

KNOWLEDGE OF BIOGRAPHICAL EXPERIENCES OF THE MENTALLY ILL AND THE QUALITY OF EMPOWERMENT

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“Breaking down of the wall separating the healthy from the ill puts the latter on equal footing with the society of the healthy. It gives the ill the opportunity to start from an equal position, and at the same time, allows them to see in the so-called healthy the same mental aberrations which are the core of the illness, so that the surrounding people become closer, more understandable, and the negative feelings change into positive ones” (Kępiński, 1989, 41-42).

The article is a reflection on the areas of empowerment which could be depicted in the social work with mentally ill. An attempt to categorize those areas is based on the findings from a biographical research concerning strategies of coping with mental illness. The research mirrors the logic of constructing knowledge from the perspective of people under investigation.

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INTRODUCTION

The article presents the individual dimension of empowerment² in the work with a mentally ill person. The study reflects the logic of constructing knowledge³ from the perspective of the subjects. In this sense, this is an example of participative research⁴. The researcher strengthens the position of the studied persons along the study process. This makes their voice the fundamental source of knowledge about coping with mental illness.

The presented conclusions are the result of biographical research conducted with the mentally ill. The research material was obtained in the course of narrative interviews. The narrators are two men and four women aged 21-31 years, members of an association of people with mental health problems⁵. The objective was to generate strategies that reflect the individual ways of coping with mental illness. The generated strategies formed the total of biographical experiences of the patients. This knowledge was the basis for reflection on the diversity of the areas of empowerment when working with a person suffering from a mental illness.

² Empowerment understood as the process of developing a sense of influence and control, independent of changes in social structure (Neighbors, Elliott, Gant, 1990 after: Szmagalski, 1996, 154, Hirayama, Hirayama, 1986 after: Szmagalski, 1994, 127). As a social pedagogue, I wanted to point out that the idea of empowerment was implemented in Poland by Helena Radlińska. Professor Radlińska created the concept of "human strengths" (Szmagalski, 2006: 414). From the perspective of the concept of "human strengths", empowering a mentally ill person may depend on the bringing out hidden powers: abilities, life experience, knowledge (Kamiński, 1985, 16).

³ The concept of "knowledge" is understood as knowledge of biographical experiences, and it should be interpreted in this text as such.

⁴ A participative research can be understood as the study which reveals the physical participation of the researcher or understanding participation. Understanding participation underlines the epistemological position of a researcher who participates in the intersubjective world of meanings of the respondents (Participative Approaches in Social Work Research / Les approches participatives dans les recherches du travail social, 2010, 10-11).

⁵ Within the group included in the research, five people had been diagnosed with schizophrenia; one person had been diagnosed with a borderline personality disorder. All the narrators had had psychotic experiences.

The article induces the Reader to reflect on utilizing the knowledge on the biographical experiences of the mentally ill in the process of empowerment.

CONCEPTS DIFFERENTIATING THE AREAS OF EMPOWERMENT

An attempt to differentiate the areas of empowerment was conducted based on two concepts: the structure of trajectorial experiences and social identity. Saturation of these concepts in the conducted analysis made it possible to identify a subjective context of the difficulties associated with mental illness.

This context provides:

- ◆ Dynamics of the experiences of the patient, showing the stream of trajectorial experiences;
- ◆ Being perceived in the “life environment” (*‘le milieu de vie*)⁶ through the prism of the illness or outside of it.

