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Diagnostic Fictions

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Introduction

What's in a Name?

If you put the DSM on your writing desk alongside *The American Heritage Dictionary of the English Language* (Morris, 1981*),* you discover two things. First you discover what seems familiar: to diagnose something, or someone, is to know that thing or that someone. Second, you discover what is, if not a surprise, at least something that is often left latent in the act of diagnosis. The root of the word diagnose is also to be found in the word ignore. Thus to diagnose is also not to know or notice something or someone.

A fair question then arises:

What do we notice and not notice, or ignore, when we know a person—a patient—through the categories of the DSM?

Already the use of the word patient illustrates this point. While I have been dissatisfied with the biological and medical implications of the word patient, I have always preferred it to the word client. Insofar as my therapy practice has been informed by my disposition toward and education in existential-phenomenological philosophy and psychology as well as depth psychology, I have found the term client inadequate to frame the complex and unconscious dynamics of human interaction.

Nevertheless, neither term is neutral. Each describes an approach to the person who comes to a therapy room. So, if a therapist is more or less unaware of what's in a name—patient, client--then each term betrays a prejudice. The person seen as a patient is not seen in the same way as one regarded as a client.

Merleau-Ponty **(1968)** has shown there is a dialectic relation between language and embodied perception. We speak about the world in terms of how we see it and we see the world in terms of how we speak about it. Applied to the DSM, I would add that its diagnostic categories, which envision the person as patient, inform how we practice psychotherapy and, in addition, write our case histories.

When that dialectic relation becomes a linear one in which a speaking and thinking mind is regarded as split off from a perceiving and acting body, a space is opened where our words can become labels. For many of us in the healing professions the categories of the DSM have too frequently slipped into becoming identified with the individual that they label. The threshold of the therapy room becomes a border crossing where the story the person comes to tell is placed in a DSM cage.

If we are to change how we see those persons who enter the therapy room, we have to know that our DSM categories are perspectives that reveal and conceal something about the person. To change the DSM so that it becomes a real paradigm shift, requires a paradigm shift in our thinking, a shift away from thinking and speaking literally to thinking and speaking metaphorically.

Who is in the DSM Categories?

The patient person haunts the categories of the DSM, and, as these special issues of the *Journal of Humanistic Psychology* indicate, the time is ripe to be impatient about it.

What do the categories of the DSM know about the human person and what do they ignore about the human person?

My essay is a reply to this question in three parts. In Part One I describe a case, which sowed a seed toward the possibility of a diagnostic manual based in the humanities.

In Part Two, I explore some necessary changes in our ways of thinking about and doing psychology if an approach to diagnosis is informed by the humanities. In Part Three, I give a specific example of a DSM category amplified through a literary work.

Part One

Lucy

In the early years of my training as a psychotherapist, I had several patients who were actors. One of them taught me to appreciate how he got into character for a figure in a play could apply to how one might work with the figures of one's dreams. That nugget was in the background of my work with a student who was referred to the Counseling Center of a large university where I worked.

The student, whom I will call Lucy, was referred to me because of her increasingly erratic behavior mid way through her first year at college. She had become increasingly moody, withdrawn and unkempt in her appearance, was missing many of her classes, and was often unable to sleep. In addition, there were reported instance where she would approach someone and begin speaking to that person as if they had already been having a conversation.

In the initial interviews she appeared depressed and was extremely uncommunicative. The back and forth of our conversations consisted mostly of my questions and her minimal, often, one word replies. More often than not she seemed to be elsewhere, there and not there in the room with me. It was uncanny because her being elsewhere did not feel like she was either just preoccupied or in some delusional schizophrenic state.

Having had my early internships at state hospitals where I saw many types of schizophrenic reactions, that diagnosis did not seem to apply to her. It left too much out of the picture. Suspending a diagnosis, I began to sense that our therapy room was a stage and that Lucy the person was also a character in some story she was living out without awareness.

Psychotherapy is as much a vocation as it is a profession. One is drawn into that work for reasons that are beyond reason, and in the nearly fifty years that I have practiced as a therapist and taught and supervised graduate students, I have always given the vocational origins of this art a central place by emphasizing the necessity to attend on a regular basis to the question, 'Who are you as a psychotherapist'? Moreover, I have learned over the years that the patient who challenges the assumptions of our training—the diagnostic categories and the skills and techniques of practice—is the one who best leads you into the mysteries of this kind of work.

