

Metaphors of Regulation and Transformation: Narrating Depression Through Neuroscience and the Humanities

By Christina Wusinich

Depression is a collection of stories, each providing an explanation of an experience that can be life-threatening, life-impeding, or potentially transformative. Through the stories told by neuroscience, by clinical psychology, and by the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, one can gather a range of understandings of depressive symptoms, of neurobiological theories of depression, and of the various evidence-based treatments prescribed for depressive disorders. These understandings, while useful to some, reduce depressive phenomenology to a list of symptoms and exclude the lived content of depressive experiences and the ways of narrating suffering that diverge from the pathological. Literary narratives of depression as well as philosophies about sadness and suffering illuminate the phenomenological and existential aspects of certain kinds of depressive experiences, but no individual depressive experience can be adequately defined through any single humanities discipline either. Instead, a project that is more complex, but potentially more useful, involves appreciating narratives of depression from many disciplines while also determining how this multiplicity of narratives can be useful. Here, I will present a range of narratives, from personal accounts of suffering to explanations of depressive symptoms from affective neuroscience, in a manner that I hope will be accessible across disciplines and that will highlight that there are many useful approaches to narrating depression.

The term “narrative” is used to describe a certain genre of writing, and narrative theory borrows the story-telling aspects of that style to provide a method for discussing the ways in which we try to make sense of ourselves and our worlds. Narrative theory defines components of a story, such as plot, character, point of view, and metaphor, and in doing so, provides the tools for constructing and reconstructing “narrative identity” as life unfolds. “The expression ‘narrative identity’ for what we call subjectivity is neither an incoherent series of events nor an immutable substantiality, impervious to evolution,” as the events in one’s life are understood through their narrative, and that narrative is continuously developing and being updated with each new moment of a person’s life (Ricoeur 32). The application of narrative theory to texts about suffering, psychic diversity, and even neuroscience research allows for development and flexibility in narration as well as for these texts to be examined without being put into competition over which single narrative presents the absolute truth of the matter. Through a lens of narrative theory, depression is malleable and can be understood in a multiplicity of ways—chemical, existential, or

otherwise—as a person works through it, as “all models of depression involve a process of story telling and story re-telling” (Lewis, *Depression* 88).

The stories presented here make use of metaphors of regulation and transformation, and they speak to theories of emotion regulation in depressive disorders as well as lived experiences where “symptoms” of depression are experienced as acts of regulating, as reasonable and even necessary reactions during times of stress or oppressive circumstances, and sometimes as critical for transformation of the self. Narrative psychiatrist Bradley Lewis explains that “metaphors are critical for understanding the many models of depression because metaphors and models work in similar ways” and that “a model, in short, is a metaphor developed over time” (Lewis, “Narrating Our Sadness” 312). Lewis makes the case for utilizing narrative theory in examining a multiplicity of understandings of depressive experiences (Lewis, “Listening to Chekhov”); I aim to provide additional evidence to that end and to more closely examine the way in which neuroscience research utilizes metaphor to communicate its narratives of depression. The purpose of exhibiting multiple metaphors of depression is to display that there are many useful models or ways of narrating depression, and to privilege one story in clinical practice, in research, or in our communities is to obscure our understanding of suffering and to limit the ways we support ourselves and each other.

Perspectives from Affective Neuroscience

The mainstream biopsychiatric narrative of depression takes the form of Major Depressive Disorder (MDD), named and defined in the *DSM* as “the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function” (American Psychiatric Association 155). Neuroscience has a variety of methods and narratives for discussing and conceptualizing depression, some which focus on the processing of negative emotions and allow for an understanding beyond simple observations of symptoms. Research concerned with the regulation of negative emotions has investigated whether mechanisms of regulation differ between individuals with and without a diagnosis of MDD (Gross & Muñoz). I will use the phrase “with and without a diagnosis” to indicate criteria that are used in research studies and to be precise in my language in describing participants as people who have been given a diagnosis and not as people who necessarily identify with a biopsychiatric narrative of depression (i.e. “depressed subjects” or “participants who have depression”), as that piece of information is not reported in these studies.

Neuroscience research on emotion regulation includes a body of literature exploring what happens in the brain when people attempt to regulate negative emotions. A popular methodology involves regulating one's emotions when exposed to an aversive stimulus (e.g. a violent image). To give an example, imagine viewing a picture of a car crash. When you are told to “attend” to the image, you will simply look at the image without making an active effort to minimize the negativity of its content. When you are told to “reappraise,” you will make an effort to feel better about the image, perhaps by remembering that it is only a picture or imagining that no one was injured in this crash. This task of attending or reappraising allows researchers to compare how your brain processes an image passively to how your brain functions when you are making an effort to overcome negative emotions.