THE STRUCTURE OF TRAJECTORIAL EXPERIENCES

In all the examined narratives, there emerged a trajectory, as the process structure, in which a disorder, suffering, lack of control over one’s own life are inherently imprinted (Schütze, 1997). The structural course of trajectories of the mentally ill was different from the course described in the generalized concept of trajectory by Fritz Schütze (Prawda, 1989; Riemann, Schütze 1992; Schütze, 1997). This statement was based on a comparison of the dynamics of the trajectory of the mentally ill with the phase course of the trajectories by F. Schütze (Riemann, Schütze, 1992). In the concept of F. Schütze, the accumulating and initially hidden potential of a trajectory is triggered under the

⁶ This is a concept from social pedagogy. It covers all the possible configurations of the elements of the life environment in which a human individual is present. Depending on how these individuals place themselves in the environment, their attributes are displayed such as objective, subjective, invisible, material, wider, and direct dimension (Marynowicz-Hetka, 2006, 54).

influence of some event and turns into a process (Ibid.). In the case of the mentally ill, the trajectorial potential is inherently imprinted into biographical experience. This is related to internally experienced difficulties connected with the illness. Thus, the stage of “crossing the border from an intentional to a conditional state of mind” is not so clear as in the trajectory caused by an unexpected event, e.g. bereavement, accident resulting in permanent disability, etc.

The biographies of the respondents differed as regards the dynamism of the trajectory of the illness. The structure of dynamic trajectories⁷ includes the phase of “cumulative mess” (Riemann, Schütze, 1992, 104). In this phase, the maximum extent of the dominance of the “drift” rule over the “intentional action of the subject”⁸ manifested itself. Below, there are some fragments of narratives, which illustrate the phase of “cumulative mess”:

THE LOGIC OF SUFFERING DOMINATES THE LOGIC OF INTENTIONAL ACTION

N1: “(...) *It was already hard to call it functioning at all and life, because yy I practically yy, do not know, do not know how to call this state at all, but it was such a strong depression with some psychotic symptoms to it y that yy I practically lay in bed, I had some schizas, some halluns yy (...)*”.

N3: “(...) *I opened y the door to the balcony, I wanted to jump from the fourth floor at the beginning. My dear father yyy he me yyy well sss yyy well y pulled me out from there ... (8 sec), because I just yyy how to say, anxiety, stress, I did not feel anything yyy, I was not afraid of anything, yy I felt no pain anything at all, yy that is, how to yy say it, (...) as if I did not have nerves, so I felt*”.

⁷ Categorization of dynamic and stretched-out structures of trajectorial experiences was based on the conducted studies.

⁸ The distinction between “action” and «drift» is considered by Schütze as the conceptual foundation allowing to define the character of biographical sequences from the perspective of an individual (Prawda, 1989, 84-85. “Action” corresponds to the principle of intentional action, and “drift” refer to the forms of activity and experiencing conditioned and controlled externally (Ibid., 84).

The course of this type of trajectory⁹ can be described by a sine wave illustrating the course of trajectorial experiences. The sine wave is cut by a horizontal line that represents the recovery phase of a precarious new balance of everyday life. It is a time of attempting to counteract the dominance of suffering in the biographical experience. The individual in this phase has enough strength to resist the dynamics of the trajectory. The sine wave - when rising above the horizontal line - represents building up of the trajectorial potential. At its peak, the above-mentioned potential reaches the stage of "cumulative mess" where pain dominates the biography. Then, the sinusoidal line goes down, which symbolizes regaining the control over the trajectorial experiences. This leads to another failed attempt to create a balance. There is a renewed phase of total domination of the "drift" rule over the "intentional action of the subject" (cf. Konecki, 1988).

⁹ Trajectory as a process structure has a structural conduct. It consists of the following phases:

- 1) build-up of the trajectory potential - a slow process during which the trajectory builds up;
- 2) crossing the border from an intentional to a conditional state of mind - an individual realizes that her or his life is steered by external forces and that the usual strategies of action are useless;
- 3) precarious new balance of everyday life - after experiencing the shock related to the inability to implement the plans in the usual manner, there appears a new state of unstable equilibrium;
- 4) breakdown of self-orientation - there are new developments of the situation, which means that the individual intensifies irrational efforts to halt the deteriorating situation, and as a result of his or her actions, the situation becomes increasingly difficult;
- 5) attempts of theoretically coming to terms with the trajectory - the individual creates a new definition of the situation focused on the description of suffering, its impact and reasons, he or she seeks to answer the questions on how to cope with the unjust fate, on the acceptance or rejection of the trajectory and on the fight with the results of the trajectory of a life course;
- 6) practical working upon or escaping from the trajectory - depending on how the individual has defined the situation, he or she begins to control the trajectory or to escape from it (Reimann, Schütze, 1992, 103-106), Björkenheim, Lev-älähti, Karvinen-Niirikoski, 2006, 54-56).

