IDENTITY COMMITMENT IN THE CONTEXT OF PSYCHOSIS: A GROUNDED THEORY STUDY

A thesis presented to Dublin City University for the Degree of Doctor in Philosophy

By

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May 2009

DECLARATION

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Degree of Doctor in Philosophy is entirely my own work, that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

Signed:_____ Date: 8th May 2009

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ACKNOWLEDGEMENTS

Thank you to Pamela Gallagher and Chris Stevenson for their help as my research supervisors. In particular, I sincerely appreciate Pamela's continuing support, ready availability and diligent attention to the details of this project.

My deepest gratitude goes to the eighteen persons who participated in the interviews for this study. They made this thesis possible and they have my greatest respect for what they have endured and achieved. I think about them a lot.

Thank you to colleagues working in mental health care who were supportive of this project and made it possible.

My appreciation goes to my colleagues in Dublin City University for their encouragement and for sharing my load as I undertook this study.

Thank you to Barney Glaser and my fellow 'troubleshooters' at seminars in London and New York. Your help and enthusiasm were a genuine motivation for me.

Thank you to my children, Callum and Alex, who make my work and life worthwhile.

Most especially, thank you to my wife, Sharon, who teaches me the meaning of commitment every day, never lets me down and who I love.

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ABSTRACT

In the context of psychosis, persons encounter problems in self-experience and in the 'social predicament' posed by psychiatric diagnosis and unwanted identities. This means they are concerned with self-viability: with how to 'get along with themselves'.

The aim of this study was to develop a grounded theory of how persons deal with this concern of self-viability. Using the 'classical version' of grounded theory methodology, data were collected through interviews with eighteen persons with experience of psychosis and psychiatric treatment as well as through examination of eleven autobiographies authored by persons who also had first-hand experience of psychosis. Data were collected and analysed according to established grounded theory research procedures of open and selective coding, memo-writing, and theoretical sampling.

The essential theoretical discovery associated with this study is that *identity commitment* is fundamental to how persons deal with their concern for self-viability in the context of psychosis. This refers to a pattern of self-relation in which persons commit *to* and are committed *by* their self-conceptions.

There are three modes of *identity commitment*. The first is *keeping true (to) self-conceptions* in which persons keep true *to*, and reproduce truths *of*, themselves. The second is *struggling through with Me's* where persons endeavour to sustain or retrieve identities that are threatened or lost. And the third mode of *identity commitment* is *engaging to identities* that incorporates *finding things in common* with new identities and implication in *binding self-attachments*.

These patterns of truth-keeping, struggle and engagement can inform distinctive understandings of a range of issues in the context of psychosis. Resistance to psychiatric identification, entrapment by unwanted identities, 'downward' and 'upward' acceptance are particular examples of issues that *identity commitment* can elucidate. Furthermore, this concept merits further inquiry in the substantive area of psychosis as well as wider fields.

CHAPTER ONE

‘THE MAIN CONCERN’ AND INTRODUCTION TO THE THESIS

Introduction

In this introductory chapter, self-viability is identified as a main concern for persons in the context of psychosis and this provides the basis for an overview of the whole thesis. More specifically, the chapter unfolds in the following order.

First, it is argued that a concern with self is prevalent in Western societies and this is linked to a widely held assumption that self is a site of action for self.

Second, some theoretical accounts of self are examined and particular attention is paid to the symbolic interactionist concept of active self-relation.

Third, it is suggested that psychosis is associated with particular problems of self-relation and this means that persons are especially concerned with self-viability. On this basis, the purpose of the current grounded theory study is introduced.

Finally, the theory of *identity commitment*- which is emergent from this study- is briefly introduced and each of the following chapters are outlined. Some aspects of operational terminology are also clarified.

Self and self-relations

The prevalent concern with self

Within Western societies, ‘self’ is a highly prevalent concern. One indication of this concern is intellectual. The self is a common focus for the

work of scholars in philosophy, psychology, sociology, literature, and neuroscience. In the USA especially, there is also a tradition of cultural commentary in which the state of the self within general society is viewed as a cause for worry (Riesman et al. 2001/1961, Lasch 1984, Bellah et al. 1985) or for optimism (Lifton 1999, Gergen 2000).

An academic concern with self is matched in popular culture. In magazines, newspapers, biographies, autobiographies, talk shows, and 'reality television,' a variety of scandalous, tragic, amusing, successful, and inspirational selves are produced for the consumption of mass audiences. As well as derive entertainment from these public spectacles, it is possible that audience members get to do something with their own selves. For example, in a study of the Jerry Springer Show, Lowney and Holstein (2001) argued that viewers contrast themselves with the troubled characters on view and thereby assure themselves of their own normality.

At the end of his shows, Jerry Springer cautioned his audiences to 'take care of themselves.' This links with another aspect of the cultural ubiquity of self. In many settings, persons are directed and expected to work on themselves, better themselves, or change themselves in some way. In self-help groups, persons encounter "formula stories" that offer potentially new interpretations of one's experiences; re-definitions of oneself as, an 'alcoholic' or a 'battered woman' for example, and direction upon what one should do with oneself (Denzin 1993, Loseke 2001). Psychotherapy can be understood as an effort to help persons construct new selves (Miller 2001) or monitor, evaluate, challenge

and change themselves (Beck et al. 1979, Beck 1989). In prisons, personal reform is urged on inmates by reference to concepts like “cognitive self-change” (Fox 2001). And in mental healthcare, recovery is often related to notions like “self-empowerment” (Weinburg 2001), “self-directed healing” (Deegan 2001), or “self-transformation” (Tooth et al. 2003).

All of these instances point to a widely held assumption that self is a site of action for self. This implies that persons engage in self-relations.

Self-relations

In a detailed and wide ranging analysis of the emergence of Western notions of self, Taylor (1989) suggested that a self is defined by what is significant to itself:

"We are selves only in that certain issues matter for us. What I am as a self, my identity, is essentially defined by the way things have significance for me….To ask what a person is, in abstraction from his or her self-interpretations, is to ask a fundamentally misguided question, one to which there couldn't in principle be an answer." (Pg.34)

Ricoeur (1994) made a similar point in rejecting the idea of defining personhood in terms of “basic particulars” that transcend persons’ designations of themselves:

"We may wonder…if we can get very far in determining the concept of person without bringing in, at one time or another, the power of self-designation that makes the person not merely a unique type of thing but a self. We may even wonder whether persons can be distinguished from

bodies if self-designation is not included in the very determination of the meaning ascribed to the sort of things to which identifying reference is directed." (Pg.32)

In both of these passages, the authors defined 'self' in terms of a self-relation. For Taylor, being a self is essentially about interpreting oneself and, for Ricoeur, it is about designating oneself. Implicit in these notions is an interaction between a self that interprets or designates and one that is interpreted or designated. In other words, there is tacit reference to a relation between self-as-subject and self-as-object.

By contrast, this subject-object relation is made explicit in symbolic interactionist accounts of 'self.' It was Blumer (1969) who named and formulated the symbolic interactionist perspective even though he traced its tenets to the earlier works of James (1950/1890), Cooley (1983/1922), and Mead (1934). For Blumer (1969), 'self' was a key concept in symbolic interactionism or what he called a "root image." And he defined self in the following terms:

"It means merely that a human being can be an object of his own action. Thus, he can recognize himself, for instance, as being a man, young in age, a student, in debt, trying to become a doctor, coming from an undistinguished family and so forth. In all such instances he is an object to himself, and he acts towards himself and guides himself in his actions toward others on the basis of the kind of object he is to himself. "(Pg.12)

In this passage, self is defined in terms of a subject-object distinction. Earlier writers associated with the symbolic interactionist tradition, specifically James (1950/1890) and Mead (1934), referred to self-as-subject as *I* and self-as-object as *Me*. Employing these concepts in a reading of the passage quoted above, Blumer made illustrative reference to several *Me's* that *I* can recognise: as a man, young, indebted, a prospective doctor, and so on. This raises another key point about the passage quoted above and about symbolic interactionism in general: the self refers to a plurality of selves and self-relations.

So, although symbolic interactionists wrote about 'the self,' this was somewhat misleading because they actually conceptualised every self as a multiplicity of selves. This point was made by Holstein and Gubrium (2000) as part of a background to their own account of "postmodern identity." These authors also took up the idea of the active relations of *I* to *Me*:

"As we think things through, "I" and "me" are very much like two separate, yet related, entities. It's as if we can stand outside of ourselves, look back, and identify who we are. We take stock of our identities, evaluate what we see, formulate who we are, and proceed as if we are the kind of person we've been considering. The "I" makes statements about the other, as if that other- "me"- were someone to be singled out, critiqued, and evaluated. The "me" takes on a distinct life of its own, as an object that we might love, hate, or not understand. What we describe, what we feel, and what we do about that "me" can be as rich, varied, and

consequential as if the "me" were actually someone else." (Gubrium and Holstein 2001. Pg.7)

In this passage, and in the symbolic interactionist tradition to which it owes lineage, there is an assumption that self-relations are of considerable significance for most persons for much of the time. And this concept of active self-relation was- in the parlance of grounded theory research methodology- a 'theoretical code' that 'earned its way' into data analysis as part of the current project (see Glaser 1978, 1998, 2005). Indeed, how persons relate to themselves in the context of psychosis emerged as an underlying question to which the whole project is directed. More specifically, this grounded theory study is oriented to how persons 'get along with themselves' in the context of psychosis. This is because- in this context- self-viability is 'a main concern'.

Self-viability as a main concern in the context of psychosis

Problems of self-experience and psychosis

Psychosis commonly involves problems in how persons experience themselves. For one thing, persons can experience a kind of self-estrangement in which they become subjectively disembodied. This is illustrated in the following account by a man just before a full immersion in psychosis:

"I am no longer myself…I feel strange, I am no longer in my body, it is someone else; I sense my body but it is far away, some other place. Here are my legs, my hands, I can also feel my head, but cannot find it again. I hear my voice when I speak, but the voice seems to originate from some other place." (Parnas 2003. Pg.227)

This person conveyed an awareness of his own body to the extent that he knew his body as *his* body. But he experienced a separation of *I* and body: *I* was no longer fully resident within the body. This man's legs, hands, head, and voice existed for him as aspects of a detached *Me* associated with a loss of embodied *I-ness*. He experienced his own body as objectively recognisable but subjectively alien: there was a disconnection between *I* and *bodily Me*.

Parnas (2003) cited this case example as part of a more general phenomenological account of how persons, with schizophrenia, can lose their sense of self *in* experience. This is a recurrent theme in phenomenological research related to psychosis. In one study, Walton (1999) identified a common experience of not feeling at home with oneself and a continuing sense of strangeness. This strangeness was also noted by Koivisto et al (2003) in their study of the experiences of persons diagnosed with psychotic illness and resident on a psychiatric in-patient unit. Similarly, McCann and Clark (2004) suggested that persons often experience themselves as 'other,' as 'not themselves.'

So, psychosis provides a context within which persons often lack a sense of *mine-ness* in their relations with themselves. This pattern of self-experience is well recognised in psychiatry. In contemporary psychiatric literature, schizophrenia is frequently considered a disorder of self-awareness in which persons lose something of the sense of themselves as originators of their awareness and owners of their experience (Gallagher 2000, Davidson 2003, Knoblich et al. 2004, Blakemore and Frith 2003, Sass 2003, Kircher and Leube

2003, Frith 2007). This loss is not only associated with a sense of self-strangeness but also often with persecution by others.

With immersion in psychosis, 'hearing voices' is a common experience. These 'auditory hallucinations' or 'voice hallucinations'- in psychiatric parlance- are regarded as a 'symptom' that is especially characteristic of schizophrenia (American Psychiatric Association 1994, Berrios and Markova 2003). From a psychiatric perspective, it is commonly suggested that auditory hallucinations represent a failure of recognition: that persons do not recognise their own 'inner voice,' or their own thoughts, as their own (Blakemore and Frith 2003, Fu and McGuire 2003). On this basis, what *I* would normally recognise as *Me* is experienced as *them*.

