and wound up in the psychiatric system.

The reports made by "B" and those in his treatment and historical psychiatric records conflict in describing these events. It is important to note that, to the author's knowledge, "B" rarely if ever discussed these events with professional mental health staff. When directly asked, he would usually give evasive and tenuous answers, or simply state that he "prefer(red) not to discuss it," then begin to laugh. The following description was voluntarily given by "B" to the author during their last year of working together. The context of his description was his seasonal anxiety given the coming of winter and the snow season.

According to "B," he couldn't pay rent anywhere and brought himself to a men's shelter in Manhattan. When he arrived, he was treated poorly due to his "sensitive" appearance and the stigma associated with people's assumptions about his sexual orientation. He left the shelter, went to central park in the middle of winter and slept in a secluded area surrounded by leaves and newspapers. Due to the severe cold, he began to freeze and his clothes, more suited to the southern climate, were far from sufficient in keeping him warm or insulated.

"B" describes that one morning he awoke to find his legs completely frozen, and realized he couldn't move or get up, and was dependent upon "the luck of being found by another person." "B" resolved that if he was "meant to die" that he would, since the situation was beyond his control, but he hoped that someone would discover his predicament and rescue him. He noticed several volunteers seeking to help the homeless by bringing sandwiches to them in the park, but describes that they were too far away for him to call out to them. The next day, "B" found himself even more seriously frozen. In the middle of the evening, "B" states that a man came into his secluded spot and attacked him with a knife. He tried to defend

himself but this was difficult to impossible due to his inability to stand or move. The man sliced open his face and neck and left him there, he says, to die.

"B" describes the keen awareness of simultaneously bleeding and freezing to death. He says he "looked up into the dark sky and found an inner peace in seeing the stars," knowing he was "entering a place where no further harm could come" to him. He told the author that he prayed that some help would come, but knew at the same time that he had entered the "underworld," and could not be certain if he would "escape." A volunteer for the homeless found "B," very near death, and he was brought via ambulance to a nearby hospital. Both of his legs were amputated at the knee and when he awoke he found himself in the process of being transferred to a psychiatric hospital, and eventually joined some rehabilitative groups.

Although initially isolated, over time, "B" presented as articulate, attentive and with above average intelligence. "B"'s conversation evidenced a strong familiarity with poetry, literature, social sciences, psychology and his stated favorite subject, mythology. However, while seemingly related, "B" maintained an eerie distance from everyone and manifested paranoid, schizoid and disassociative symptoms regardless of his mood or surroundings. He frequently laughed and stared at others, laughed to himself for no reason immediately obvious to others, and refused to talk about his past or any emotions whatsoever. Clearly "B" was seriously traumatized by the events described above.

While hospitalized, "B" met the same drama therapist who he would meet again 10 years later, in the outpatient day program where the author was his social worker. The drama therapist saw in "B" a potential for growth and communication, and he became involved in several plays and dramatic, therapeutic activities, with the use of his wheelchair. He was one of the leads in a performance of "Guys and Dolls," and the drama therapist reports the impact of seeing "B" come out onto the stage for the first time, with his new prosthetic legs. This was the first time he walked since he lay down in his secluded place in central park.

"B" joined the outpatient day program shortly thereafter and was a client there for many years before he was assigned the social work intern under the author's supervision. "B" also moved into a mental health residential facility, where he is still teased, and reports feeling misunderstood by the majority of his fellow residents. The author first encountered "B"

when he became one of the first members of the poetry group she facilitated for seven years. The group included a use of mythology to address storytelling, poetic principles, and the value of metaphoric and symbolic language. "B" was very participatory and engaged in this group, and seemed to enjoy the leadership role of helping his peers understand mythical and symbolic concepts. However, he maintained emotional distance and never discussed anything other than intellectual associations with the beauty or existential value of the writings used in the group.

When the student intern was assigned "B," she found him distant, aloof and more paranoid with her than in the general community. He began to have increasing problems with peers due to his staring and "inappropriate" laughter, and their feeling, due to their own paranoia, that he was tormenting or seeking to otherwise provoke or trouble them. The author suggested to the student that she encourage "B" to teach her about mythology, since it was his favorite subject, and might promote trust between them, encouraging him to have a sense of mastery and purpose in forming a therapeutic alliance. Otherwise, her main role with "B" was intervening to prevent these peer difficulties from re-surfacing and causing arguments within the community. "B" was, at that time, also volunteering to read stories with the group facilitator responsible for the clients with the least ability to relate to others, due to negative symptoms of schizophrenia (isolation, non-communication, withdrawal, etc.) or dual diagnoses of mental illness and developmental disabilities.