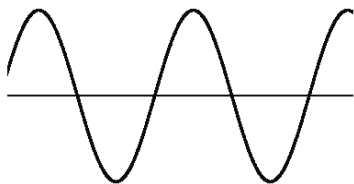


FIGURE 1. THE COURSE OF DYNAMIC TRAJECTORY

Stretched-out trajectories were devoid of cumulative mess. This type of trajectories illustrates life with the trajectorial potential, which is not supplanted by another type of biographical experience, nor is it subject to intensification. Trajectorial potential manifested itself in specific difficulties associated with the illness, such as lower efficiency of thinking, dissociation, disintegration of thoughts.

DIFFICULTIES ASSOCIATED WITH THE ILLNESS

N5: "And slowly I forget, sometimes I have it so that I switch the computer to the English system and I cannot remember the basic words (...) and I cannot read so good, shoot (...) Rather, it is as if it was a momentary forgetfulness - that I look at the word, like I know it, but I do not know the meaning. This is so weird, aaa and later, for example the next day, I sit and remember the word, so strange it is. At least when talking to me one cannot follow me, because sometimes a thousand thoughts a minute, and there comes nonsense out of it. And sometimes it is so that I think nothing at all and then this is the worst, then I have problems with myself".

N3: "(...) I had such a disorder, that yyy how to say it mm, yyy, all the functions of the body how to say it, I could not control yyy, I could not put into words, nothing at all, I could not control anything, all internal and external stimuli (...)".

Living with trajectorial potential meant for the subject certain consequences. The narrators complained about chronic sense of fatigue, exhaustion. Interlocutor N4 felt what we could call a permanent effort state. She exploited her forces to the maximum. It was a constant struggle, which induced in the narrator a state of prostration. This was not a momentary tiredness, but fatigue, which was a result of living with biographical baggage of trajectorial experience.

Such trajectorial experiences (of non-stretched-out nature) are characterized by creation of relative stability. However, this is a kind of balance which causes high biographical costs because it involves a constant effort that exhausts the energy of the individual (cf. Reimann, Schütze, 1992, 104).

N4: "I no longer want to play this. I have had enough. I do not feel like doing it. I just sometimes do not want to fight anymore. (...) I have a feeling that it has been like this for a long time, yyy, that, that such a state yyy of feeling better, worse has been going on for practically thirty years. Sometimes (...) I do not feel like getting out of bed. I would rather lie yyy, on the other hand, I have this / that, after all - I would have a lot to lose, and I do not want to lose it".

The conducted research has failed to clearly identify the factors that influenced the structure of trajectorial experience (dynamic or stretched-out one). It showed, however, that the phase of trajectory called the phase of trajectory rationalization and coming to terms with it became the beginning of a systematic reduction of the trajectorial potential¹⁰. This issue has been widely described in section 3.1.

SOCIAL IDENTITY

The analysis of the narratives showed that people with mental disorders differed among themselves in terms of the attributable social identity. People with the social identity of a healthy person (a "normals")¹¹, were most often seen in everyday interactions as

¹⁰ In two narrative interviews, there was found a dynamic structure of trajectorial experiences. In the case of narrative N1 trajectorial type of biographical experiences was replaced with a biographical action scheme.

¹¹ Using the neologism "normals" after E. Goffman emphasizes the situational nature of the social identity of the mentally ill (cf. 2007, 19-20). The analysis of narratives showed that being assigned to the role of a "normals" or a "bearer of a stigma" (stigmatized) was dependent on: the situational context and attributes of the individual. The situational context, for example, concerned the disclosure of psychiatric diagnosis in the workplace. On the other hand, the attributes predestining an individual to be stigmatized were associated with specific facial expressions, dress, manners, or manner of speaking.

persons that do not deviate from the social norm. Their biographical experiences represented the attributes of the healthy, which was expressed in consistently maintained active lifestyle and extended area of social participation.