For many psychiatrists, then, this problem of self-recognition is constitutive of schizophrenia and psychosis more generally. Another common problem- defined from a psychiatric perspective- is that persons develop erroneous beliefs (delusions) and 'lack insight' into their illness (Greenfeld et al. 1989, American Psychiatric Association 1994, Greenhouse et al. 2000, Fu and McGuire 2003, Bora et al. 2007, Cooke et al. 2007, Warman et al. 2007). But, regarding oneself as mentally ill can provide another dimension to troublesome self-relations in the context of psychosis.

Problems of unwanted identities

In the context of psychosis, considering oneself as mentally ill can have distressing consequences. In a review of a number of research studies, Lewis (2004) identified an association between suicide and awareness of mental

illness following psychosis. It seems that a number of persons would rather die than live with a conception of themselves as mentally ill. Similarly, Iqbal et al (2000) identified a phenomenon of 'post-psychotic depression' in a longitudinal study of persons recovering after psychosis and that was associated with 'entrapment' by a diagnosis of psychotic illness (this notion of entrapment is revisited in Chapter Eight).

These are illustrations of the 'unwantedness' of psychiatric identities: of how it can be extremely difficult for persons to live with conceptions of themselves as mentally ill. This can link with a broader social context of negative valuations of mental illness and madness. When persons employ these valuations and yet they are diagnosed with mental illness, they commonly encounter difficulties concerning how they regard, and feel about, themselves. As Sayre (2000) suggested in a study of persons admitted to a psychiatric hospital and diagnosed with psychotic illness, persons encounter a "social predicament" associated with how they regard themselves. A psychiatric diagnosis threatens persons' established self-conceptions and, if they do self-identify as mentally ill in these circumstances, this is often associated with diminished self-regard. This latter possibility is illustrated in studies of stigma and mental illness (Wright et al. 2000, Dickerson et al. 2002, Camp et al. 2002).

Furthermore, in the context of negative social valuations of mental illness and psychiatric diagnosis, there is evidence that persons actively deal with questions of how to regard, and how they feel about, themselves (Sayre 2000, Hall and Cheston 2002, Camp et al. 2002, Hayne 2003, Jackson et al.

2009). They process their own identities and their self-conceptions can change as part of ongoing relations with self and others.

Self-viability as a focus for the current study

To summarise the previous two sections, persons commonly experience a variety of problems of self-relation in the context of psychosis. These problems can be constituted through direct experiences of psychosis and the varying implications of psychiatric formulations of those experiences. In addition, these problems contribute to a pressing concern- a main concern- that persons deal with in relating to themselves. It is a concern for self-viability, for getting along with oneself.

This provided a starting point for the current study which is a grounded theory project oriented to how persons 'get along with themselves' in the context of psychosis. Persons deal with a main concern of self-viability and this was established through initial data collection and analysis. The emergent aim of the study, then, was to develop a theory of how persons deal with this concern. This approach to theory development is consistent with the 'classical version' of grounded theory methodology (see Glaser and Strauss 1967, Glaser 1978, 1998, 2001, 2003, 2005) that guided the conduct of the whole study.

Introducing the thesis

A theory of identity commitment in the context of psychosis

Identity commitment is the principal theoretical discovery associated with the current project. This concept refers to ways in which persons commit *to*, and are committed *by*, self-conceptions. Through patterns of *identity*

commitment, persons realise self-truths, self-obligations, self-entrapments, self-attachments and self-preferences. In the context of psychosis, these realisations shape how persons get along with themselves and reflect how they deal with matters of self-viability in ongoing self-relations.

In this thesis, the theory of *identity commitment* is elaborated in considerable detail. The methodological approach is explored, the methods of data collection and analysis are explained, the theory itself is explicated, its significance is considered, and its worth is judged.

The sequence of chapters

In Chapter Two, the methodology of grounded theory is overviewed and key debates are critically examined. The current study is aligned with the so-called classical or orthodox version of grounded theory methodology and the implications of starting a study with minimal conceptions are considered.

In Chapter Three, approaches to data collection and analysis are explored as aspects of 'doing grounded theory'. Sources of data are identified in terms of interviews with eighteen participants and eleven published autobiographies. How data were collected and analysed is examined in some detail. In addition, ethical aspects of the study are discussed.

In Chapter Four, the core category of *identity commitment* is introduced. An extant literature- employing various prior conceptualisations of identity commitment- is reviewed. Then, the concept of *identity commitment*- emergent from this study- is initially presented by reference to an extended case example

and an overview of three patterns of committed self-relation which constitute sub-core categories.

In Chapter Five, *keeping true (to) self-conceptions* is examined as a mode of identity commitment in the context of psychosis. This refers to a pattern of self-relation in which persons enact faithfulness to particular self-conceptions and, at the same time, reproduce its truth.

In Chapter Six, a second mode of *identity commitment* is explored: *struggling through with Me's*. This refers to what happens when self-truths are threatened or lost and how persons endeavour or sacrifice to keep or retrieve the truth of their self-conceptions.

In Chapter Seven, *engaging to identities* is explained as a third and final mode of *identity commitment*. This is concerned with the question of how persons become implicated with particular identities and with various patterns of binding self-relations.

In Chapter Eight, the implications of the theory are explored in terms of what it offers to an understanding of five issues: resistance to psychiatric identification, entrapment by unwanted identities, acceptance, self-comparison, and relations between preference and obligation. It is suggested that the theory of *identity commitment* offers distinctive understandings in each of these areas.

In Chapter Nine, the focus is on the worth of the theory. Criteria are identified for evaluating the theory and it is judged to have merits of 'workability' and relevance as well as offer a basis for further research and theoretical development. The thesis concludes on this note.

On matters of terminology and operationalisation

In this study, a number of terms are employed that are open to various interpretations. On this basis, it is worth explicitly operationalising some commonly used terms:

1. **Psychosis**: As the American Psychiatric Association (1994) noted, this term is subject to various formulations. In this current study, it is used to refer to experiences of perceptual- like 'hallucinations'- and interpretive- like 'delusions'- realities that are considered by others unreal and probably outlandish. These experiences are associated with a diagnosis of a functional psychotic illness or a disorder with psychotic features.
2. ***Me***: Self-as-object in the symbolic interactionist sense, especially as employed by Mead (1934) and Strauss (1969).
3. **Self-conception:** Another term for *Me* and consistent with its meaning.
4. **Identity:** Often used interchangeably in the literature with concept of self. In this study, identity is used in the same way as *Me* and 'self-conception'.
5. **Self-relations**: All that persons do in communicating with themselves, feeling about themselves, designating themselves, indicating to themselves, and acting on themselves.

In this chapter, then, self-viability is introduced as a main concern for persons in the context of psychosis. This provides the direction for the grounded theory study which is examined throughout the rest of this thesis.

CHAPTER TWO

CLASSICAL GROUNDED THEORY METHODOLOGY

Introduction

There are a diverse range of accounts on how to do grounded theory research. In addition, these accounts are conflicting and so grounded theory researchers need to establish some clarity about the particular orientation they adopt. Before starting out on a grounded theory research project, or at least early in its development, researchers should be clear about the particular assumptions and approaches they will employ as well as the rationale for their choice.

In this chapter, then, grounded theory methodology is considered in some detail. First, a methodological overview of grounded theory methodology is developed. The origins of the methodology are explored along with the development of various versions of grounded theory research and associated disputes. Second, the current study is aligned with the 'classical version' of grounded theory methodology that is most especially associated with the work of Barney Glaser (Glaser and Strauss 1967, Glaser 1978, 1992, 1998, 2001, 2003, 2005). In the light of this alignment, 'starting out with openness' is examined as a way of initially approaching the study and prior to a detailed account of the conduct of the study that is provided in the next chapter.

Grounded theory research: a methodological overview

Discovery as a founding concept

Discovery is a key concept in grounded theory methodology. In a contemporary context of theoretical debate and epistemological doubt, this claim is controversial and requires justification. But, in the first book on grounded theory methodology, discovery was clearly fundamental to the strategies for research inquiry that Glaser and Strauss (1967) proposed.

Most obviously, the significance of discovery was reflected in the title of the book, *The Discovery of Grounded Theory*. Discovery was also integral to the rationale for a grounded theory methodology. Glaser and Strauss (1967) argued for sociological theory that is relevant and that such theory is more assured when discovered in actual data derived from inquiry into the social world. They contrasted relevant theory with the 'thought up' theories devised by 'great men' of sociology and which sociological researchers were often enlisted to verify. Verificational research, they claimed, often involved forcing data to fit with preconceived theory and this resulted in sociological theory that was divorced from empirical realities.

So, Glaser and Strauss (1967) identified discovery with relevance, preconception with irrelevance. In order to make theoretical discoveries, researchers were directed to combine openness with systematic procedures. Research questions, sources and kinds of data, sites and participants to access, and extant theoretical literature to incorporate were each matters for minimal preconception that should emerge through an ongoing interactive process of

data collection and analysis. The same was true of theoretical categories and their properties as well as relations between categories.

Research should begin with a general topic area or subject, data sourced in keeping with the topic area, incidents (identified in the data) coded into as many categories as possible, and comparisons made between incidents within the same categories to start to develop the theoretical properties of each category. Data collection should subsequently be driven by the need to develop these properties. This should involve 'theoretical sampling' that entails the selection of comparison groups that can assist the development of emerging categories. Data should be collected in relation to each emergent category until the point of 'theoretical saturation'- when no additional data can be found that helps to develop the properties of a category. Analytically, the level of comparisons should progress in ascending conceptual levels. After starting with incident-to-incident comparisons, researchers should shift to incident-to-properties comparisons and category-to-category comparisons. Higher-level categories should be identified, progressively integrated with their properties and in relation to each other.

These procedures, then, were the means to discover theory through analysis of data. Furthermore, grounded theory methodology was itself conceptualised as a theoretical discovery. Glaser and Strauss (1967) presented grounded theory methodology as a theory of research that emerged from their analysis of their own empirical inquiries in the field of dying (Glaser and Strauss 1965, 1968). This point was later made more explicit by Glaser (2003)

who also accounted for grounded theory as emergent from the joining of the University of Chicago symbolic interactionist tradition, represented by Strauss, and his own formative background at the University of Columbia where he was taught sociological theory by Robert Merton and inductive approaches to quantitative analysis by Paul Lazarsfeld on top of which he learned 'explication de text' at the University of Paris (Glaser 1998).

To summarise, discovery was fundamental to the initial statement of grounded theory methodology by Glaser and Strauss (1967). When discovered through systematic analysis of data, theory was more useful than when preconceived and grounded theory procedures were a means to such discovery, procedures that were themselves discovered. If the initial presentation of grounded theory methodology constituted a theory of research then discovery seemed to be the core category, a basic pattern that accounted for 'the action' in research inquiry. To a significant extent, the subsequent history of ideas about grounded theory research was marked by Glaser's efforts to elaborate and defend the logic of discovery and others' attempts to dispute or qualify it.

Theoretical sensitivity

With the encouragement of Strauss, Glaser (1978) subsequently reiterated the key points in *The Discovery of Grounded Theory* and provided more guidance on the procedures of theoretical sampling, coding and writing memos. Significantly, he also more fully developed concepts of theoretical sensitivity and theoretical coding. Essentially, he suggested that openness to discovery is not associated with an 'empty head' but with an informed sense of

theoretical possibility. Researchers require prior theoretical knowledge, not relating to the particular (substantive) area of research inquiry, but a general knowledge of abstract concepts (theoretical codes) that offer a repertoire of options for the integration of categories and their relations. Choice of such codes should reflect best fit with data and emergent categories and, to emphasise a key point, such choice requires prior theoretical learning (Glaser 1978).