During their individual meetings, the student and "B" embarked upon an adventurous discussion of myths. "B" began not only to teach the student, but chose specific myths each time they met which seemed to illustrate something about how he was feeling on that particular day. Most frequently, he described the adventures of Ulysses/Odysseus and Hercules. "B" became increasingly able to briefly discuss why he liked these particular stories and what they meant to him.

In the cases of Ulysses and Hercules, he liked describing and admired the strength and physical stamina of each hero. He did not allude to his own physical challenges and limitations during these discussions, and the student never imposed this view upon him. However, it is one among many interpretations to suggest that "B"'s reason for selecting these two heroes is because of his wish to be like them or identify with them. Indeed, although now termed

physically and psychiatrically disabled, "B" survived a physically and emotionally devastating set of circumstances that could have killed him. The mythical stories seemed to provide him with the opportunity of speaking about very personal and painful feelings in a universally understood language without being overwhelmed or terrified by those feelings.

The student and author agreed, as in "A"'s case, that the best plan for "B" was for his case to be assigned to the author when the student's internship ended. "B" was comfortable with this decision, especially since he knew the author from their ongoing relationship during the poetry group. "B" and the author shared a readily available and mutually passionate interest in mythical language. This made the conversations between them smooth and unencumbered by jargon. "B" began the individual meetings by describing Hercules and other physically and psychically powerful figures, but eventually "B" began to focus on the story of Osiris and Isis. Osiris was then the frequent figure of choice during the meetings.

Occasionally, "B" and the author would discuss other myths, including the Greek guardian spirits of nature, or nymphs. "B" was familiar with the tree (dryad), spring/pool/lake (naiad), hill/rock (oread) and sea (nereid) nymph characters but was most fond of discussing the water nymphs. The author conjectured, without saying this to "B" until later in their relationship, that his interest in the water nymphs may have been connected to his experience with ice and freezing.

One year before "A" joined the new client gathering of the same group, "B" joined the journey group, when it first began. He expressed being pleased that the drama therapist he met again after years of separation was the facilitator of the group. One of the group tasks involves mask-making, and the clients work in duos to make masks literally on each other's faces. These masks are then used in a series of increasingly complex and varied therapeutic activities, most of which revolve around self-expression and group intimacy.

When "B"'s group ended, he asked a staff social worker to hold his mask in her office, which he told her was the "safest place" for it to stay. This social worker and "B" had a longstanding history of conflict due to "B"'s invading her privacy, by approaching her near her office door and in community areas, for no apparent reason, staring and laughing in the same way as with his peers. Apparently, this unexplainable behavior had significance, since he asked her to hold

this important personal object for him, and she agreed.

The author interpreted this interaction as representative of "B"'s increased ability and wish to seek connection with others, particularly those with whom he had past difficulties. He simultaneously demonstrated fewer incidences of inappropriate laughter and staring, and began to describe his laughter as a "replacement for, and an expression of my feelings." This is not the type of statement the staff team expected to hear him say, and some staff members didn't believe he was capable of even considering such a thought. During the journey group, his fellow members encouraged him to take responsibility and acknowledge the possible meanings of his laughter, which seemed to contribute to the change in him.

When the author resigned her position at the program, "B" told her during their last meeting that he "felt blessed by the stars, which answered my prayers when I saw them from my dark place" in central park. Several months prior to that was when he told her the entire story of his entry into chaos and darkness, and his subsequent movement away from it by using the language of mythology.

"B" maintains many of his behaviors of isolation and social awkwardness, but has shown enormous growth over time. He seems more in control than had previously been the case of choosing to be disassociated when it is necessary for his comfort and survival, but can also choose, more freely, to relate with others.

The author attributes symbolic and therapeutic significance to "B"'s shift from predominantly discussing Hercules and Odysseus to a focus upon Osiris. Addressing this provides further evidence to support the need for understanding the psychotic's individual language as including the potential for change and not only operating within loss, self-death and drowning. Edith Hamilton states,

> Hercules was the strongest man on earth and he had the supreme self-confidence magnificent physical strength gives. He considered himself on an equality with the gods—and with some reason. They needed his help to conquer the Giants. In the final victory of the Olympians over the brutish sons of Earth, Hercules' arrows played an important part. He treated the gods accordingly. Once when the priestess at Delphi gave no response to the question he asked, he seized the tripod she sat on and declared that he

would carry it off and have an oracle of his own. (1942, p. 225)

Here Hamilton describes not only a quality of physical prowess, but immortals' reliance upon and need for it and Hercules' related audacity in his awareness of his own value to them and the world. "B"'s choice of discussing Hercules therefore may go beyond the metaphor of physical and emotional strength, and may be interpreted as a need to be needed. Perhaps it also involves an acknowledgment, or a wish to acknowledge, private, self-worth.