FUNCTIONING ACCORDING TO SOCIAL STANDARDS

N1: "I (...) have just started to try, I have just started, yyy, I've started to try to function normally. Normally, normally, somehow live yyy. I signed up to volunteer in the P. yyym I began to teach. (...) I went to work, yyy, I worked in a supermarket all in all whiiich a few months earlier would have been unthinkable yyy (...) lii as just yyy, like these /, I had these tiny successes. Here /, yy here this work, this volunteering yy post-lyceum. As yy, I went also to a post-secondary education facility, which I have just forgotten [smile]".

These were usually people selected for the role of a normal person. For the subjects with healthy social identity (the normals), the illness meant certain limitations that one should learn to live with, or put up resistance to them. The illness was not a barrier preventing them from enjoying wider social participation. The narratives did not reveal any examples of stigma or rejection.

BEING PERCEIVED AS A "NORMALS"

N4: "Generally, I'm not seen through the prism of a person, I don't know, ill. (...) My life doesn't differ from the so-called normal people (...) I normally live. For me, the illness is some limitation, right? Yy I'm sick, so I cannot do something. Let's put it like this. I live normally, I do what others do, yyy, maybe it has not pestered me so much. (...) I have continued my education, it is some indicator to me that, as / it has not hampered me, it was for me important and somehow the illness has not been able to hinder me in this (...)".

The biographical experiences of the narrators having a social identity of the ill (stigmatized) illustrate social functioning with spoiled

identity¹². Having spoiled identity caused that the ill distanced themselves when dealing with others – i.e. the normals. The narratives expressed the duality of the world of interactive partners of the ill: those from the world of the healthy and those from the world of the ill.

DUALISTIC DIVISION OF REALITY

N2: "A little bit, outside, I think I'm sick, but I try to talk to everyone, from the outside mmmm".

N5: "(...) in P.¹³. it is not bad, people do not mock in P. It's worse outside (...) outside I do not have many persons".

Narrator 5: "(...) All in all, I think my father does not understand me fully. He, well, thinks too much like a healthy person. All in all, there is a saying «the healthy cannot understand the ill », well ha (...) and here I guess it is confirmed (...) at the hospital a man gets along with people, and with the normals it is not always possible".

The narrators with the social identity of the ill (stigmatized) built the image of "the rejecting other"¹⁴. It is a stranger, who on the basis of his or her recognition of the distinctive features of the ill, in comparison to others, (e.g. talking to oneself, "strange" gestures, inappropriate reactions - like laughter in social situations when seriousness should be maintained, etc.), devalues the status of the ill through the use of specific, stigmatizing practices. The narrators cite passages of the narratives revealing the reactions of rejecting others.

¹² "The key difference in shaping the personality of a stigmatized person and a «normal» one «is the fact that the first one experiences incomparably more emotionally unpleasant reactions, and, moreover, reactions that are inconsistent and incoherent - on the part of the others (...) Thus, Goffman used the concept of spoiled identity in which a person constructs his or her own image of social identity in the perspective of the feedback data" (Czykwin 2007, 189).

¹³ The initial of the name of an association of people with mental health problems.

¹⁴ This is a conceptual category derived from the analysis of the narratives.

STYGMATIZATION AND REJECTION

N3: *“So yy ... (4 sec.). How to say it, I was “dogged”... (5 sec.) yyy what else was there yy, I had no wish to live (12 sec.), y I was beaten ... (11sec.). Because of this illness I had y fears, yy no one likeed me ... (2 sec.) Except my y family ... (11 sec.)”*

N1: *“(...) I was yyy somehow on the side track, somehow I don’t know, not liked at all yyy not treated seriously...”*

To fully understand the subjective context of difficulties associated with mental illness, the relationship between the structure of biographical experience and the social identity should be traced in detail for each narrative. This is not possible though in this text, which aims to ponder upon the possibility of utilizing the knowledge on the biographical experiences of the mentally ill for the process of empowering¹⁵.