The notion of theoretical sensitivity is relevant to debates about grounded theory and acts as a counter to charges of 'naïve inductivism' that were subsequently levelled at Glaser (by Dey 1999, Bryant 2003, Kelle 2005). In actuality, he never viewed the process of discovery as simply a matter of openness to theory that is 'out there'. Instead, he argued for an educated openness, along with systematic procedures, that enables researchers to recognise and explain the patterned regularities of social existence.

In any case, following the publication of *Theoretical Sensitivity* in 1978, Glaser left full-time academic life and it was some time before he added further contributions to the grounded theory methodology literature. In the meantime, the popularity of grounded theory grew beyond the cohorts of nursing and sociology doctoral students that Glaser and Strauss taught in the School of Nursing at University of California San Francisco (for a first-person account of being taught by Glaser and Strauss at UCSF, see Stern and Covan 2001). There were many people, in diverse fields, that attempted grounded theory research without mentorship or training by experienced grounded theorists. Concerns

grew about a tendency for researchers to claim the use of grounded theory methodology when no such use was evident and to confuse the aims of grounded theory with that of other methodologies (Stern 1994).

To counter these erosions of grounded theory and to provide more specific guidance for novice grounded theory researchers, Strauss (1987) wrote a methodology text of his own and one in collaboration with Juliette Corbin, one of his former students (Strauss and Corbin 1990). These publications prompted Glaser's 'comeback' into methodological writing and, from then on, grounded theory became a focus for overt debate and dispute among its own adherents.

The Glaser-Strauss schism

In exploring how to do grounded theory research, Strauss (1987) extensively and approvingly made reference to the work of Glaser (1978). And Strauss presented his own text as an explanation, not a reformulation, of grounded theory methodology. In keeping with pre-established grounded theory terminology, he examined how to do an initial line-by-line analysis of data and open coding. However, he also introduced some new ideas about data analysis and described a process of 'axial coding' using a 'coding paradigm'. This involves an analysis of a pattern relating to a social event or process (identified as a category) in terms of the conditions of its occurrence, interactions among the people involved, the strategies and tactics they employ, and the consequences of the pattern. Through this analysis, Strauss (1987) suggested

that theoretical categories can be developed in terms of sub-categories and relations between them.

In a subsequent book, written by Strauss in collaboration with Corbin and read by a wide audience, these ideas about data analysis were further elaborated and more new terms were employed (Strauss and Corbin 1990). Potential grounded theory researchers were given guidance on how to think about data through, for example, the 'flip flop technique', 'waving the red flag' and making 'far out comparisons'. The 'conditional matrix' was introduced as a tool for representing complexity and the inter-relationships of conditions relating to a particular category. And the notion of axial coding was again given substantial emphasis.

These two books prompted a trenchant critique from Glaser (1992) and a set of 'corrections'. Part of his ire related to intellectual property and a sense that a wrong was committed against him personally. As he saw it, grounded theory methodology was re-written without his consent despite the fact that he was the co-author of the original seminal text. In addition, Glaser viewed this re-writing as almost completely inconsistent with the established principles and procedures of grounded theory methodology. He objected to Strauss' account of open coding in which small data fragments are individually labelled (see Strauss 1987). This, Glaser argued, reflected a misunderstanding of what is meant by 'breaking down' data:

"By breaking down and conceptualizing the data <u>we do not mean</u> taking apart a single observation, sentence, or paragraph, and giving each

discrete incident, idea, or event a conceptual name, which indicates something that stands for or represents a phenomenon. This single incident analysis would end up in a helter skelter of too many categories and properties that yield no analysis: that is that will not pattern, sort or integrate out or are not relevant to an integrated core variable analysis. It would end up in an over-conceptualization of a single incident…..<u>We do mean</u> comparing incident to incident and/or to concepts as the analyst goes through the data. We look for patterns so that a pattern of many incidents can be given a conceptual name as a category, and dissimilar incidents can be given a name as a property of a category, and the compared incidents can be seen as interchangeable indices for the same concept." (Glaser 1992. Pg.40)

Furthermore, Glaser asserted that this process of comparative analysis is compromised when accompanied by the range of preconceived questions that Strauss/Strauss and Corbin recommended. The proper logic of grounded theory is reflected in two formal questions:

"They are: What is the chief concern or problem of the people in the substantive area, and what accounts for most of the variation in processing the problem? And secondly, what category or what property of what category does this incident indicate? One asks these two questions while constantly comparing incident to incident, and coding and analyzing. Soon categories and their properties emerge which fit and work and are of relevance to the processing of the problem. The researcher must have

patience and not force the data out of anxiety and impatience while waiting for the emergent. He must trust that emergence will occur and it will." (Glaser 1992. Pg.4)

On this basis, grounded theory analysts should just 'stick to the data' and use comparative analysis. Glaser (1992) argued that there was no need for axial coding and a coding paradigm:

"In grounded theory <u>we do not</u> link properties and categories in a set of relationships denoting causal conditions, phenomena, context, intervening condition, action/interactional strategies and consequences. This would be preconception and forcing theoretical concepts on data to the max. The grounded theorist simply codes for categories and properties and lets whatever theoretical codes emerge where they may. To use this model out of hand will merely give the appearance of making the analyst think systematically about data and relate them in complex ways. In actuality it teaches the analyst to force a full conceptual description on data with no questions about whether the links are relevant to any emerging theory that really explains how the participants process their main concerns." (Pg.63)

Overall, Glaser (1992) sought to defend the inductive orientation of grounded theory and the openness to discovery that this implies. This openness should be maintained throughout the inquiry process- beginning with a broad interest (rather than preconceived questions) in a substantive area, attending closely to what is in the data and ending with a theory that should be regarded as a set of integrated hypotheses rather than definitive findings. By contrast,

Strauss (1987) argued that it was mistaken to characterise grounded theory as an inductive methodology, that deduction and verification were also important. This toned down view of openness meant that prior theory, especially if grounded theory, can be used to derive research questions and approaches to data collection and analysis. It also meant that preconceived questions were more admissible and that Strauss/Strauss and Corbin were inclined to more definite claims about the reproducibility and verifiability of the theoretical products of grounded theory research.

In brief, then, the degree of emphasis that should be given to openness and discovery was a key element in the emergent differences between Glaser and Strauss on how to do grounded theory research. This issue was also central in subsequent debates.

Theoretical perspectives and grounded theory

Following the Glaser-Strauss schism, there was an increasing diversity of claims about how to do and, more especially, how to view grounded theory research. Many of these claims centred on the question of taking a general theoretical position or perspective prior to the commencement of grounded theory research. Feminism was one such perspective with Wuest and Merritt-Gray (2001) seeking to reconcile feminist praxis and its emancipatory intent with grounded theory methods. MacDonald (2001) sought a similar kind of reconciliation between a critical perspective- informed by a knowledge of structural inequality and power relations- and grounded theory methods. And there were claims that symbolic interactionism was a necessary theoretical

foundation for the practice of grounded theory research (Milliken and Schreiber 2001, Jeon 2004, Clarke 2005).

Dealing with the feminist example, Glaser (2003) suggested that gender should not be assumed as a relevant category and that such an assumption might obscure more relevant and ranging conceptualisations. He made the same point about issues of social structure and power (Glaser 2005). In the case of symbolic interactionism, Glaser (2005) acknowledged the widespread belief that symbolic interactionism is constitutive of grounded theory. He attributed this belief to the influence of Strauss with his symbolic interactionist background and to the preference of a large number of nurse researchers for data drawn from in-depth interviews. Such data, he suggested, is especially amenable to the meanings-oriented perspective of symbolic interactionism but this is only one kind of data. Not all data relates to participants' meanings and grounded theory researchers can make use of a far greater range of theoretical concepts- such as structure, systems, economics- than symbolic interactionism allows. Furthermore, he pointed out that symbolic interactionism was just one influence on the development of grounded theory methodology alongside his own background in survey research analysis and theoretical training provided by Merton.

For Glaser (2003, 2005), then, no theoretical perspective should be privileged prior to the commencement of a grounded theory study. He argued that theoretical concepts need to 'earn their way' into a grounded theory

analysis, that their relevance needs to emerge from such analysis. Grounded theory, he suggested, is a general method and free of any particular perspective: **"GT is just a relatively simple inductive model that can be used on any data type and with any theoretical perspective. It is just a general inductive model, or paradigm, if you will, that is sufficiently general to be used at will by any researcher in any field, any department and any data type. No one theoretical perspective can possess it."** (Glaser 2005. Pg.144)

So, not for the first time, Glaser reacted against any suggestion that theoretical preconception should precede grounded theory research and he sought to preserve an emphasis on discovery. But the very idea of discovery came under critical scrutiny from advocates of reflexive research and a new variant of grounded theory, constructivist grounded theory.

Reflexivity and constructivist grounded theory

There were critics who associated the idea of discovery in grounded theory with an epistemology that is outdated and indefensible. Glaser, in particular, was criticised for his assumption that it was possible to be free of preconceptions and to begin research from a position of 'not knowing'. This was characterised as 'naïve inductivism' by a number of authors who argued that such a stance is not tenable (Dey 1999, Bryant 2003, Kelle 2005). Researchers, it was reasoned, cannot get away from the fact that they 'already know things' and this prior knowing inevitably influences every aspect of their inquiry.

Furthermore, several authors argued that reality is not 'simply discovered' but actively constructed and that researchers are therefore necessarily implicated in the making and interpretation of data (Charmaz 1994, 2003, 2006, Hall and Callery 2001, Clarke 2005). In other words, it was argued that researchers cannot be detached observer/analysts that find out what is going on 'out there'. Glaser, and to a lesser extent Strauss and Corbin, were accused of assuming such detachment and thereby overlooking the role of researchers in the making of research.

To correct this assumption of detachment, Hall and Callery (2001) advocated a reflexive approach to grounded theory research. Researchers, they suggested, should examine the ways in which their own perspectives play a significant role in every aspect of their inquiries. This point was echoed by Charmaz (2003, 2006) who proclaimed a new variant of grounded theory that she called 'constructivist grounded theory' although she did previously use the term 'social constructionist grounded theory' (Charmaz 1994). She did not appear to discern a significant distinction between these two terms and it is certainly common to see them regarded as equivalent by authors in the literature of grounded theory (Hall and Callery 2001, Bryant 2003) and social theory more generally (Ravn 1991, Schwandt 2003). However, Gergen and Gergen (1991) pointed out that social constructionism and constructivism are separate theoretical traditions- the latter being concerned with the cognitive processing of individuals and the former with the creation of social meanings, especially through language. This distinction seems reasonable on the basis of any reading

of literature that is explicitly social constructionist (for example, Berger and Luckmann 1971, Burr 1995) or avowedly constructivist (see Bannister and Fransella 1986, von Glasersfeld 1988, 1991).

Hence, there is potential for confusion in the name of constructivist grounded theory. However, the extent to which Charmaz (2003, 2006) offers useful additions to the literature of grounded theory methodology is perhaps a more consequential issue. To a significant degree, much of her work relies on a distinction that she drew between 'objectivist' and constructivist grounded theory, between Glaser's ideas (and to a lesser extent those of Strauss/Strauss and Corbin) and her own. Objectivist grounded theory involves an assumption that meaning is inherent in data and discoverable:

"In this approach, the conceptual sense the grounded theorist makes of data derives from them; meaning inheres in the data and the grounded theorist discovers it...This view assumes an external reality awaiting discovery and an unbiased observer who records facts about it." (Charmaz 2006. Pg.131)

By contrast, constructivist grounded theory attends to how and why participants construct meanings in particular situations and it involves reflexivity on the part of researchers:

"A constructivist approach means more than looking at how individuals view their situations. It not only theorizes the interpretive work that research participants do, but also acknowledges that the resulting theory is

an interpretation...The theory depends on the researcher's view; it does not and cannot stand outside of it." (Charmaz 2006. Pg.130)

Glaser (2003) responded to these ideas and argued that there is indeed a "conceptual reality" that exists independently of researchers:

"Conceptual reality DOES EXIST. For example, client control is real; cautionary control is real; social structural covering is real. These processes and a myriad of others discovered in GT research, impinge on us every day. Just go to the doctor, drive a car or go into surgery and/or take on the Catholic Church and the reader will see the reality of these researches and apply the conceptually, generated theory." (Pg.175)

Furthermore, he argued that such conceptual realities- latent patterns in social life- are discoverable by researchers (albeit provisionally). These discoveries are rendered objective by constantly comparing data from a range of sources and participants so that the idiosyncratic constructions of researchers are 'patterned out' (Glaser 2003). On this basis, he dismissed constructivist grounded theory as a misnomer.