Lucy was one of those patients. With her I was drawn into asking as a fundamental question, 'Who is the patient'? My encounter with her has been an ongoing education, which has informed much of my writing about psychotherapy. From the nature of the symptom, the art of dream work, the necessity to attend to the embodied gestural field of patient and therapist to the art of psychological writing, I have been drawing on those moments with her, amplified over the years with other patients. But the one thing that I learned with Lucy that has hovered over all these concerns and has lingered in the background is the idea that diagnosis could be approached from the side of the humanities.

Who is the patient?

The person who comes *to* therapy *is* and *is not* the figures or characters who come *for* therapy. This distinction already challenges our conventional idea of time as a line. When time is a line, we are more likely to be listening to the person who is remembering those past events. But if we lend an ear to the more subtle voice (s) of the figure(s), we might

hear a figure who is re-membering the past right there and then in the room. With the therapist, the figure is re-making the past as a story. The space of the therapy room has become a place to make a scene, a place to enact a drama, a place to stage a performance.

Therapy has become theater and the question of 'Who you are as a psychotherapist?' becomes paramount. The therapist is challenged to remain vigilant about the role(s) he or she is playing in the dramas of the figure(s).

It is difficult enough to regard clock time, that Satanic invention that measures time as a line, that devilish device that measures one's life as a series of dead-lines, as an abstraction from the lived time of our human embodiment. It is even more difficult to do so today in the age of the internet and cellphone where one is on call 24/7. In this context lived time can feel like wasted time with a moralistic invective about failing to keep on track and adhere to schedules. Lived time even breaks the chain of causality that defines time as a line.

Time moves differently in the therapy room. Even the so-called fifty-minute hour is not so much a measure of time as it is a frame within which a story unfolds. In the ambience of the therapy room the causal line of time uncoils into a spiral in which one re-members a past as one is imagining a future just as that imagining of a future is a re-membering of a past.

The origins of psychotherapy with Freud is a helpful reminder of the crucial nature of this difference between clock and lived time, as well as a reminder of how easily it was, and in the age of STEM psychology still is, forgotten or dismissed. When Freud noted that the hysteric suffers from reminiscences, he understood that the past lingers and haunts the present. This insight was also present in his observation that there is no time in the unconscious. We know, however, that the causal and reductive method of analysis betrayed these origins.

Lucy, who as far as I know never read Freud or any depth psychology, was suffering from reminiscences. In the therapy room even her long periods of silence and being seemingly absent were telling a story. Most significantly her gestures were re-membering a past waiting to be witnessed by another. She was, therefore, not just suffering from reminiscences, she was also suffering from an inability to imagine any kind of future.

Lucy taught me to regard those subtle clues clothing even the sparse words she spoke. In her gestures, in the different modulations of her voice, in the different attires she wore to the session, and even in the different ways she combed her hair, I learned to listen for and to hear through the words she did speak as the person who came to therapy the characterization of her words. I learned to regard her symptomatic displays as the ways in which the figures/characters were trying to tell their side of the story.

Part Two

"Psychology would do better to turn directly to literature rather than to use it unawares." James Hillman makes this point in *Healing Fictions* (1983, p.18*)*, a work that not only strongly supports a literary approach to psychology, but also uncovers the fictional foundation of Freud's, Jung's and Adler's psychological work. Indeed, he credits Freud with creating the genre of case history as fiction. Why not now make the move from case history as fiction to fiction as case history? After all, as he says, "Those in literature see the psychology in fiction. It's our turn to see the fiction in psychology." (Ibid.)

Using literary forms as a foundation for psychological diagnosis begins with acknowledging that our current DSM categories are also fictions. This admission does not mean they are false. On the contrary, the biological basis of these fictions with their reductive, materialistically based explanations are a useful perspective. The problem lies with identifying these perspectives with what is true. Forgetting they are perspectives, we even forget we have forgotten.

Notwithstanding the value of our DSM categories as ways of seeing and imagining the sufferings of the human person, the consequence of this double amnesia is that it conceals what is most human about the human person: the ability to transform the biological conditions of behavior and experience into the meanings of our actions and experiences. It is a consequence that not only creates an image that is a monstrously inadequate caricature of the human being it also shackles this image with economic, pharmaceutical and insurance chains.

If, however, we take up another perspective, which regards our current DSM categories as very brief sketches of characters in search of their images and stories, then the stories and characters found in the treasure house of literary fiction and films could flesh out the DSM character sketches and enliven our imaginations. At the very start of therapy, then, we would be faced with an immediate question regarding who the person is who has entered the therapy room. What stor(ies) is she or he within and whom might he or she resemble among the cast of characters that we find in literature and film.