EMPOWERMENT OF THE PERSONS WITH MENTAL ILLNESS – GENERAL ASSUMPTIONS

When considering an arrangement of empowerment, the perspective of perceiving mental illness as a trajectorial process¹⁶ should be taken into account. Following this idea, we can conclude that the goal of empowerment should be destruction of the trajectorial potential in the life of the mentally ill person (cf. Riemann, Schütze, 1992, 106). A practitioner¹⁷ working as a professional operator of trajectory should

¹⁵ More on experiencing mental illness from the perspective of the narrators in: Kamińska I. (2011), Tactics to cope with the stigma of mental illness - a research report, In: (Micro)worlds of adults, (Mikro)światy ludzi dorosłych, (ed.) M. Pryszmont- Ciesielska, Wrocław, Published by Wydawnictwo LIBRON.

¹⁶ The analysis of illness as a trajectorial process was commenced by A. L. Strauss who focused on the complexity of this phenomenon: death, pain, chronic illness and disease in general. More in: Strauss A., Glaser B.G. (1975), Chronic illness and quality of life, Saint Louis, C.V. Mosby Company.

¹⁷ Professional operators of trajectories are: teachers, doctors, care institutions officials, persons who due to their professional function have an impact on the lives of others (Reimann, Schütze, 1992, 105).

direct his or her diagnosis towards the determination of what factors in the life of the mentally ill person act as brakes meant to avoid lapsing into trajectories or to slow down this phenomenon. Such knowledge could be utilized in the process of empowerment.

Empowerment is both the process and the goal (Swift, Levin, 1987 after: Dubois, Miley, 1999, 141). Empowering is defined as a process, and empowerment as the goal or final state (Dubois, Miley, 1999: 143). As a goal, empowerment defines the final state, i.e. gaining power (strength). Empowering is also associated with specific orientation of the activities, which focuses on the strengths and adaptability of people subject to it (Ibid., 143).

Therefore, in the course of empowering a mentally ill person, a feasible goal of empowerment should be adopted, which can be, for instance, achieving by the ill a state of mind such as: self-esteem, competence, the feeling of power and control over oneself (Swift, Levin, 1987 after: Dubois, Miley, 1999, 141). As a social pedagogue, I assume that there are no individuals that do not have strengths (abilities, desires, interests, aspirations). However, there are difficulties in identifying these strengths and selecting the motivating factors triggering them (Kamiński, 1985, 15).

THE AREA OF EMPOWERMENT: LOOKING AT ONESELF IN RELATION TO THE ILLNESS

Empowering a mentally ill person can be achieved by the use of a narrative as a tool to induce changes in the life of a sick person (Nousiainen, 2005 after: Björkenheim Levälähti, Karvinen-Niinikoski, 2006, 70). Narratives can be used for “building identity, conferring a new interpretation of the experiences of life, creating a new story of life and empowering” (Ibid).

In the case of people with mental disorders, empowering through the use of narratives can be used for looking at oneself in relation with the illness. It is aimed at empowering the ill to take up biographical work. Such work involves recounting of the past, repeating the story of life, interpreting and redefining it (Reimann, Schütze, 1992, 94).

This is a process of developing self-understanding, which makes the basis for more reflective and deliberate strategies (Björkenheim, Levälähti, Karvinen-Niinikoski, 2006, 70). This type of self-reflection is associated with emotional and intellectual effort (cf. Kokoszka, 1999 after: Kaszyński, 2004, 39).

As regards the mentally ill, whose structure of trajectorial experience is of dynamic nature, empowering in order to look at oneself in relation with the illness may be more effective at the stage of rationalization of the trajectory and coming to terms with it. This is the stage following the time of experiencing intense suffering, in which the need arises for a radical redefinition of life situation (Reimann, Schütze, 1992, 105). "This redefinition is an attempt to describe the nature and mechanics of suffering" (Ibid).