In explicitly dealing with the subject of reflexivity, Glaser (2001) was characteristically direct in describing 'reflexive paralysis':

"What happens is that the researchers……examine extensively and intensively themselves, their participants, the research is a struggle to locate themselves and their subjects in reflexive texts. This generates a crisis in representation in the description. They do not "go" with the data. They are so intent on critiqueing themselves and the data they collect,

using rhetorical concepts such as interpretation, constructionism, ethnographic field, spoken interaction, differential perspectives, etc. It is hard to cut through the jargon to know what is actually going on in a substantive area. It is paralyzing, self-destructive and stifling of productivity. It is an evidentiary block to good findings and ideas." (Pg.47) Such reflexivity, he argued, is irrelevant to generating categories and their properties, constant comparisons and the achievement of an abstract, conceptual level.

On the face of it, then, grounded theory researchers face a clear choice between the objectivism associated with Glaser's work and the constructivism of Charmaz (2003, 2006). This choice (which is actually poorly framed) is explored in a subsequent section but first one more proposed variant of grounded theory methodology is explored for the sake of complete coverage.

Postmodern grounded theory

Associated with the constructionist tradition mentioned in the previous section, some authors argued for a postmodern version of grounded theory. MacDonald and Schreiber (2001) asserted that the world has changed in the time since the development of grounded theory methodology. Grounded theory research, as done by Glaser and Strauss, was part of a realist tradition associated with the idea that there is a real world that can be studied and understood. But, MacDonald and Schreiber (2001) suggested, this tradition is outdated in the contemporary 'postmodern landscape' associated with scepticism of grand narratives, a lack of firm ground for truth claims, relativist

perspectives on knowledge, and focus on the local and situational rather than the universal and abstract. To be relevant in this context, they argued, grounded theory researchers need to abandon the rhetoric of discovery, jettison a correspondence view of knowledge (which they attributed to Glaser), recognise that truth is constructed without firm foundation and focus on the local rather than the general.

Taking these ideas forward, Clarke (2005) presented a view of grounded theory 'after the postmodern turn'. She is an ex-student and colleague of Strauss and pointed out that grounded theory methodology was always oriented to processes, contingencies, negotiations, relationality, arenas and social worlds. To this extent, she argued that grounded theory methodology is 'already around' the postmodern turn. However, she argued that grounded theorists' traditional neglect of reflexivity, over-simplifications in the direction of coherence and commonality, lack of attention to difference and incoherence means that grounded theory is also 'recalcitrant against' this postmodern turn. On this basis, she proposed a version of grounded theory that more fully incorporates postmodern notions:

"My argument is that we need to conceptually replace modernist unidimensional normal curves with postmodern multidimensional mappings in order to represent lived situations and the variety of positionalities and human and nonhuman activities and discourses within them...This alternative seeks not to frame a 'basic social process' or even processes but to draw maps. The goal is to understand, make known, and

represent the heterogeneity of positions taken in the situation under study and/or within given (historical and/or visual and/or narrative) discourses in that situation." (Pg.25)

For Clarke (2005), postmodern grounded theory research involves theorising but not producing theory because it makes no sense to make theories about situations that are always changing. In other words, she rejects the possibility of theories that are abstract of time, place and person and takes this rejection to its logical extreme. And this involves doing grounded theory without producing theory. This raises the question of the appropriate uses of a name. Surely it is misleading to characterise research inquiry as grounded theory if no actual theory is produced.

In any case, in relation to the current study and in the light of the foregoing arguments, it is the 'classical' version of grounded theory methodology that was employed. And this meant 'starting out with openness' in line with the recommendations of Glaser (1978, 1992, 1998). But these recommendations first needed to be understood.

Starting out with openness

Not knowing

For Glaser (1992), one aspect of starting out with openness is to "just not know" (Pg.50) prior to commencing data analysis. Now, there is potential for different understandings of a 'not knowing' position. As mentioned previously, some authors took this idea to quite literally mean not knowing anything and thereby considered it naïve or even absurd (Dey 1999, Kelle

2005). From this perspective, ‘not knowing’ is impossible because observation is necessarily a theory-laden activity. In processes of observation, persons employ concepts they already learned and this shapes ‘what they see’. On this basis, it is argued that knowledge cannot be inductively generated.

Yet, it can equally be argued that nothing new is learned when persons process information only to confirm what they already know. Interestingly, constructivist psychology involves an emphasis on the self-confirming ways that people cognitively process information and defend concepts and theories they found useful in the past (von Glasersfeld 1988). This is an overlooked aspect of the theoretical tradition that advocates of constructivist grounded theory, like Charmaz (2003, 2006) and Bryant (2003), invoke. Constructivism is open to the charge of psychological conservatism in which people are trapped inside their own subjectivity and what Gergen and Gergen (1991. Pg.79) called “an infinite regress of cognitive dispositions.”

However, it seems plausible to suggest that observation and interpretation are neither completely free of prior theoretical influence nor entirely trapped inside it. Openness is a question of degree and there are measures that can be taken to increase and optimise it. One measure involves a belief in discovery- in the possibility of finding things out that are not known beforehand and a commitment to realising this possibility. Another measure involves de-emphasising what is already known in favour of what is not known. In my own case, I have nearly twenty five years of experience of meeting persons that experience psychosis and I am relatively well read in this field. So

I do know something. But I know very little next to persons that are living through psychosis and, if I wanted to develop a theory that is relevant to such persons, then I needed to begin with their perspectives and inquiry into their concerns. I should cultivate an open mind, begin with open questions and initially analyse data in terms of open theoretical possibilities.

This is how I understood Glaser's injunction to ' to just not know' when getting started on grounded theory research (Glaser 1992). There is nothing naïve about this injunction: it is a practical, reasoned and deliberate strategy for discovery. Part of this strategy also involves a particular position in relation to theoretical perspectives that are often associated with research.

Refusal of an initial overarching theoretical perspective

A number of authors locate grounded theory within particular theoretical perspectives and some use these perspectives to distinguish and judge various approaches to grounded theory research. Often, longer established approaches to grounded theory, especially those associated with Glaser, are considered 'realist' (MacDonald and Schreiber 2001), 'positivist' and 'objectivist' (Charmaz 2003, 2006). These theoretical labels are typically depicted as outdated and indefensible in contrast with newer, contemporary theoretical perspectives like postmodernism (MacDonald and Schreiber 2001, Clarke 2005) and constructivism (Bryant 2003, Charmaz 2003, 2006).

However, these attempts to dichotomise realist and postmodern, objectivist and constructivist, grounded theory are actually unconvincing. For one thing, they are premised on a criticism of Glaser that he accepts data as a

straightforward reflection of social reality (MacDonald and Schreiber 2001, Bryant 2003, Charmaz 2003). But this is simply inaccurate. On a number of occasions, Glaser (1998, 2001, 2003, 2005) emphasised that there are different kinds of data and a task of analysis involves working out what kind of data is at hand. He explicitly acknowledged that data may be co-constructed with researchers but also argued that data can be a more straightforward reflection of participants' realities (Glaser 2003). In other words, Glaser's dictum was that it 'all depends' and:

"Whether GT takes on the mantle for the moment of prepositivist, positivist, postpositivist, postmodernism, naturalism, realism etc, will be dependent on its application to the type of data in a specific research." (Glaser 2005. Pg.145)

Each of these theoretical perspectives may, then, be relevant to grounded theory research but do not shape or determine it. Like other theoretical concepts, their relevance is not assumed but instead needs to be earned.

So to begin a project from a 'not knowing' perspective does not involve a commitment to, or rejection of, a particular theoretical perspective. Instead, it implies openness to a variety of theoretical perspectives that can be employed as and when it is useful. This kind of flexibility is consistent with the notion of theoretical sensitivity that was emphasised by Glaser (1978) a long time ago. However, it is inconsistent with a certain orthodoxy in qualitative methodology- especially associated with the work of Crotty (1998)- which suggests an approach to research design in which epistemology, theoretical perspective,

methodology and methods should each be arranged in a preconceived ‘fit’. Yet, even outside of classical grounded theory methodology, this orthodoxy is challenged. Seale (1999), in particular, argued that epistemological and methodological disputes should not encourage researchers to entrench themselves in particular epistemological positions. Rather, they should recognise that various positions offer insights and ways of thinking that are potentially useful to the practical conduct of research.

In this light, the case for distinctively postmodern or constructivist grounded theory is substantially weakened. Classical grounded theory is not out of date and not founded on any particular epistemological position. Furthermore, it implies no rejection of postmodernism or constructivism- they are potentially useful perspectives amongst others. In other words, classical grounded theory is not the adversary that is imagined by those who advocate a commitment to postmodern (in the case of MacDonald and Schreiber 2001, Clarke 2005) or constructivist (in the case of Bryant 2003, Charmaz 2003, 2006) grounded theory. Yet without this imagined adversary, this nonexistent Other, it is difficult for constructivist or postmodern grounded theory methodologists to distinguish themselves. Rather than responding to the genuine challenge posed by openness and flexibility, there is probably more appeal in depicting oneself as a champion in a fight against positivism and objectivism - those perennial ‘reds under the bed’ in qualitative methodology literature.

The credibility of a dichotomised typology of grounded theory methodologies is further undermined by reference to actual research. In comparing grounded theory research involving Glaser (Glaser and Strauss 1965, Glaser and Strauss 1968, Glaser 1972) and Charmaz (1983, 1991, 1997), there are certainly differences. Charmaz showed a preference for greater levels of detail and evocation relating to participants' experiences and this was a focus for criticism by Glaser (2003). He argued that she preferred story-telling over conceptual abstraction and that "she gives but a nod to pure GT by some conceptual description" (Pg.178). Whatever about these differences between the two authors, their work suggests no clear distinction between a so-called objectivist and constructivist epistemology. Charmaz appears no less confident in her claims about social realities and no more reflexive than Glaser.

Given that the actual research of the leading advocate of constructivist grounded theory does not appear epistemologically distinct from the classical version she criticised on an epistemological basis, there seems little reason to follow her recommendation of preconceived commitment to constructivism. It seems more reasonable to follow Glaser's injunction to just get on and do grounded theory research (Glaser 1998, 2001).

So, in the early stages of the current study, there was no deliberate prior alignment with epistemologies (like realism or constructionism) or theoretical perspectives (like symbolic interactionism or post-positivism). Instead, these perspectives were regarded as potential resources to be employed as and when they could assist a viable understanding of data. This position on overarching

theoretical perspectives is consistent with the initial ‘not knowing’ stance recommended by Glaser (1992). The initial use of theoretical literature was also consistent with this stance.

Using the literature

The uses of theoretical literature are a focus for debate in grounded theory texts. Glaser (1992) suggested an avoidance of theoretical literature, relating to the substantive area of research, prior to the commencement of data collection. However, Morse (2001) criticised this idea:

"Such a naive perspective as working without consulting the literature may be possible for a senior investigator with a vast knowledge of social science theory with many concepts at his or her fingertips and with real theoretical wisdom. However, ignoring the literature is a strategy that is fraught with danger for a new investigator. Literature should not be ignored but rather "bracketed" and used for comparison with emerging categories. Without a theoretical context to draw on, new investigators find themselves rapidly mired in data- the very state that Glaser himself warns against." (Pg.9)

She went on to argue that the licence to ignore the work of others is destructive to building knowledge and undermines the potential for theoretical cohesion between studies. However, Glaser never suggested that anyone should ignore the work of others. Instead, he warned against pre-forming research by reference to the theoretical work of others (Glaser 1978). Once data analysis is underway and a core category is emergent, Glaser (1978, 1992) suggested that

relevant theoretical literature should then be incorporated into analysis. The theories of others can help to refine the analysis, point the way to further data collection and should be incorporated into the written grounded theory. So the theoretical literature, relating to the substantive area of research, should not be ignored but deferred.