In fMRI studies, the active reappraisal of negative stimuli has been associated with coupling of the amygdala and frontal cortex regions. What is described as “coupling” is the

higher covariance that has been found during reappraisal than during “attend” tasks, specifically between the amygdala and areas of the prefrontal cortex (PFC) (Banks et al.; Ochsner; Phan et al.). This connection between your PFC and amygdala is an important relationship in neuroscience narratives of depression. The PFC is often cited as the part of the brain that is responsible for executive function; of course, there is much more to the story, but for the purposes of this paper, it is important for its role in regulating activity of the amygdala, which is a key player in emotional reactions and memory (LeDoux).

Further research looking at this amygdala-PFC relationship found differences between participants with and without a diagnosis of MDD (Johnstone et al.). Johnstone and his colleagues found that participants with a diagnosis MDD recruited different regions in the PFC during the reappraisal tasks than did the participants without that diagnosis. The interesting finding of this paper was that overall the group of people with a diagnosis of MDD had a different pattern of neural processing when faced with the task of reappraising negative stimuli. This pattern of activity was referred to as a “counterproductive” effort in the authors’ interpretation due the finding that efforts to reappraise and *decrease* emotional responsiveness were actually associated with an *increase* in activation in emotion-related areas, including the amygdala (8882). But what does that really mean? Well, setting aside issues with the diagnosis of MDD itself, there is at the very least some evidence for a different way of processing emotions in individuals exhibiting symptoms of depression. Whether a different way of processing is ineffective or counterproductive is a larger question.

In some cases, this evidence from affective neuroscience may provide an understanding that depression is simply a difference in the way people process emotions when they are faced with threatening stimuli, which may include anything in one’s life that causes stress, acutely, chronically, individually, or structurally. If an individual seeks to react differently to stressors, they may seek a route that will help them learn to reappraise in a way they feel is more productive. Individuals may also not find these differences to be an impediment to their goals at all. The latter possibility will be explored more later, but for now, these basic findings concerning depression and emotion regulation can serve as one example of a neuroscience metaphor of regulation as a component of a mainstream biopsychiatric narrative and also of alternative narratives psychic difference.

Despite the potential utility of neuroscientific narratives of depression, the binary distinctions between healthy and ill, normal and pathological, that arise in this research is still potentially a cause for concern unless we also take account of social and structural factors that help shape these binary distinctions for groups and individuals. What is a “healthy” psychological reaction to discrimination against one’s identity or embodiment? What is “normal” behavior in a state of precarity in terms of housing, food, or safety? It still seems important to keep in mind that even categories determined by some validated measure gain their meaning in relation to the society in which they are created and the values that society holds. Particular patterns of connectivity in corticolimbic circuitry are only relationally healthy or unhealthy, and the behaviors that result from those patterns are interpreted as adaptive or not, based on how well they fit with social norms and ideals.

Appreciating those limitations, neuroscience research requires the sophisticated work of designing studies that investigate complex topics, such as emotion, in an extraordinarily complex organ. Even the act of interpreting data requires a consideration of

the metaphysical and methodological assumptions associated with the tools used for observation, which are never directly measuring “brain activity” but are measuring its supposed correlates, such as blood oxygenation as a correlate of neural activity in fMRI (Ogawa). Narrative theory provides a way to both appreciate the complexities of this research and how interpretations of data in neuroscience publications are saturated with metaphors of what depression *is*.

Though a narrative lens may not be embraced by neuroscientists, when they use language to convey their findings, they *are* constructing narratives; words are used to signify particular brain regions, and these words are arranged to tell a story that connects an identified behavioral or cognitive pattern with a patterns of activity in brain regions. This is not to say neuroscientific explanations of depression are comparable to first-person phenomenological accounts in terms of methods, nor is it a comment made in ignorance of the years of work that researchers dedicate to each study they conduct. Rather, to call these explanations of neuroscience “narratives” and to name neuroscientific definitions of depression as “metaphors” is to challenge an idea that those who do science occupy an Archimedean point in which their explanation of depression is objective and approaching the absolute truth of the matter. My concern is not whether neuroscientists believe they occupy such a space, but that in an embrace of science, clinicians and laypeople may be increasingly elevating these neuroscientific narratives of depression as the only way to understand depression.