The biographical experiences described by Narrator N1 suggest that the ill had reformulated her attitude towards the illness in the period of rationalizing the trajectory.

The analysis of the biographical experiences of the mentally ill person, namely narrator N1, showed that the effort incurred for in-depth self-reflection resulted in the reduction of the trajectorial potential.

N1: "(...) Above all, yy, I started to feel differently about myself, myself as myself in general. Yyy myself as the person I am. Y in general everything became y ordinary, just ordinary. The fact that I get up in the morning yy, that I do not know at all, yyy, that I'll read a book. That I'll make coffee for myself. Everything I do has become ordinary. Yy no, it was not, it was not a success, I do not know, yy ordinary yyy washing the sweater. It has not become a fantastic success at all yy worthy of applause. It has just become something common, y natural. My life has become something common and natural. Iiii it has been so beautiful [smile]"

The reduction of the trajectorial potential in the life of the narrator resulted from the process of metamorphosis, which took place at the level of individual identity (self-identity)¹⁸. The ill stopped building

¹⁸ Self-identity – a continuous process of self-development, defining one's own personal identity during which we form a unique sense of ourselves and our attitude towards the world around us (Giddens, 2004, 736).

the image of herself through the prism of the illness. The work on the identity was associated with empowering the subject by a professional operator of trajectories – a psychiatrist. The psychiatrist helped the mentally ill person to develop specific ways of distancing herself from the illness. Such person learned to distinguish the manifestations of the real illness from a bad mood, worse psychophysical condition:

N1: "(...) To just yy figure out what's going on in my psyche. What's going on in my illness? Is it an illness? Yyy whether yyy this and this symptom are these really symptoms of this illness? Or maybe, or maybe I am just getting ideas into my head? Maybe I'm simply stretching the truth? Or maybe it is normal and natural yy? Or, for example, yyy maybe this fear that I feel today, this morning, this is something quite natural iii normal that happens to everyone? Or, maybe I will continue to persuade myself that that this is my illness and I am more and more ill, and should not leave the house at all because I'm already so sick that I should not, I should stay in bed".

The mentally ill person no longer saw herself through the prism of the illness, which in turn meant that a new stage in her life began, in which she attempted to increase her social participation. Her social identity changed. She started to be viewed through the prism of one of the „normals“.

Empowering people with mental disorders to take up biographical work can turn out to be an important means of support also in the case of the mentally ill people with a healthy identity (of a “normals”) with stretched-out structure of trajectorial experiences¹⁹. Biographical work for this category of people with mental disorders could be used to increase the level of acceptance concerning the difficulties related to the illness.

Narrator N1, before taking up biographical work, had developed her image of “I” through the prism of the disease. This way of perceiving oneself had effected in the narrowing of the range of social participation. The narrator had had a social identity of the ill (the stigmatized).

¹⁹ See: narration N4, p 6.

THE AREA OF EMPOWERMENT: EXTENDING SOCIAL PARTICIPATION

Empowering the mentally ill can also be performed through extending his or her social participation. This applies to the category of the ill with social identity of an ill person (stigmatized). Such persons withdraw from “mixed contacts”²⁰ fearing rejection and stigmatization. The process of empowering this category of people with mental disorders can be channeled towards rooting them within self-help groups. A self-help group can provide space for the acquisition of social skills and sharing common experiences. Such action is consistent with the concept of the “spiral of kindness” by S. Kawula, which involves the creation of social support networks comprising only positive relationships (Kawula, 2005, 132).

The analysis of narratives provided by the mentally ill who lived in the world of “their own” showed that being rooted in a group of people with similar problems allowed the ill to establish a relative balance in life. The ill functioned among “their own”, i.e. those who bear the same stigma (Goffman, 2007, 52). They felt at ease and were accepted.