Furthermore, Glaser did not direct against prior reading before the commencement of research, only the prior reading of substantive theoretical literature. He considered other kinds of prior reading as useful. General theory was identified as useful as a source of theoretical sensitivity and ethnographies, autobiographies, and official documents as potential sources of data (Glaser 1992).

It is on this basis that the current thesis does not reflect the conventional format in which a review of theoretical and research literature is employed as a background to, and justification for, the research aims or questions. Instead, some relevant literature is employed in Chapter One to set out the 'main concern' to which the subsequent grounded theory is directed, in Chapter Four as part of an introduction to the 'core category', and in Chapter Eight in exploring the theory of *identity commitment* and its implications.

In summary, this chapter provides an overview of grounded theory methodology and a rationale for the choice of the classical version which was used to guide the conduct of the current study. 'Starting out with openness' is explored as a basis for a detailed account of data collection and analysis in the next chapter.

CHAPTER THREE

'DOING GROUNDED THEORY'

Introduction

On occasion, Glaser (1998, 2001) suggested there is too much emphasis on debating grounded theory methodology. Instead, he argued that many persons would do better to read the methodology books and then 'just get on and do it'. In this chapter, then, an account is provided of the conduct of the current study: of how it was done.

First, the aim of the study is identified and predicated on a 'main concern' with self-viability in the context of psychosis. Second, aspects of data collection are examined and these include how participants were recruited for interviews, the profile of interviewees, the interview process, how interviews were recorded, autobiographies as a data source, and theoretical sampling. Third, methods of data analysis are explicated with particular reference to the use of computer software, open coding, memoing, selective coding, theoretical coding and theoretical saturation. Finally, some ethical considerations are considered. Specifically, issues of consent, confidentiality, anonymity and 'doing no harm' are explored.

Aim of the study

As mentioned in Chapter One, persons experience troubling self-relations in the context of psychosis and so they are concerned by how they live with themselves. The aim of the current study was to generate a grounded theory of how persons deal with or resolve this concern for self-viability. Put

another way, the aim of the study was to theorise how persons ‘get along with themselves’ in the context of psychosis.

This aim was emergent from initial data collection and analysis. Through analysis of data from initial interviews with participants, their ‘main concern’ with self-viability was identified and this clarified the theoretical focus of the study. This is consistent with the inductive orientation of grounded theory research and with the guidance of Glaser (1998) whereby inquiry should begin with an area of interest then proceed to an understanding of the main concern of persons in that area:

"Grounded theory accounts for the action in a substantive area. In order to accomplish this goal grounded theory tries to understand the action in a substantive area from the point of view of the actors involved. This understanding revolves around the main concern of the participants whose behavior continually resolves their concern. Their continual resolving is the core variable. It is the prime mover of most of the behavior seen and talked about in a substantive area. It is what is going on! It emerges as the overriding pattern." (Pg.115)

The current study began with my interest in how persons endure and survive in the context of psychosis. It was on this basis that persons were recruited to involvement in the study once issues of access and ethical approval were negotiated. But, once the aforementioned main concern was identified and the purpose of the study was clarified, subsequent data collection and analysis

was directed by the need to conceptualise how persons get along with themselves in the context of psychosis.

Data collection

Access, recruitment and profile of interviewees

Along with published autobiographical materials, interviews were a principal source of data. Interview participants were all recruited through a mental healthcare organisation in North Dublin. Ethical approval for the study was received from research ethics committees in Dublin City University and in a hospital that formed part of the aforementioned mental healthcare organisation. A recruitment leaflet (see Appendix One) was circulated to professionals within this organisation who made it available to persons who might participate. Where persons were interested in possible participation, they signalled their interest to a nurse or psychiatrist. In turn, I was informed by the relevant professional and I then contacted potential interviewees with a view to discussing their involvement and addressing questions of consent.

In this way, eighteen persons were recruited to involvement in the study and the participants were each:

- diagnosed with schizophrenia (fourteen persons) or bipolar affective disorder (four persons) that incorporated past experiences of 'manic psychosis';
- living in a community setting (fifteen in their own homes, two in a hostel for homeless people and one in a nursing home);

- admitted to an in-patient psychiatric facility on at least two occasions in the past;
- current service users in community mental healthcare.

Thirteen of the participants are men and five are women. In age, they range between 29 and 67 years old although most are in their forties. Six have some history of substance misuse (two principally relating to alcohol and four to illicit drugs), two have served prison sentences and two were once in-patients in the Central Mental Hospital (a forensic facility). Three of the participants are married and live with their wife or husband whilst one is widowed.

The interview process

As part of 'doing' this project, I kept methodological memos (memos are discussed in more detail in a subsequent section). Interviewing was one focus for these memos and, through memoing, I progressively developed a perspective on the interview process and my role within it. Indeed, what follows in this section is an edited version of those memos.

One issue in the interview process was emotional distress. Persons talked about events and experiences- such as hospitalisation and immersion in psychosis- that were of negative emotional significance. In talking about these events and experiences, there was potential for the interview to be a distressing experience and, for four of the participants, this potential was actualised to some degree. These participants are discussed in more detail in a subsequent section on ethical considerations. For now, it suffices to point out that, as an interviewer, I tried to be sensitive and responsive to the possibility of interview-

related distress. I observed for any signs of such distress and asked participants if they wanted to continue when it was evident. Before the interviews ended, I checked out how they were experienced by participants and whether there were likely to be negative emotional consequences. I was ready to offset these consequences with my own input, if this was possible or necessary, or to explore any relevant follow-up actions.

Linking to this issue of distress, I assumed that persons are more comfortable and less threatened in situations where they feel respected, valued and others are making an effort to understand them. In such situations, persons talk more openly and freely and may positively experience the opportunity to 'be heard'. I tried to contribute to the likelihood of this kind of situation and to build rapport with interviewees, remain relatively relaxed, maintain awareness of pace and flow, listen more than talk, enable more than push or force and sensitively attend to the emotionality of interviewees.

These aspirations, as an interviewer, carried implications for my degree of involvement in the interviews. There are different perspectives on this issue in the literature of qualitative interviewing. Holstein and Gubrium (1995) suggested that interviewers should deliberately 'activate' various interviewee perspectives and invite responses from different standpoints. However, I agree with Wengraf (2001) that this approach runs a considerable risk of being experienced as authoritarian or forced by interviewees. This means that interviewees may feel unheard, somewhat disregarded and that their central concerns are overlooked by interviewers. Such a possibility is antithetical to

grounded theory methodology with its focus on the perspectives of the researched and attempts to minimise forcing of data through the preconceptions of researchers (Glaser 1992). Hence, I rejected 'active interviewing' as potentially over-active.

On the other hand, I wanted to avoid 'under-active' interviewing. Wengraf's account of the Biographical Narrative Interviewing Method (BNIM) sets out strict directions on an initial interview in which interviewers are admonished to ask a broad question about interviewees' lives and to take an absolutely minimal role from then on (Wengraf 2001). To the greatest extent possible, interviewers are supposed to only listen and not talk. Judiciously used, interviewer silence can encourage interviewees to talk about things as they see them. But dogmatically used, such silence can make interviewers seem detached and interviewees unduly uncomfortable.

Hence, I chose a stance that lies between the extremes of active interviewing and the free association of initial interviews in BNIM. I tended toward a lesser degree of interviewer direction but needed to incorporate enough involvement to promote engagement and interviewee comfort.

Furthermore, I wanted to explore the perspectives of the interviewees. From a grounded theory point of view, interviewing involves inquiry into participants' main concerns and how they process them (Glaser 1992). So I was primarily interested in interviewees' perspectives as a basis for the whole study. My role, as an interviewer, was to try to 'get at' these perspectives and I reckoned that it is possible, more or less, to do this through interviewing. This

did not mean that I disregarded my own participation in the interviews and role in the construction of data. As I stated in the previous section, co-constructed data is of potential significance. But data can be more or less co-constructed and I reject the view of many authors that interview data is necessarily defined by its co-construction (Jorgenson 1991, Holstein and Gubrium 1995, Ellis and Berger 2003). Persons can be encouraged, and some need no encouragement, to talk about what is of most concern to them. It may be as (relatively) simple as that.

In any case, as a grounded theory interviewer, my interest was more in the participants than myself. In a sense, I sought to minimise me so that I could maximise them. I asked broad, open questions and then looked for specific detail in the wake of interviewees' answers. Following Glaser (1992), I did not ask direct questions that reflect preconceived concepts but instead explored interviewees' answers to open questions. Even as I theoretically sampled and refined my categories, I kept my initial questions general with a view to prompting exploration.

Finally, there is the question of interview guides. Initially, I used an interview guide designed for inquiry into processes of survival and enduring (see Appendix Two). For Glaser (2001), however, interview guides shift in line with the direction of emergent theory and with that of theoretical sampling. After the first four interviews, then, I developed a different guide reflecting categories that were emergent in my data analysis (see Appendix Three). For example, I became interested in the relationship between self and a language of

mental illness. As the study progressed, I continued to adjust the interview guide to assist the development and refinement of theoretical categories in ongoing data analysis.

Another issue was how to record the interviews and this is explored in the next section.

Transcripts, audio recordings and session notes

In qualitative research practice, it is conventional to audio-record and fully transcribe interviews. This is associated with thoroughness, a commitment to accurately capture the full details of people's talk. Indeed, some methods- such as conversation analysis and BNIM- involve a heavy emphasis on such thoroughness (Perakyla 1997, Silverman 2000, Wengraf 2001). But, in the grounded theory methodology literature, there is some debate over this issue of audio-recording and transcribing.

Glaser (1998) opposed audio-recording and transcribing of interviews. He argued that transcribing is time consuming and inhibits the speed of grounded theory research. For Glaser, data collection should be quickly followed by analysis and further data collection guided by theoretical sampling. Such theoretical sampling is 'delimiting' and it involves a focus on particular categories: on whether they continue to 'pattern out' in subsequent data analysis, the variations in such patterns and their relations to other categories. On this basis, Glaser (1998) was concerned that transcripts are comprised of a heavy volume of data, much of which proves irrelevant. In other words, he believed that transcripts provide a poor return on an investment of analytic

time. His preference was for extensive session notes that were quickly completed and analysed after interviews.

In response, Morse (2001) expressed her surprise at Glaser's position because it undermined the notion of 'grounding'. She worried that, without audio-recording and transcripts, it is not really possible to make much use of direct quotes, the actual words of participants. And she associated such quotes with the notion of grounding in data. For Morse, it is through analysis of quotes that concepts are developed and through reference to quotes that the 'groundedness', and therefore legitimacy, of such concepts is demonstrated. But, there are some difficulties with Morse's position.

Some of these difficulties are pointed out by Stern and Covan (2001) who wrote a chapter in the same book that Morse made the aforementioned comments. They robustly countered her argument:

"With the invasion of technology, investigators have not only come to rely on its use but also consider avoiding its use as heresy. Morse (this volume), for example, seems aghast that Glaser advises researchers that using a tape recorder allows one to collect and then analyze meaningless data. While it is true that when one has an inexperienced research assistant, tape recording may be necessary, but anyone who has plowed through pages of irrelevant transcribed data must agree with Glaser. Is Morse suggesting that generations of researchers who lived prior to electronic equipment created theoretical frameworks that were weakened because a word or two might be skipped? Is the issue one of trust or of verification? We can only

speculate, but our collective heritage suggests that recording every word informants utter is not necessary in producing sound grounded theory." (Pg.28)

Perhaps the language used here is a little hyperbolic but some important points are made. In relation to the "collective heritage" of grounded theory research, the first landmark studies by Glaser and Strauss (1965, 1968) involved no use of direct quotations by participants. Their data were primarily constituted in field notes that were written following observation of particular situations. In analysing these notes, they identified incidents- such as a particular interaction between a nurse and a patient- that they compared with other incidents. Through such comparison, they were able to identify patterns that they named as concepts. None of this required direct quotes or transcripts. And their concepts were grounded in the sense that they were emergent from data pertaining to observed events in the social world.