There are many related concerns including how neuroscience research findings are communicated in the media, how neuroscience research is integrated into curricula for medical doctors, clinical psychologists, and social workers, and how these findings can be used to both deconstruct and reinforce social hierarchies and structural inequalities. Some of these concerns will be discussed further in the following section, and some are beyond the scope of this paper but are relevant to mention in representing the complexity of the social use and communication of research itself.

Narratives of Lived Experience and Philosophical Frameworks

First, it is important to recognize that the *DSM* definition of Major Depressive Disorder and a biopsychiatric narrative can be helpful for some. For clarification, the term “biopsychiatry” refers to a model of psychiatry that defines depression as a biological illness and creates treatments based on research in such fields as biology, genetics, and neuroscience, including the research presented above. Providing an example of the benefits of biopsychiatry, poet Liza Porter tells a story of her lifelong battle against depression with an emphasis on her finally hearing from a doctor that she has been “clinically depressed most of [her] life and [has] never been properly treated for it” (157). Her “shame dissipates” as the doctor “explains brain chemistry, dopamine, serotonin reuptake inhibitors,” and she “admit[s] powerlessness” (157).

Finding out that her depression is “not [her] fault” but rather “an actual physical disease” is the turning point in her life, which allows her to narrate what she used to see as a failure of character as an illness instead (Porter 157). She is able to re-narrate herself using biopsychiatric language and metaphors of dysregulation, and as a result, she learns to be patient when periods of depression come and to rely on medications with the peace of mind that there is nothing else she can do (158). Further, with her voice “mature[d]” by the tempering of her moods, she is able “to turn the hardships of [her] life into beauty” through

poetry that is “more accessible to others” and “more universal” once she finds antidepressants that work (157-158). Those are valuable outcomes to her, and through the utilization of a biopsychiatric narrative, she is able to reach them.

However, others may not find comfort in a this illness model of depression or its associated treatments and may seek to understand their depression through alternative models that provide more language for narrating such an experience. Philosophical and spiritual frameworks, such as those found in Thích Nhất Hạnh’s *No Mud, No Lotus* place depression and suffering into a framework of meaning that gives philosophical guidance on how to cope with and grow through experiences of suffering and sadness. Although “embracing our suffering may seem to be the opposite of what we want to do, especially if our suffering is very large, as with depression”, Nhất Hạnh explains that “once you have offered your acknowledgement and care to this suffering, it naturally will become less impenetrable and more workable; and then you have the chance to look into it deeply with kindness” (27). “Through looking deeply,” Nhất Hạnh argues that those suffering can “transform the organic ‘garbage’ into compost, which in turn may become many beautiful flowers of understanding, compassion, and joy” (28). Locating experiences of depression in the natural allows depression to be both recognized as painful, as garbage, but also as organic and as an experience that holds within it, like compost, the nutrients and potential for growth and beauty. Though not as medicalized as Porter’s understanding, this framework also emphasizes the growth possible in experiences of depression through the use of metaphors of transformation.

Pivoting to another way of narrating sadness not as weakness or illness, author and activist Gloria Jean Watkins, under her pen name bell hooks, writes about being prohibited from expressing sadness in her youth because “in [her] household...strong black females did not cry” (189). She explains her crying was in response to abuse at home but also that her “tears were a constant reminder that somewhere, something was very wrong” and that it was her “sadness that kept [her] feeling” (190-191). She claims that “many hurt children lose the capacity to feel”, but instead of suppressing her emotions, her “strategic mourning...helped [her] resist” and “heal” (191-192). For hooks, expressing sadness in response to her own traumatic experiences and the suffering of others was important to her eventual transformation into a “healthy loving selfhood” (192). Her way of narrating long-term sadness does not cast it as disorder or dysregulation but rather as adaptive and strategic for coping in her context and, eventually, transformative.

Considering that “symptoms” of depression may be adaptive responses and even acts of resistance within one’s context, philosopher Catherine Malabou explores the role of society in an individual’s narrative, arguing that the language of neuroscience, specifically concerning neuroplasticity, must be considered in relation to the demands of capitalist society. She relates “current psychiatric discourse, characterized by a clear tendency toward the ‘biologization’ of psychical or mental disturbance” to the “political discourse of exclusion, which presents the disaffiliated as individuals ‘with broken connections’” (Malabou 47). Labeling depression as a brain disorder, or as associated with a PFC that is not capable of regulating amygdala activity efficiently, could potentially be connected to a capitalist value system of productivity that seems to have no time to spare for the fatigue or deep emotional reflections that may come with depression. Malabou claims that “to ask ‘What should we do with our brain?’ is above all to visualize the possibility of saying no to

an afflicting economic, political, and mediatic culture that celebrates only the triumph of flexibility” (79). Malabou’s text encourages an understanding of plasticity as the ability to re-narrate oneself while respecting that humans can only bend so much without breaking under social expectations of productivity.