The story of Odysseus/Ulysses is also one of a hero with incomparable physical and emotional power whose fallibility, like that of Achilles' heel, manifests on his voyage back home. The theme of returning home may be metaphorically relevant to "B," due to his departure from home for mysterious reasons and his later experience of homelessness. During poetry group and individual discussions, "B" expressed great interest in Odysseus' struggles to free himself from obstacles which were designed to keep him from returning home, the third and final stage of the heroic journey, according to Campbell.

In *Six Myths of Our Time*, Marina Warner (1994), addressing the complexities of what is meant by "home", states, "The question of home's so simple in the *Odyssey*. Odysseus earns his return through suffering and perseverance—and fidelity throughout to his goddess Athena and—in spirit at least—to his wife, Penelope" (p. 108). However, Warner advises her readers that there is no such thing as the waiting, idyllic home. She describes the experience of the poet Derek Walcott, author of *The Odyssey, A Stage Version* (London, 1993):

> Over the last twenty years of writing, Walcott has struggled with the Odyssean idea of home as native place, with the yearning to return to origins, and speak out against the nationalisms that assault communities and their peace, against xenophobia. As Walcott declares, "I bear/my house inside me, everywhere." The imaginary homeland is itself homeless. There's no home except in the mind, where ideas of home are grown—"I had no nation now, but the imagination," he writes. (p. 118)

It can be conjectured in "B"'s case that the attachment to Odysseus' story, where "the question of home's so simple," confirms the myth's defensive purpose, its

telling temporarily protecting him from the truth that "there's no home except in the mind."

In entering the realm of discussing Osiris, "B" demonstrated his willingness to venture into a different level of mythological symbolism, which is aimed both at continued self-protection and reaching out in communication with others. "B" told the author that he "froze to death in the darkness." He believes that he actually died in the cold; what was found and brought to the hospital was not him, or was without the part of him which perished in central park. Hence, it does not appear merely coincidental that he chose to tell of these experiences in the context of being worried about the upcoming snow (and his losing his balance due to his prostheses).

The major metaphoric elements of Osiris's story and "B"'s own language include death, the underworld, resurrection, ice/water and darkness, all of which have mythical and archetypal functions. Even Odysseus must ultimately visit the underworld in order to learn the clearest path to get home safely, but the underworld is not as major an element in his story as in Osiris's. If the author viewed "B"'s explanation, "I froze to death in the darkness," as a psychotic delusion (rather than as symbolic) and dismissed it as such, he would not have been given the opportunity to further explore the value of his own statements within the context of the therapeutic alliance.

Campbell states,

> Myths of descent into the underworld are of a descent into those domains of your own psyche that you have not been paying attention to. We live on the surface of our own lives, and the mind is aware of only certain interests and intentions, but the body has other potentialities, other interests, and so forth. Now, when you shipwreck in the shallow waters of your intellectual notion of what your life's about, wherever you shipwreck is where your depth is. Then you go down into what old Frobenius used to call "the night sea," down into your own abyss to find there the forgotten, the omitted energy, which should have been informing your life but which was being excluded by your conscious posture. There are two ways of going into the underworld. One is by being swallowed, and the other is by killing the monster that guards the gate. In the former, being swallowed, the person is taken on the night sea journey unconsciously. (Boa, 1989, pp. 130–131)

"B" was not swallowed like Jonah by a whale, but by the darkness itself. As a result, in his own self-description, he died yet lived to tell the tale. This illustrates Campbell's idea that the psychotic person's process is that of the mythical hero's. However, "B," who survived "drowning," and is neither "fortunate" nor an "essential" schizophrenic, managed not only to reach but, in his own way, complete the stage of return.

Conclusion

Psychotic clients by definition have a unique way of thinking and speaking, which our society views as pathological. What would happen if non-psychotics accepted the individuality of psychotics, without insisting upon their inherent deviance? If the psychotic person is suffering, this idea would require a different way of approaching the therapeutic situation other than making the person feel separate or encouraging him to move away from his defense systems due to their incongruity with consensual reality.

Marie-Louise von Franz, who worked directly with Jung for 31 years and was one of the founders of the Jung Institute, reminds us, "it is precisely myths and mythical religious systems that are the first and foremost expression of objective psychic processes" (1978/1980, p. 79). If we assume that one of the goals of the therapeutic process, whether working with the psychotic or non-psychotic, is to help the client safely enter into his psychic processes in order to promote healing, then this entry must not only include an examination of universal mythical systems, but the individual mythologies that clients may use to protect themselves and bridge communication with others.