So, if it is accepted that the founders of grounded theory research knew how to do it, it is not necessary to predicate conceptualisation upon transcripts-as-data. However, it might be argued that the aforementioned Glaser and Strauss studies consisted primarily of observational data and that interview-based data needs to be regarded differently. Certainly, it is true that interviewing, at least when set up as a primary method of data collection, is different from observation of an everyday social setting or situation. Yet, in an interview, participants can account for their experiences of such settings or situations and can describe particular significant incidents. To regard these

incidents as correspondent with what actually happened or as constructions of what happened is a matter for the grounded theory analyst but a key point is that such incidents can be conceptualised whether they are identified in transcripts or session notes- whether they are exactly in the words of participants or the summarising words of researchers.

In addition, people do things within an interview situation. They talk, think, feel, react, relate, and so on. Hence, the interview situation is itself a source of incidents to be compared and conceptualised. But again there is no necessity for transcripts. These incidents can be detailed and identified in session notes and then conceptualised in data analysis.

However, there is an important counter-argument here. Session notes may be sufficient for the purposes of conceptualisation but transcripts offer greater possibilities for coverage and for ensuring that something important is not missed in data analysis. But, the comparative orientation of grounded theory research is relevant here. For one thing, as Glaser (1998) observed, immediately written session notes allow for immediate analysis and speedy movement into further data collection guided by that analysis. In this way, in a given time, it is possible to derive data from a greater range and number of cases than is possible with the more time-consuming transcribing approach. So, transcribing may offer the advantage of coverage within a particular interview but at the cost of coverage across interviews. Yet there is likely to be more variation between cases than within cases, between the interview accounts of different participants

than within the account of a particular participant. In other words, a speedier approach offers more efficient opportunity for comparative analysis.

Nonetheless, this still does not completely banish the worrisome possibility of missing something important. Unless this possibility is fully addressed then a decision to eschew transcription cannot be adequately justified. Yet there is an argument still to be considered. As mentioned repeatedly already, grounded theory analysis is essentially the conceptualisation of patterns. By definition, patterns recur and significant patterns recur a lot. Once these patterns are conceptualised by reference to a number of incidents, such incidents are considered indicators of a concept (Glaser 1978). According to Glaser (1998), these indicators should be interchangeable which means that a concept is grounded in the analysis of a number of incidents and can be illustrated by reference to different incidents.

It is in this light that the worrisome possibility of 'missing something' needs to be considered. Taking the example of interview data, it is conceivable that grounded theory analysts miss opportunities to identify patterns in data analysis through reliance on session notes and through eschewing transcription. But given the necessarily recurrent nature of patterns, analysts will identify them at some point. They conceptualise these patterns as categories and properties of categories and direct further inquiry into such categories and properties through theoretical sampling. This inquiry continues until theoretical categories are fully understood in terms of properties, variations and relations to other categories.

In the context of interviewing, all of this implies that grounded theory researchers do not have to capture every detail of every interview. They do not need to transcribe every word spoken in an interview just in case they miss something of analytic significance. But they do need to compile session notes that are sufficiently detailed to permit proper analysis and to follow the logic of grounded theory inquiry which ensures that conceptualisations are both relevant and thoroughly developed.

Yet, there is still one last point to examine in relation to the issue of transcribing. Returning to Morse (2001), and as already mentioned, she argued that direct quotations have a legitimating role in the presentation of grounded theory research. She appeared to assume that direct quotations are required in order to render theoretical concepts believable. This reflects a tendency, in qualitative research more generally, to attach a special status to the actual words of participants. It is commonplace to find qualitative research publications in which excerpts from what participants actually said in interviews are presented in such a way as to lend weight to the claims of researchers about a particular essential experience or theme. Often, it is as if such excerpts validate these claims. And if the validating role of direct quotations is accepted then transcribed interview data is clearly essential to the employment of such quotations.

However, the validating function of direct quotations requires some examination. Silverman (2000) pointed out the dangers of ‘anecdotalism’ in qualitative research writing where direct quotations are selectively employed to

support whatever points authors want to make. In other words, direct quotations can form part of a writing strategy, a rhetorical approach, designed to make claims credible and cannot be taken as straightforward evidence for such claims. This is part of the reason for the development of a range of strategies- such as visual displays that reflect full ranges of data (Miles and Huberman 1994), 'member checks' and 'audit trails' (Lincoln and Guba 1999)- designed to assure readers that particular qualitative research findings are generated out of rigorous data collection and analysis and are therefore trustworthy.

Hence, methodologists are aware of the limitations of direct quotations in validating the claims of qualitative researchers. In reflecting this kind of awareness, Glaser (2003) distinguished between illustrations and evidence. Grounded theory writing, he suggested, involves explanations of theoretical concepts, and their relations, that are assisted through illustrations. These illustrations are incidents that are indicative of concepts but do not validate or verify them. This raises the question of how grounded theory research should be judged but this, along with the aforementioned issue of trustworthiness, is explored in Chapter Nine as part of an evaluation of the current study. For now, it suffices to note that the quality of grounded theory research is not predicated upon the use of transcribed interview data and direct quotations.

Bringing all of this into my own research project, I digitally recorded and transcribed the first four interviews. From then on, I still digitally recorded the interviews but refrained from full transcriptions. Instead, I kept rough notes during the interviews and then more fully typed them up afterwards. These

notes contained all that I could recall about what was said and what happened during an interview as well as my initial reflections. Subsequently, I listened to the digital recordings and made additions to the session notes. This made it possible for me to analyse data (for the first time at least) within a day of the interview from which it was generated. This allowed for the possibility of theoretical sampling (shortly to be considered) and for an ongoing relation between data collection and analysis.

However, interviews were not the only source of data in this study.

Published autobiographical accounts

As well as interviews, published autobiographical accounts were a source of data. In particular, the following books were employed and they were each written by persons with some kind of direct experience of psychosis:

- Bassman, R (2007) *A Fight to Be: A psychologist's experience from both sides of the locked door* Tantamount Press, Albany
- Behrman, D (2002) *Electroboy: A memoir of mania* Random House, New York
- Boyles, D (2004) *My Punished Mind: A memoir of psychosis* iUniverse Inc., New York
- Jamison, K (1996) *An Unquiet Mind: A memoir of moods and madness* Picador, London
- Millett, K (2000) *The Loony Bin Trip* University of Illinois Press, Urbana

- Saks, E R (2007) *The Centre Cannot Hold: A memoir of my schizophrenia* Virago, London
- Schiller, L and Bennett, A (1994) *The Quiet Room: A journey out of the torment of madness* Warner Books, New York
- Scott, A (2002) *Is That Me?My life with schizophrenia* A&A Farmar, Dublin
- Snyder, K (2007) *Me, Myself and Them: A firsthand account of one young person's experience with schizophrenia* Oxford University Press, New York
- Steele, K and Berman, C (2001) *The Day the Voices Stopped: A memoir of madness and hope* Basic Books, New York
- Vonnegut, M (2002) *The Eden Express: A memoir of insanity* Seven Stories Press, New York

These books provided opportunities for analysis of variation in theoretical categories that were emergent from data analysis, for refinement of those categories and for suggesting further possibilities for data collection. In other words, they were important as part of the theoretical sampling strategy that was adopted for the study.

Theoretical sampling

Theoretical sampling is a procedure that is integral to grounded theory methodology. This involves decisions about participants and sites to access on the basis of the development of theoretical categories. Once a category is emergent through data analysis, its properties and their relations need to be

elaborated. Subsequent data collection is guided by this purpose and continues until no new data are found that can contribute to further elaboration and refinement of the particular category. This is the point of 'theoretical saturation' in classical grounded theory parlance (Glaser and Strauss 1967, Glaser 1978, 1998).

In this study, I was able to follow the logic of theoretical sampling to the extent that my inquiries were directed by ongoing data analysis. For example, in Chapter Six, I present a category called *contesting identity with others*. In developing this category, I asked mental healthcare professionals to think of anyone who had resisted psychiatric involvement and I also sought out and found autobiographical literature that proved useful in further analysis. In this way, I was better able to account for variations in the outcome of *contesting identity with others*. Furthermore, I thought of theoretical sampling as a 'backward' as well as a 'forward' strategy. When I identified a category, I went back to session notes from previous interviews and notes from autobiographies already read. Usually, I was able to identify incidents in this previously accumulated data that helped in the further development of a category.

Data analysis

The limits of computer-assistance

In qualitative methodology, there is considerable interest in the uses of computer programmes for data storage, retrieval and analysis (for example, see Richards 1999, Coffey et al. 1999). Responding to this trend, Glaser (2003) was unimpressed by the potential for computerised assistance of grounded theory

research. For one thing, he argued that the computerised capacity to organise and manage very large amounts of data is not really relevant to grounded theory inquiry. This is because there is no potential for 'data overwhelm' if grounded theory procedures are properly applied. These procedures are 'delimiting' which means they are directed by the conceptualisation of patterns rather than exhaustive details of every case. Furthermore, computers cannot facilitate the flexibility and pace required in grounded theory data analysis:

"Theoretical sampling, a form of delimiting, keeps changing the data. Going from open to selective coding changes code naming of categories. This cumulative buildup keeps growing and outrunning computerization. Clearly computerization blocks this cycling of GT procedures." (Glaser 2003. Pgs.22-23)

From my own perspective, there is some substance to Glaser's criticisms. In my initial data analysis of the first four interviews, I used NVivo as I coded transcripts and session notes. But my initial attempts at coding were relatively misconceived and when I learned to apply a dialectical relation between coding and memoing, there was a need to recurrently change the name of concepts. I found that this was better achieved through pen and paper than through computer-assisted analysis. However, I continued to store data, memos and codes in NVivo because of ease of retrieval.

Open coding

As mentioned in previous sections, grounded theory research involves an ongoing interactive process of data collection and analysis. An initial step in

analysis is open coding that involves analysis of incidents line-by-line or incident-by-incident (Glaser 1978). A key point is that a code is a conceptualisation of a pattern that, in analytic terms, is viewed as a category or a property of a category (Glaser 1978). In order to name a pattern, there is a need to notice some kind of recurrence and so various incidents need to be compared. This is not the same as placing a myriad of labels on every line or incident in the way that Strauss (1987) and Charmaz (2006) recommended.

In my initial efforts at data analysis, I did not properly incorporate Glaser's directions in relation to open coding. For the first four interviews, I wrote full verbatim transcripts from audio-recordings. I examined each line and incident in each transcript and labelled them. Very quickly, I had a large number of codes (or what I thought were codes)- 146 after four interviews. This seemed overwhelming but, with the help of ongoing reading and training (specifically with Barney Glaser at a troubleshooting workshop), I more fully grasped the idea that grounded theory analysis is oriented to the identification of patterns using a comparative approach. And I recognised the sheer impossibility of 146 codes after only four interviews. In the Glaserian sense, these were not codes at all. They were merely labels.

With this in mind, I re-analysed the initial four transcripts. This time, I followed the guidance of Glaser (1998) on the questions to ask of data during open coding. He suggested three coding questions:

- What category does this incident indicate?
- What property of a category does this incident indicate?

- What is the main concern of the participants? (Pg.140)

Taking this guidance on board, and making more use of memos, I identified some provisional categories and properties. These informed, and were refined in, subsequent data collection and analysis but a key point is that I was no longer bewildered by a multiplicity of so-called codes. And I could progress with theoretical sampling.