Years ago I had such a moment when Mr. Z first entered my office resembling a Don Quixote figure forever tilting at windmills. His way of being transformed the space of the therapy room into a place where this drama could be told. It was essential for me to know that this was the landscape of the therapy room, which at times proved helpful for me to imagine my role as Sancho Panza.

The DSM categories as sketches of characters in search of their images and stories have had their animation squeezed out of them. The sketches have become ossified and hardened into a literal and lapidary language of application. Time now to crack them open. Time now to irrigate those dried up tissues of forgotten metaphors with literary animation.

While the time for it is now and the need is dire, a literary approach to a diagnostic manual poses many challenges, not the least of which is the challenge to imagine a

philosophical foundation for such a project. I describe here some features of such a foundation.

The willing suspension of dis-belief

This phrase is how Samuel Taylor Coleridge describes a specific kind of attitude that is necessary if one is to take seriously the creations of the imagination. (Cited in Romanyshyn, 2007, p.150) Its power lies in the term dis-belief because it indicates the many resistances that need to be overcome to believe in those creations. While it is the attitude that comes quite naturally when one is watching a play, it is curtained off from life outside the theater. Outside, the world of facts is real while inside the world of fiction is real.

Lucy's presence broke down that barrier of the outside and the inside and expanded my understanding of what is real. In the therapy room her presence was like an actress on stage. But unlike the actress who knowingly can hold the tension between her person and the characters she enacts on stage, Lucy was not able to do so. She was like an actress in an empty and dark theater, who wakes up but does not know what play is taking place, or what character she is playing and what the next lines might be.

In the gap

The French poet Baudelaire said the gap was the domain of the eponymous poet Orpheus, who not only bridged the abyss between the humans and the divine, but also translated the messages of that domain of the gods to us. It is the gap that the poet John Keats bridges when he calls the world the vale of soul making and claims that in that gap we find the use of the world. (Cited in Romanyshyn, 2002, p.131)

But the psychotherapist is no more a poet than he or she is a scientist, even while he or she shares with the scientist the same respect for facts and shares with the poets the same sensibility of fiction making. Indeed, the therapy room, which in its origins with Freud

was neither a medical clinic nor an academic lecture room, is a third place where psychological life shows how the perturbations of soul fictionalizes the factual. It is a place where fiction—*fingere*—exemplifies, for example, the art that defines the human domain of culture whose creations, through the handiwork of fingers, preserves the soil of the earth while transforming it into a clay pot.

Symptoms follow the same art. They are, as it were, the clay pots of psychological life, containers that hold the stories of the characters who come for therapy. They are the habitats of those figures, the habits that in their repetition call for attention. In passing I would add that all our programs designed to engage will power to break our habits, our addictions and our compulsions imprison the characters, silence the stories and bury those containers that are for the suffering person so psychologically radioactive. Such efforts might make us better citizens in relation to some collective norms, but they are akin to character assassination.

In the therapy room our symptoms shape the past into stories while preserving them. Symptoms are not, therefore, only a sign of what is wrong. They speak in two voices, the voice of the person who tells his or her tale and the voice of the figures who spin another story. They are a vocation that calls us to remember something too vital to forget but which has been forgotten because it is too painful to remember. In this regard, we would have to acknowledge that the therapy room is itself a work of fiction, that third place that Freud so creatively made as a place that would host what makes us most human—this capacity to re-member what is as what might still be.

Sitting in the therapy room with Lucy so many years ago, I have gradually understood that therapy is the art of creating a place for the figures/characters to tell their side of the person's story—the untold side that lives on in symptomatic displays enacted in the embodied gestural field between therapist and patient. When it works therapy is a *poiesis*, a making, the handiwork of making stories together.

But is a psychology that is based in *poeisis* possible today in the age of technology in which a psychological education rooted in the arts of fiction is increasingly overtaken by psychological training that trumpets techniques?

The Poetic Realism of Psychological Life

J.H. van den Berg's phenomenological psychology is, perhaps, the best example I have ever encountered of the poetic realism of psychological life. A master story-teller, his work is a bridge between a psychological imagination and the poetic imagination, which John Keats described as one characterized by negative capability. This negative capability is the art "of remaining in un-certainties, Mysteries, doubts, without any irritable reaching after fact and reason." (Quoted in Romanyshyn, 2002, p.120)

Such an art seems unimaginable today when bottom line thinking stands as an emblem for certainty, when mystery is almost equated with magical thinking suitable for children up to a point, and when doubt is not a place to linger with wonder but is tolerated as a step to further enlightenment. For example, one has only to read Yuval Noah Harari, the best selling author of *Sapiens* (2011), to see the forces arrayed against the imagination. While he acknowledges that the ability to invent fictions is the most unique quality of human beings, the story of the evolution of *Homo sapiens* that he tells dismisses these fictional stories as illusory compared with the facts of science. Although he does admit that our stories do matter to us, his book *Sapiens* and its follow up, *Homo Deus* (2017) are well argued account of the dangers of our fictions. Ironically, then, what is most unique about us is also most illusory and dangerous.