Campbell (1971/1993) advises, upon examining the potential to survive and return whole from the perils of the heroic journey,

> The whole problem, it would seem, is somehow to go through it, even time and again without shipwreck: the answer being not that one should not be permitted to go crazy; but that one should have been taught something already of the scenery to be entered and powers likely to be met, given a formula of some kind by which to recognize, subdue them, and incorporate their energies . . . There is always in the adventure great danger of what is known to psychology as "inflation" which is what overtakes the psychotic. He identifies himself either with the visionary object or with its witness, the visionary

subject. The trick must be to become aware of it without becoming lost in it. . . . (pp. 230–231)

It is conceivable, given the illustration of the two case examples included here, that one way of helping the client to safely enter these psychic processes, while embracing the mythical sub-strata which exist there, is for the practitioner to be willing to become "lost" with his client. Here, the practitioner's belief that healing is possible and real comes from trusting the therapeutic alliance's intersection between the client's individually designed (yet universal) myths and the relationship's shared reality.

If this happens, the therapeutic practitioner, in his willingness to become "lost" with his client while maintaining his own self (perhaps "lending some ego" to the client in the process) is "joining" with what may appear to be a psychotic, delusional system, but which may also be an example of an archetypal truth. This process allows the client to safely choose between travelling through places within and without himself. As a result, the client may ultimately have more options about how to be in the world.

The psychiatric survivor's verbalizations of his inner world, and even his outward behavior, may at first indicate to an observer that he is irretrievably "lost" or a mere shell for his "dead" self. Psychiatric care providers who retain this narrow view of a psychotic client's presentation, and who are not willing to enter into his mythical realm, may actually be contributing to what maintains him as lost and without hope. In contrast, if more social service practitioners were willing to enter these dark, psychotic and magical places, it is conceivable that, not only would the client's wellness be promoted, but the clinician himself might glimpse the truth layered inside myth—something sacred and powerful, possibly used as a defensive structure by all humans throughout time.

This approach, particularly when used in combination with groups like the journey and poetry ones described above, gives clients like "A" and "B," who might otherwise be seen as drowning, hopeless or dead, the opportunity to be taught "something of the scenery to be entered and powers likely to be met, given a formula of some kind by which to recognize, subdue them, and incorporate their energies." We have seen here that not just the fortunate or the essential schizophrenic have the potential for healing.

The ethnopsychology of humanity's shared, universal myths can promote the capacity for wellness within all people. Therapeutic practitioners can offer

this approach to their clients by attempting to see each client not only as a unique collection of psychological and social responses to personal history but as a specific intonation of the mythical realm which lives within and around everyone. Clinicians can foster accepting and non-judgmental intentions in their work by responding to clients' metaphors, rather than simply focusing upon their suffering, perceived impairments, status of disenfranchisement or the embodiment of the psychiatric diagnoses assigned to them.

References

Boa, F. (1989). *The way of myth: Talking with Joseph Campbell*. Boston: Shambhala.

Caldecott, M. (1993). *Myths of the sacred tree*. Rochester, VT: Destiny Books.

Campbell, J. (1995). *The flight of the wild gander: Explorations in the mythological dimension*. New York: HarperPerrenial. (Original work published 1951)

Campbell, J. (1993). *Myths to live by: How we re-create legends in our daily lives to release human potential*. New York: Penguin/Arkana. (Original work published 1972)

Doty, W. (1986). *Mythography: The study of myths and rituals*. Tuscaloosa, AL: University of Alabama Press.

Hamilton, E. (1942) *Mythology*. New York: Little, Brown & Co..

Laing, R. D. (1965). *The divided self: An existential study in sanity and madness* London: Penguin/Pelican. (Original work published 1959)

Morrison, T. (1996). Language alone protects us. In J. Young (Ed.), *SAGA: Best new writings on mythology* (pp. 198–205). Ashland, OR: White Cloud Press.

Piercy, M. (1976). *Woman on the edge of time*. New York: Knopf.

Szasz, T. (1974). *The myth of mental illness: Foundations of a theory of personal conduct* (rev. ed.). New York: Harper & Row.

von Franz, M. (1980). *Projection and re-collection in Jungian psychology: Reflections of the soul* (Kennedy, Trans.). La Salle, IL: Open Court. (Original work published 1978)

Warner, M. (1994). *Six myths of our time*. New York: Vintage.