Memoing

Another important aspect of grounded theory analysis involves writing memos. Glaser (1978, 1998) describes memoing as the write-up of ideas relating to theoretical categories and their relationships. They should be written freely and whenever such ideas emerge. The resulting memos are part of the dialectic of coding and, as a project progresses, become developed enough to provide a basis for subsequent write-up of the grounded theory. Furthermore, memos can be 'sorted'- literally shuffled around in various combinations- as a means to generate ideas about the relations between categories and identify a core category.

This was the manner of memoing that I adopted for this project. When coding data, I identified a concept that seemed to represent some sort of pattern. If this concept was new, or some new aspect of it occurred to me, I immediately wrote a memo. This related to a new category, properties of a category, the re-naming of a category or property, and relations between categories or properties. In the light of this memoing, I went back to the analysis of data and often returned to data that was already analysed so it could be re-

conceptualised. Through ensuing analysis, I looked to develop further understandings of the concept- whether it captured a genuine pattern, how the pattern varies, and so on. In turn, this generated more memoing.

Furthermore, I spontaneously 'got ideas' about various concepts at any time of the day or night. Usually, this occurred when I was awake although there were occasions when my sleep was disturbed by a realisation, some new insight about how to think about data. On most such occasions, I quickly wrote a memo although I confess there are also times when I just went back to sleep or carried on with some other activity. Nonetheless, I agree with Glaser (1978) on the importance of what he called 'preconscious processing' to ongoing data analysis.

In preparing memos, I initially made use of a notepad, writing freely and quickly. Often, I followed this up with a typed version that I banked in NVivo and in a Word document. Some of these more 'mature' memos are incorporated into sections of this thesis.

Selective coding

For Glaser (1978), selective coding involves the development of a core category that integrates the whole theory and that accounts for relations between other key categories. The core category needs to be central, recur frequently, take more time to saturate because it is related to other categories, relate meaningfully and easily to other categories, have clear and 'grabbing' implications for formal theory, be variable, and partly explain its variation

(Glaser 1978). It also needs to account for how participants process or resolve their main concerns (Glaser 1998, 2001).

There is some debate about the idea of one core category and Charmaz (2006) argued that some phenomena might not be amenable to a single 'core'. However, Glaser (1978) did not really dispute this but suggested that each theory requires a core category whilst it is perfectly feasible to develop more than one theory from the same data. After all, this was the basis on which Strauss and himself developed a theory of 'awareness contexts' (Glaser and Strauss 1965) and 'dying trajectories' (Glaser and Strauss 1968).

In discovering the core category for this study, I made extensive use of memoing, 'memo sorting' and mind maps. But the key point was that I developed a succession of potential core categories that I 'tried out' for a while but which did not adequately 'pattern out'. This process was recurrent as I collected and analysed data until I eventually discovered a category that integrated and accounted for variation within and between other categories.

Theoretical coding

Substantive codes are emergent from direct analysis of data and theoretical coding is a way of conceptualising relations between substantive codes. Grounded theory analysts should command a repertoire of theoretical codes so as to employ ones that best fit with emergent substantive categories (Glaser 1978, 1998, 2005). In the case of the current study, symbolic interactionism (Mead 1934, Blumer 1969) provided a concept of self-relation that 'earned its way' into the emergent theory and enabled the conceptualisation

of the core category- *identity commitment*- as a fundamental pattern of self-relation. Prior to undertaking this study, I only had a vague notion of symbolic interactionism and only consulted its texts as part of a growing realisation- emergent from data analysis- that the project was fundamentally about how persons live with themselves.

Theoretical saturation

As already mentioned, theoretical saturation refers to a situation in which, through theoretical sampling, no further variations can be discovered in relation to a particular category (Glaser and Strauss 1967, Glaser 2001). This notion was criticised by Dey (1999) who argued that theoretical saturation is inconsistent with the partial approach to data analysis that is associated with theoretical sampling and 'delimiting'. He suggested that 'saturation' implied a more comprehensive coverage of data analysis than the focused approach of theoretical sampling allows.

However, with this argument, Dey (1999) signalled a misunderstanding of the whole grounded theory methodological project. It is difficult to see how any theory could ever be developed if ongoing analysis was always 'comprehensive' in the sense of oriented to any number of concepts. Grounded theory methodology deals with this problem by beginning with openness, developing a range of concepts, and progressively elaborating and refining those that are most recurrent, significant and integrative. Theoretical saturation is a way of signalling to the researcher that there is a time to stop collecting data in relation to a particular category whilst recognising that grounded theory

is always necessarily modifiable and, in Glaser's words, "..as good as far as it goes.." (Glaser 2003. Pg.147). In other words, theoretical saturation is a concept of practical use to researchers rather than an ultimate claim to have 'seen everything'.

In any case, in the present study, confidence in the saturated status of the core category was reached when there was no further evidence of its variation, especially in 'backward' theoretical sampling- in going back over data accumulated from interviews and autobiographies.

Ethical considerations

Recruitment, consent, confidentiality and anonymity

As mentioned, approval was received from a university and a hospital research ethics committee to undertake the study. In recruiting participants to the study, I wanted to avoid any possibility of undue pressure and so it was on this basis that the information leaflet was first distributed to professionals who passed it on to potential interviewees. It was only after potential participants indicated an interest that I contacted them by telephone. On the telephone, I briefly discussed whether they were actually interested in participation and, if this was confirmed, arranged to meet at a location that suited the individual (which was usually a day centre or health centre premises).

On meeting with each potential recruit, I again gave them written information about the study, asked them to read it and we discussed any questions that emerged. A consent form (see Appendix Four) was signed when persons signalled they were willing to go ahead with an interview. I emphasised

that consent could be withdrawn at any time and that I was simply grateful for any of their time. No one did withdraw their consent.

As part of this process, confidentiality and anonymity was assured insofar as this was possible. There were nurses and psychiatrists who knew about persons' participation in the study because of the high level of professional involvement in recruitment. Also, I explained legal limitations on confidentiality. Furthermore, I assured each potential participant that I would use pseudonyms and change any obvious identifying details when I 'wrote up' the study. However, I also offered no guarantees here and mentioned that some detail of their stories might be recognisable to others that know them. This is an important and often overlooked point about any research that makes reference to details from persons' life stories (Ford and Reutter 1990).

Anyway, none of this seemed to perturb any of the potential participants at this stage and consent was given by all eighteen participants in a way that seemed unproblematic. However, the issue of non-maleficence was a little more troublesome.

Do no harm

When ethical approval was initially sought within the university, the research ethics committee asked for clarification about some details of the study and required that a distress protocol should be written. In this protocol, I set out the measures that I would take to limit the potential for interviewee distress (see Appendix Five).

Obviously, the research ethics committee were concerned by potential harm to participants that might arise from the interviews. As mentioned in an earlier section, these concerns were well founded to the extent that three participants were increasingly anxious as their interview progressed and this was associated with 'going back over' past experiences that were distressing or traumatic. In each case, I asked whether they wished to continue the interview and each of them did continue. Also, at the end of the interview, each of them told me that they were not unduly distressed and they did not regret their participation.

A fourth participant (with the pseudonym of Sarah) seemed saddened during the interview as she talked about her isolation from others because 'no one believed her'. She talked about persecution by 'stalkers' and how her relatives and psychiatric professionals disbelieve her when she insists on the truth of this victimisation. As a result, she does not talk about the stalkers because, in doing so, she risks conflict with her family as well as more medication and potential hospitalisation with the involvement of psychiatric professionals.

Although Sarah did not seem unduly distressed during the interview, I received a telephone call from her just a few minutes after I left the setting for the interview. She asked to see me again because there was more she wanted to tell me. I agreed to see her and we arranged to meet again at the day facility she was attending. Prior to the meeting, I was concerned that she might be distressed after the interview and, if this was the case, planned to discuss what

help might be needed. However, when we did meet, she wanted to know whether I believed her story of the stalkers.

In hesitant response, I said that the story sounded implausible to me but that I did not dismiss it. This seemed to disappoint her but we then discussed her current options. Although I had no wish to act as a therapist, I nonetheless sought to be immediately helpful in assisting her to work out a next step because she seemed to be in need of this kind of conversation. Fortunately, partly through talk generated by the kinds of scaling questions that are used in solution-focused brief therapy (de Shazer 1988, DeJong and Miller 1995, Sharry et al. 2001), Sarah did say that she found the conversation useful and identified some ways of getting on better with her family as a useful next step. Overall, she said that she found the interview distressing but that she was pleased to have the opportunity to be heard and now had some positive ideas about what to do next.

For me, all of this raised a general ethical issue about 'doing no harm' and emotional distress in research. Sarah was both distressed by the interview and yet said that it was beneficial. This is consistent with a large American study in which participants who were distressed by personal questions in a survey tended to be nonetheless positive about the need for the research and their participation in it (Cromer et al. 2006). Of course, researchers should not be glib about emotional distress- potential or actual- generated by their inquiries. At the same time, there is room for the possibility that emotional distress may be part of a mixed experience of research participation that is, on

balance, positive. This is a possibility that members of research ethics committees should be prepared to countenance.

In summary, this chapter provides detail on how I ‘did’ grounded theory research in terms of how its aim was clarified, how participants were recruited, what data was employed, how it was collected and analysed, and how ethical considerations were addressed. This paves the way for the theory of identity commitment- emergent from the current study- to be introduced in the next chapter.

CHAPTER FOUR

IDENTITY COMMITMENT

Introduction

In the context of psychosis, persons relate to themselves in a variety of ways. They communicate with, designate, monitor and judge themselves; they struggle with and care for themselves; and they experience a range of feelings about themselves. In all of this, persons are concerned with self-viability: with 'getting along' with themselves.

Identity commitment is fundamental to how persons deal with this concern for self-viability in the context of psychosis. This refers to a pattern of self-relation in which persons- with varying degrees of awareness- commit *to*, and are committed *by*, particular self-conceptions. Through patterns of commitment, persons variously realise truths of themselves, obligations to themselves, bonds to themselves, confinement by themselves, and preference for themselves. It is these realisations that shape the extent to which persons get along with themselves in the context of psychosis and that form an ongoing dynamic of self-relations.

The scope and complexity of *identity commitment*- in the context of psychosis- is the essential 'discovery' associated with the present study. This is not to claim that identity commitment is a new term because there are several fields of inquiry in which identity commitment is already conceptualised. The first part of this chapter, then, is a review of extant concepts of identity commitment that were formulated and employed in lifespan psychology,

sociology and other fields. Second, a particular case example is examined as a way of signalling some key features of *identity commitment* as they are conceptualised in the current study. Third, three modes of *identity commitment* are overviewed as a basis for more detailed examination in subsequent chapters.

Extant concepts of identity commitment

A 'grand theory' of identity exploration and commitment

In the original methodological text of grounded theory and as mentioned in Chapter 3, Glaser and Strauss (1967) were critical of what they saw as a dominant convention for developing theory in sociology. They argued that 'great men' of sociology customarily devised 'grand theories' which- however brilliant and erudite- were not grounded in systematically collected and carefully analysed data relating to the phenomena of interest. In turn, these conjectured theories were followed up with research that was oriented primarily to verification. It was in contrast to this pattern of theory development that Glaser and Strauss (1967) proposed grounded theory methodology as a strategy of systematic discovery and a way to produce theory of genuine relevance.

These ideas are pertinent to the extant theoretical and research literature on identity commitment. Within this literature, there is a tradition that developed along the aforementioned lines that were criticised by Glaser and Strauss (1967) and by Glaser (1978, 2001, 2005) on several subsequent occasions. This tradition is in the field of lifespan psychology and the positions of 'great man' and 'grand theorist' are occupied by Erik Erikson.