To further investigate the role of social expectations, especially when a culture of productivity may itself facilitate aspects of depressive experiences, such as fatigue, the power structures and performativity involved in mental health care in the U.S. must also be studied. Writing about metaphors of regulation is not merely an academic exercise; this is a point which becomes clear when considering how individuals may regulate themselves to align with social expectations and requirements and how they may *be* regulated by mental health care and interactions with biopsychiatry. In her work on this topic, China Mills cites a study in which researchers pretend to hear voices and are immediately hospitalized and identified as mentally ill (Rosenhan), which stands in contrast to stories of those who hear voices but pretend they do not in order to avoid hospitalization (Mills 211). “The researchers passed as voice hearers; they passed, posed, masqueraded as what they were ‘not really’,” giving them a sort of double identity (Mills 211). To themselves, they were researchers playing the parts of patients, and to the doctors, they were patients with broken brains. One might think the only problem lies in the psychiatric establishment failing to give “correct” labels in the case of the researchers or of the “passing” voice-hearer; however, another concern is that “if we assume that the person passing ‘really’ is mentally ill and is secretly passing for what they are not – passing as sane – then this maintains the binary of sanity and insanity” (Mills 212).

This way of performing and of narrating oneself to appear psychologically “normal” is what Mills calls “sly normality”; using metaphors of colonization, Mills notes similarities between psychiatry and institutions that “other” and oppress certain groups. When those who are colonized can mimic an aspect of their colonizer’s identity in order to pass in some way, such as performing sanity to pass in the context of a society colonized by psychiatric establishments and ideologies, “the agency of the colonized emerges” (Mills 213). The idea of “passing” or of regulating one’s appearance and behavior to “appear sane” is powerful in that it allows a person to exist with some freedom while keeping their “abnormal” identity a secret, subverting the power of their society by choosing how they will be identified. In this case, regulation is not a metaphor relating to one’s inner journey to understanding their suffering in a more useful way; instead, it is an act that serves the purpose of allowing someone to fit in, even if they still feel sad, exhausted, or purposeless within. Of course, the very necessity for passing is a “symptom of oppression,” but passing is a way to utilize a complex narrative identity to gain certain freedoms within an oppressive system (Mills 223).

Further, Mills questions the use of psychopharmaceuticals in the work of being sly, wondering if they help or if they are tools of the psychiatric establishment to create an identity of “actual” normality, the identity of the colonizer in which a person is not being sly to subvert authority but rather to fundamentally change their otherness by attempting to regulate their brain chemistry. Sly normality is not presented to disempower those who benefit from medication but rather to provide another way of conceptualizing biopsychiatry as a force that can feel oppressive to some individuals with a diagnosis of MDD, including those experiencing sadness that is pathologized and perhaps those who would say they

experience very severe symptoms as well; it is not my purpose here to decide for whom this framework could or could not be useful.

With those considerations in mind, a framework of sly normality may be useful to a patient who both seeks freedom from a psychiatric institution and who also wants to maintain their psychic difference; however, the concept of sly normality itself seems to signal a much larger structural problem in which doctors and individuals in privileged positions can use the language and tools of mental health to gain control over others. Narrating with metaphors of transformation or regulation may be useful for some experiences of depression, but are these stories told from a place of privilege in which every individual has the option to rebel against capitalist expectations or to seek meaning in a painful experience? It is not the case for everyone that depression can be relieved by resisting social expectations, and is everyone allowed to decide *how* they will narrate their suffering?

Margo Jefferson, born into 1950s America and what she deems “the Chicago branch of Negroland” or the “African-American upper class” answers in her memoir that it is a privilege to narrate an experience and even call it “depression” (8). She writes that,

One white female privilege had always been withheld from the girls of Negroland. Aside from the privilege of actually being white, they had been denied the privilege of freely yielding to depression, of flaunting neurosis as a mark of social and psychic complexity. A privilege that was glorified in the literature of white female suffering and resistance....Because our people had endured horrors and prevailed, even triumphed, their descendants should be too strong and too proud for such behavior. (Jefferson 171-172)

“Suffering the long-term effects of profound fatigue” which was “the result of all the work...required to be wholly normal and wholly exceptional” in her youth, Jefferson recounts writing practice suicide notes and sitting with her head in the oven in such a way that if she turned it on, she would not “be found in an ugly sprawl or a fetal position” (177). She wanted to “set an example for other Negroland girls who suffer the same way” by “[giving] them a death they can live up to,” a death of an intentional and morbidly respected aesthetic found in Sylvia Plath’s suicide, for example (177).