Insofar as this capacity for story making is what constitutes the poetic realism of psychological life, a consequence of the mind set that would devalue our story making capacities is a disregard for any psychology that would value this ability. This consequence is in fact already at work in psychology's addiction to the STEM initiative, and as well in the continuing efforts to devise an improved DSM manual keyed to biological markers to explain human suffering.

Still, we need to ask what might be an antidote to this addiction not as a cure or an alternative but as another perspective that is responsive to the fictional character of psychological life. We need to ask about this possibility because what is at stake is the issue of who we are and who we are becoming. Indeed, this issue is a already contained within the question of 'Who is the patient?, because the perturbations of soul are more than individual moments of suffering. John Donne's line about death—'And therefore never send to know for whom the bell tolls; It tolls for thee--" (Donne, (1624) 1941) sounds true today The alarm bells of our sufferings are going off in our ecological disasters as well as in the breakdowns of our political, economic, educational and medical institutions.

Part Three

An Invitation

Over the years I have tentatively explored with some colleagues in literature the possibility of developing a diagnostic manual that would use fiction and film as ways of understanding those who make their way to the therapy room. But the vast scope of this possibility requires a number of specialists who would bring their expertise in literature, film and psychology to such a project. Having presented a case example that inspired this project, and having described some of the philosophical foundations for such a project, I close with an example of this possibility.

My hope is that an example might inspire others to explore and develop it. As a start we could imagine as a first step a DSM 6 manual whose diagnostic categories contained a section that listed fictional works and films. Such a manual would bring together psychologists and specialists in film and literature like, for example, Susan Rowland (1999, 2010, 2016). Moreover, this step would begin to balance the one-sided STEM initiative in psychology and restore the rightful place and necessary role of the humanities in psychological education.

In my example I use Mary Shelley's story, *Frankenstein; Or, The Modern Prometheus (Shelley (1818) 1984).* Her story has gripped the collective cultural imagination for 200 years, prompting the novelist Joyce Carol Oates to describe it as a parable for out time. (Oates,1984, p.252). In addition, I also use a recently completed but not yet published book, *The Frankenstein Prophecies: The Monster's Tale—Eight Questions and Replies*, to retell her story in a way that presents the character of Victor Frankenstein through the eyes of the Monster, who is not named but is labeled by his creator devil, demon and monster, and who is abandoned and exiled to the margins of the human community.

The Frankenstein Prophecies takes place on the margins where the relation between Victor Frankenstein and the Monster haunt us today in the multiple technological crises we face. Describing how Victor Frankenstein and his Monster appear in the guises of climate issues, the swelling number of refugees created by catastrophic climate events, as well as our economic policies, unending wars, and religious conflicts, and the radical transformations of genetic and computer technologies that are increasingly moving toward a disembodied life lived in the digital ocean of overwhelming waves of information, the story confronts us with the question of Who is the Monster? and challenges us to awaken to our participation in creating these monstrous problems.

Reading the diagnostic categories for the Narcissistic Personality Disorder via Mary Shelley's novel and my retelling of it, my example emphasizes that a literary approach to diagnosis is not an interpretation, explanation or reduction of Victor Frankenstein or his story to that diagnosis. On the contrary, my example attempts to do quite the opposite. Using the story and the characters of Victor Frankenstein and the Monster as a lens to magnify the range and depth of this diagnosis, the example uncovers themes that are latent in the diagnosis. For example, *The Frankenstein Prophecies* shows that Victor Frankenstein is an emblem of a god of matter whose materialism severs its bond with the spiritual dimension of the human being. This split dramatically shows itself in the descriptions Mary Shelly gives of those moments when Victor Frankenstein prowls the sacred grounds of churchyard cemeteries to dig up the body parts for his work. For him

these hallowed grounds have become mere receptacles not for dead bodies but for anatomical specimens deprived of life.

Magnifying the range of the diagnosis of Narcissistic Personality Disorder through this moment and others like it, we can wonder if this diagnosis reflects the godless character of our age, if this personality disorder is also a spiritual disorder.