N2: “(...) and then I went tooo P. [name of an association for people with mental health problems] or y [words indistinct] iii there I had girl acquaintances and friends evennnn”.

The self-help environment may create favorable conditions for mixed contacts. Due to the fact that mixed contacts take place in the conditions in which the mentally ill feels safe, they can constitute an attempt to tame the world of the normals. The image of a “rejecting another”, rooted in the minds of the ill, may be weakened through such initiatives. This could be an impulse to go beyond the world of the ill.

In case of the mentally ill taking up occasional, unsuccessful attempts to contact with the healthy, attention can be paid to the role of certain

²⁰ A mixed contact means an interactive situation between a bearer of a stigma and a normals, i.e. a representative of the majority (Goffman, 2007, chapter I).

interests in the life of an individual person. Interests may become a mechanism for introducing the person with a mental disorder into the world of the healthy. Integration with the healthy would then be performed through sharing a common passion and via measures taken for the sake of its implementation. A mentally ill person would have the opportunity to build a mutual contact with the “normals” based on his or her strengths.

N3: “(...) since then, when yy I became ill I started to be interested yyy in science and yyy it also keeps me alive, for example, ... (6 sec.)”.

N5: “(...) I had the nature of a pack rat I just did not /, exaggerate with this. I collected almost everything and so too were the problems with it and all. Starting from old bottles, ending with the ... (3 sec.) I do not know - a plate, I do not know from something, who knows what. (...)”.

CONCLUSION

The aim of this article was to stimulate the reflection of the Reader on utilizing the knowledge about biographical experiences of the mentally ill people in the process of empowerment. The knowledge about the experiences related to the mental disorder was subjective – it came from the narrators, namely the mentally ill. The study made it possible to get to know the fundamental differences in the biographical experiences of the subjects. The differences concerned the structure of the course of trajectorial experiences and possessed social identity.

The text demonstrated the possibility to use the knowledge gained from the respondents in two areas of empowerment. It is therefore an example of using the conclusions drawn from participative studies for the sake of the area of practice associated with empowerment of the mentally ill. The study created space for the subjects to give their own meaning to their lives. Thus, it became possible to get to know the variations in the scope of their social identity and different structures of trajectorial experiences. The reflection on the practical

proposals concerning the process of empowering people with mental disorders was therefore based on examining the real problems told in the narratives. The answer to the difficulties associated with the inner experience of the illness is the use of a narrative in the process of empowering. The narrative allows the persons with mental health problems to take up biographical work, which can lead to changes in the way of experiencing the illness and oneself. On the other hand, a way of encouraging the ill to get accustomed to contacts with others - the normals, is building safe social space. Such space, in which a mentally ill person has a chance of redefining the experiences with people from outside the group of "theirs".

The proposed areas of empowering a mentally ill person serve to reduce the trajectorial potential, which remains permanently imprinted in the biographical experiences of the mentally ill.

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RÉSUMÉ

CONNAISSANCE DES VÉCUS BIOGRAPHIQUES DES MALADES PSYCHIQUES ET LA QUALITÉ D'EMPOWERMENT

L'article est une réflexion sur les champs d'empowerment que l'on peut délimiter dans le travail socio-éducatif avec un malade psychique. L'auteur essaie de définir ces champs en s'appuyant sur les résultats des recherches biographiques portant sur les stratégies des personnes malades à surmonter les difficultés liées à leur maladie. Ces stratégies sont étudiées à travers les vécus biographiques des personnes interviewées (malades mentaux).

Les champs d'empowerment proposés se différencient par : la structure des trajectoires dominant la biographie du malade et l'identité sociale déterminant le niveau de sociabilité des malades.

Cette recherche est réalisée dans la logique de construction des savoirs de la perspective des personnes interrogées. En effet, c'est une recherche participative qui confirme la position des personnes interrogées dans le processus de la recherche, celles-ci sont la source fondamentale des savoirs sur les stratégies utilisées pour surmonter une maladie psychique.

Traduction: Grażyna Karbowska

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