In the last few paragraphs of this memoir, Jefferson writes of her continued mental health care, including therapy and medication, and how “there are days when [she] still want[s] to dismantle this constructed self of [hers]” (240). Jefferson’s narrative provides a perspective that both values biopsychiatric treatments for depression, while also recognizing that one’s self and one’s experience of depression are constructed and shaped by powerful structural and social factors – factors which may even restrict the narratives that individuals can or should tell in order to “pass” or survive.

Clinical Applications of a Narrative Approach

To both capture depression’s complexity and appreciate each narrative’s individual value, depression must be viewed from many angles to “allows us to appreciate different models while at the same time remaining humble about them and without dogmatically insisting on a single perspective” (Lewis, *Depression* 67). These narratives presented, which have a multiplicity of interpretations outside of the ones provided, show that literature can yield insights, even within a biopsychiatric narrative, into the heterogeneity of

MDD or into the diversity of experiences of suffering. Fortunately, “a growing number of people in the medical field have come to appreciate that a knowledge base consisting primarily of the sciences is incomplete,” and “medicine is reaching out to the humanities to better understand and cope with illness and suffering” through the integration of literature and narrative approaches (Lewis, “Listening to Chekhov” 57).

One model that has emerged from medicine’s incorporation of the humanities is Rita Charon’s narrative medicine model, which “provides the means to understand the personal connections between patient and physician, the meaning of medical practice for the individual physician, physicians’ collective profession of their ideals, and medicine’s discourse with the society it serves” (Charon 1897-1898). Narrative medicine allows for a multiplicity of narratives on both the level of the individual patient and doctor as well as many understandings of medicine as a practice performed by and for societies in different ways.

Translating the framework of narrative medicine into psychiatry, Bradley Lewis argues that “when we apply these philosophic aspects of narrative multiplicity to psychiatry and depression, new forms of freedom and flexibility emerge” (“Listening to Chekhov” 62). By understanding that there are “multiple ways to organize human life” and one’s experience of depression, clinicians have many possible narrative frames to suggest to clients, which allows clients the freedom to choose the narrative that is most useful to understanding and working through their depressive experience (Lewis, “Listening to Chekhov” 62).

Narrative psychiatry creates space for a client to express themselves and engage in constructing an individualized narrative with their therapist. The therapist can take into account the sorts of details that have been brought out in the texts examined above, including the client’s history, ideologies, language, values, and the social and structural factors that shape their experience in the world. In this way, narrative psychiatry can provide a framework that helps clinicians to be aware of structural factors and to consider how treatment will interact with the individual’s narrative of themselves and their social location (Hamkins 122). In a narrative psychiatry setting, “clinical competency for depression means a tremendous familiarity with the many possible stories of sadness” because, as has been stated many times thus far, not everyone will benefit from the same understanding of depression (Lewis, *Depression* 108). Narrative psychiatry requires that the clinician understand the many languages and ways of understanding suffering, while taking into consideration the powerful structural factors that may threaten a client’s preferred narrative as soon as they leave the office.

Narrative theory provides tools for clinicians, researchers, and individuals in the trenches of a depressive experience to examine the stories about depression that they tell and are told, granting space for stories of dysregulation and pain as well as transformation and resistance simultaneously. The relinquishment of any goal to discover a universal explanation of depression is what makes a narrative approach useful, as it allows for a multiplicity of valid and valuable understandings of depression. To say that depression is a collection of stories is to argue that there are many ways of understanding and navigating our greatest challenges, and it is also to offer alternatives to those still suffering – keep reading, sharing, writing, and rewriting until you have a story that speaks to you.

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Christina Wusinich is an interdisciplinary researcher, pursuing the study of depression through multiple narratives. In 2016, she earned her bachelor's at NYU's Gallatin School, where she studied depression through philosophy, psychology, and neuroscience. Last May, she completed her M.S. in Neuroscience and Education at Columbia's Teachers College, where she continued to explore neuroscientific narratives of depression. Currently, Christina is engaged in a range of research projects related to emotion regulation, community mental health programs, health psychology, and unsheltered homelessness. With a long-term goal of being a researcher and clinical psychologist, Christina is dedicated to advocating for more ethical, multi-narrative clinical practice and research.