301.81 DSM 5

The DSM 5 manual is an impressive testament to psychology's commitment to define and differentiate mental disorders, and its diagnostic categories are a useful perspective. Indeed, its descriptive criteria are, as I said earlier, like outlines for characters in a story.

Narcissistic Personality Disorder is described as "a pattern of grandiosity, need for admiration, and lack of empathy." (2013, p. 645) The pattern has nine diagnostic criteria, five of which must be manifest to make the diagnosis.

These criteria manifest themselves in a person who:

> "Has a grandiose sense of self-importance,
>
> Is pre-occupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love,
>
> Believes that he or she is 'special' and unique and can only be understood by, or should associate with, other special or high-status people (or institutions), Requires excessive admiration,
>
> Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations),

Is interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends),

Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others,

Is often envious of others or believes that others are envious of him or her,

Shows arrogant, haughty behaviors or attitudes." (pp. 669-670)

Who is Victor Frankenstein?

Victor Frankenstein is a figure who emerges in the gap between dreaming and being awake. Indeed, Mary Shelley tells us that he appeared to her in a waking dream, and her description of that state suggests that from that gap he arises as a reverie. This claim is important because it suggests that while the character of Victor Frankenstein comes through her, he is not reducible to her. Victor Frankenstein as a literary creation is an emblem of the autonomous fictional reality of psychological life. A personification of the poetic realism of psychological life, his presence requires our presence to him with that willing suspension of disbelief and negative capability described above.

The DSM is sensitive to the influence that culture and gender have on the diagnostic categories. Both of these issues do inform the character of Victor Frankenstein and do shape his work.

The cultural and historical context in which Victor Frankenstein is embedded is a world of optimism about the promises of the new sciences and its technologies. Especially attractive to him is the science of electricity, which appears to many as the engine of life. When Victor Frankenstein begins his work he imagines that its power will allow him not only to defeat death but also to create life. He will do what no one before him has yet done. Increasingly confident in his knowledge and his abilities, he will uncover the

secrets of life and death and become a new creator god. Only once and very briefly does he pause to ask himself if he should dare to do what has been the work of the gods.

Obsessed with his dream, nothing is allowed to stand in his way. Family, friends and the community of others are sacrificed to his unshakeable faith in the importance and unique quality of his work. Working alone, he forsakes even his bride to be, Elizabeth Lavenza, who, as he describes her, is a frail and delicate but delightful creature who busies herself with the airy creations of the poets. He as a man of science is above and beyond her. So, he stays in character when, as he departs from his home to begin his work, he expects she will accept and understand the postponement of their marriage until such time that he has completed his work.

Perhaps however, the one quality that most characterizes the figure of Victor Frankenstein is his lack of empathy. This feature of his personality is especially apparent in his attitude toward and treatment of the creature he creates, abandons and curses as devil, demon and monster. Throughout the story Victor is deaf to the appeals the creature makes to him to assuage his loneliness. This interaction is, indeed, the core of Mary Shelley's story, the theme that has allowed it to endure. The abandoned monster, exiled to the margins of human life, has in fact fascinated us to this day, and in *The Frankenstein Prophecies* I show how his side of the story,
his largely untold tale, is the seed of a new and much needed ethics if we are to take responsibility for the monstrous crises we face today. Through the eyes of the Monster we see Victor Frankenstein as someone who, confident in and obsessed with his work, is insensitive to its catastrophic effects on others, and who continuously refuses to take responsibility for the destructive consequences of his actions.

My example is not intended to show that Victor Frankenstein meets a specific number of criteria to diagnose him as having a narcissistic personality disorder. This would be as foolish as attempting to apply the story of Frankenstein as a diagnosis of some public figure today. On the contrary, this example indicates that a literary amplification of the DSM categories adds the depth of the image and the context of a story, which personify

and animate the categorical ideas of the DSM. This turn toward literature for diagnosing the epiphanies of psychological life as a poetic realism is a way of thinking through images. In this regard, this literary approach to diagnosis is indebted to Jung's and Hillman's work as well the phenomenological psychology of J.H. van den Berg. An approach that values the image, it is antidote for our addiction to the materialistic literalism of so much of our psychological thinking. I would argue that in this way we come closer to understanding the psychological pathologies of human life as they display themselves in the therapy room and outside it.

A Closing Remark

A literary approach to the DSM remains a quixotic quest unless psychological education returns the humanities to a central place. Programs in psychology that insist on the STEM model and the exclusion of the humanities create a monstrous psychology.

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