Erikson was a man with a wide range of intellectual and practical achievements that encompassed work in psychoanalysis, social psychology, and cultural anthropology. Drawing on this range, he wrote a series of essays on identity, identity formation and maturational development through the lifespan (Erikson 1968).[1] Throughout these essays- and this perhaps reflects something of his Jewish heritage and emigration from Austria as Nazism gained ascendancy- he dealt with issues of tyranny and freedom. For one thing, he was interested in the potential of psychoanalysis for understanding persons' "enslavement" to both their own unconscious and to their historical situation:

"..psychoanalysis first studied, as if it could be isolated, man's enslavement by the id, i.e., by the excessive demands on ego and society of frustrated organisms upset above all in their instinctuality. Next the focus of study shifted to man's enslavement by seemingly autonomous ego (and superego) strivings- defensive mechanisms which, in order to "contain" an upset libido economy, impoverish the ego's power of experiencing and planning. Perhaps psychoanalysis will complete its basic studies of neurosis by investigating more explicitly man's enslavement by historical conditions which claim autonomy by precedent and exploit archaic mechanisms within him, to deny him physical vitality and strength." (Erikson 1968. Pg.74)

In writing about identity formation, Erikson (1968) was interested in this multi-layered phenomenon of enslavement and the potential for freedom

[1] Although there are several books of Erikson's essays, the one cited here is the most complete collection and includes essays that were published in earlier books.

from it. At the same time, he was no advocate of unfettered individualism and emphasised the necessity of a fit between personal preference and social obligation, individual choice and responsibility to others. For Erikson (1968), late adolescence was an especially decisive period for persons as they deal with these concerns.

Essentially, Erikson (1968) suggested that persons move towards adulthood with a given set of issues that reflect their prior biographies and social circumstances. These issues are often conflicted so that, for example, an emergent sexual awareness is at odds with the expectations and requirements of parents. As persons move into adulthood, a key question becomes whether they remain ensnared within enduring patterns of conflicted relations (at the inter-related levels of unconscious drives and wishes, of self-relation, and relations with others) or generate some resolution of these patterns. According to Erikson (1968), these resolutions are in the form of identity commitments which reflect personal preference and decisions. Persons make choices about who they are, what they believe and what they want. And they take up responsibilities, or readiness for responsibilities, associated with particular identities.

For Erikson (1968), then, there was a form of identity commitment that reflects a particular relation between persons and their past. It is a commitment made in the context of the past but representing a certain break from it. Persons are not confined by their life histories because they play an active role in generating their own identity commitments which are a basis for an adult future

and meeting further developmental challenges. Furthermore, Erikson (1968) accounted, albeit in a general way, for how such commitments are generated.

Late adolescence, he argued, is a period of 'crisis' in which many persons experience confusion and doubt about their identities. They are less definite about themselves and this can mean they are open to a variety of identity options. Persons, Erikson (1968) suggested, are more inclined to experiment during such crisis: to test out various ways of thinking, believing, acting and associating. As a social condition for such experimentation, there is a kind of "moratorium" on identity commitment which is permissible and ceremonially structured:

"A moratorium is a period of delay granted to somebody who is not ready to meet an obligation or forced on somebody who should give himself time. By psychosocial moratorium, then, we mean a delay of adult commitments, and yet it is not only a delay. It is a period that is characterized by a selective permissiveness on the part of society and of provocative playfulness on the part of youth, and ends in a more or less ceremonial confirmation of commitment on the part of society." (Erikson 1968. Pg.157)

In this context that supports testing and exploration, persons are able to work out and decide identities that 'work' for them and, on this basis, commit to such identities.

So, for Erikson (1968), identity commitment represented a kind of achievement that is made in late adolescence and that is conditional upon a process of exploration and choice through which 'identity crisis' is resolved. He

contrasted this achievement with “foreclosure” in which persons experience no crisis in late adolescence and remain set in ways of being and believing that were established in childhood. They are closed to identity possibilities and do not engage in identity exploration. Furthermore, Erikson (1968) envisaged a kind of nether land of continuing “identity confusion” in which persons remain in crisis and fail to make identity commitments. In his early work (although still published in the collection that is referenced here), Erikson (1968) referred to “identity diffusion” in which persons remain diffident, shifting and uncommitted but he later viewed this concept as unhelpful and preferred the aforementioned concept of “identity confusion”.

However, one difficulty with all of these conceptualisations is that they are relatively non-specific. For example, it is not clear if exploration is possible without crisis or what constitutes the particular properties of exploration. Erikson (1968) wrote of the dangers of “premature commitment” without sufficient identity exploration but did little to specify such sufficiency. Furthermore, he did not account for how exploration is transformed into commitment and indeed what constitutes identity commitment. Persons were deemed to make decisions about themselves and take up obligations but it is unclear whether commitment is achieved when choices are made or obligations enacted. For example, Erikson (1968) explicitly mentioned occupation as a focus for identity commitment and seemed to suggest that such commitment was possible before starting paid employment. But he failed to explain how

identity exploration is tenable, and a sufficient condition for commitment that is not 'premature', in relation to social arenas that persons have not even entered.

In important respects, then, Erikson's ideas were vague and impressionistic. Taking these ideas on their own terms, there was a need for more conceptual exploration prior to any justifiable, rather than 'premature', commitment to this theory of commitment. However, Erikson's work was followed by the development of a research tradition in which such exploration was largely eschewed. Instead, this tradition involves the quantification of categories that were drawn from Erikson's theory, measurement of their psychosocial implications and only a limited degree of conceptual elaboration.

For example, there is research devoted to the permutations of identity exploration and commitment in respect of age (Kalakoski and Nurmi 1998), cognitive style (Berzonsky 2003), patterns of social-economic opportunity (Orgocka and Jovanovic 2006) and different patterns of exploration before and after identity commitment (Luyckx et al. 2006, Luyckx et al. 2008). In a number of studies involving adolescent populations across the world, 'identity achievement' (commitment after crisis and exploration) is correlated with a variety of positive dispositions and outcomes compared to other categories of 'identity status' like 'foreclosure' or 'identity-diffusion' (a category that remains prominent in the literature despite Erikson's abandonment of it). These dispositions or outcomes include greater perseverance, realism and effectiveness in task performance (Marcia 1966), personal adjustment (Hunsberger et al. 2001), personal agency (Berzonsky 2003), well being (Hofer

et al. 2007), and adaptive perfectionism (Luyckx et al. 2008). Also, 'identity achievement' is inversely correlated with negative or undesirable qualities or outcomes- such as depression (Berzonsky 2003) and maladaptive perfectionism (Luyckx et al. 2008)- when compared to other identity categories.

One of the difficulties with this research literature is that identity is largely depicted as a matter of 'types' and one type is compared to another with respect to various measures of psychosocial adjustment. Reading Erikson's work, it is clear that this is somewhat removed from his own intellectual project. Whilst he emphasised late adolescence as a crucial period in identity formation and achievement, he also defined identity as an ever-developing process. He favoured a dynamic conception of human development which rests uneasily with a research literature that is structured by reference to types of identity status.

Furthermore, the aforementioned research literature is largely confined within conceptual parameters set by Erikson (1968). Despite the impressionistic nature of his theory, researchers did not countenance significant departures from his work. For example, there is little attention to the possibility of alternative pathways into identity commitment to that proposed by Erikson. One exception to this rule is provided by Vleiras and Bosma (2005) in a small longitudinal study of Greek students on Erasmus/Socrates study programmes. They found no relation between exploration and changes in identity commitments in the domain of relations with parents (this was the only focus for their study). Instead, emotion-related diary entries were the only predictor of

changes in such commitments over a period of five months. In other words, it seems that changes in how persons *felt* about their parents were associated with changes in their commitment to their parents.

This small-scale study at least shows there is a need to explore the possibility of alternative pathways into identity commitment in late adolescence and go beyond the parameters set by Erikson (1968). However, this need is largely unmet when compared to the emphasis given to identity exploration by Erikson's successors. Ironically, then, a theory- emphasising the adaptive nature of commitment that is generated from exploration- guided research inquiry characterised by limited willingness to envisage and explore theoretical alternatives.

In summary, there is an extant 'grand theory' of identity exploration and commitment relating to late adolescence which is supported by research evidence and yet conceptually under-developed. It is a theory that emphasises the role and value of choosing new identities through the results of experimentation but the possibility of alternative pathways into commitment is under-explored. Furthermore, the dynamics of continuing commitments are almost entirely neglected. Erikson (1968) associated commitment with obligation but did nothing to explain how such obligation 'works'. However, outside of lifespan psychology, there is an extant literature in which identities are implicated in obliging persons to act in particular ways.

'Side bets', escalating commitment and entrapment

Whilst Erik Erikson is regarded as a 'great man' and 'grand theorist' of lifespan psychology, Howard Becker occupies similar hallowed positions in sociology. One of his theoretical contributions was focused on the concept of commitment (Becker 1960). He suggested that 'commitment' was a term that was increasingly employed in sociological research of that period but inadequately and unclearly conceptualised. On this basis, he theorised a particular account of commitment although- like Erikson (1968)- he did not generate his conceptualisations out of systematic data collection and analysis.

Essentially, Becker (1960) argued that- when persons are committed- they act in ways that are consistent over time and this is explicable by reference to the idea of a 'side bet'. To illustrate, he gave the example of a man who makes a $16000 bid for a house but the seller wants $20000. Yet the prospective buyer has already made a $5000 bet that he will not pay more than $16000. This side bet- this prior stake- means that the prospective buyer is bound to an upper limit of $16000 and the seller must admit defeat. For Becker (1960), this example was instructive about the properties of commitment:

"The major elements of commitment present themselves in this example. First, the individual is in a position in which his decision with regard to some particular line of action has consequences for other interests and activities not necessarily related to it. Second, he has placed himself in that position by his own prior actions. A third element is present, though so obvious as not to be apparent: the committed person must be aware that he

has made the side bet and must recognize that his decision in this case will have ramifications beyond it. The element of recognition of the interest created by one's prior action is a necessary component of commitment because, even though one has such an interest, he will not act to implement it (will not act so as to win his side bet) unless he realizes it is necessary." (Pgs.35-36)

In most social situations, Becker (1960) suggested that commitment does not emerge from a deliberate side bet. Instead, persons engage in a series of actions where each action is not decisive in itself. Instead, it is the combined weight of these actions that constitute a side bet:

"Each of the trivial acts in such a series is, so to speak, a small brick in a wall which eventually grows to such a height the person can no longer climb it. The ordinary routines of living- the daily recurring events of everyday life- stake increasingly more valuable things on continuing a consistent line of behavior, although the person hardly realizes this is happening. It is only when some event changes the situation so as to endanger those side bets that the person understands what he will lose if he changes his line of activity." (Becker 1960. Pg.38)

In considering the application of this idea of commitment predicated on a prior stake, Becker (1960) made reference to a range of situations. For example, he examined commitment to an occupation. One aspect of such commitment can be a pension. Each pension payment is not significant in itself but, over time, payments mount up and persons are bound to their work if they

lose pension benefits by leaving. In adjusting to the demands of a job over time, persons may find it comfortable and familiar. This comfort is another kind of side bet that can limit occupational alternatives. Also, as persons spend time in a given area of work specialisation, this confines their occupational choices because they are not employable in other occupational realms.

For Becker (1960), persons are typically committed to their work through a set of such side bets. Furthermore, he argued that a claim to be a certain sort of person can constitute a side bet. When persons have 'put on a front' to others in line with a particular identity, this provides a stake in 'saving face' in subsequent actions. This was as far as Becker (1960) went in exploring the relation between side bets and identity. He did not consider the possibility that persons' identities are side bets that account for consistencies in how persons relate to themselves as well as others. However, this possibility was at least noted by others.

With particular regard to sport but also with an interest in the development of formal sociological theory, Leonard and Schmitt (1987) hypothesised that athletic behaviour is partly explicable by reference to identities that work as a "commitment mechanism". They hypothesised that sport identities are a kind of side bet that oblige continuing athletic endeavour and that sporting versions of oneself are at stake in such endeavour. In addition, they proposed a programme of research to investigate this theoretical possibility. However, no such research was ever forthcoming and the concept of identity commitment as a side bet is an undeveloped area of inquiry.

Nonetheless, there are researchers who explored notions quite similar to that of Becker's side bet and linked them to identity commitment. Brockner et al (1986) were interested in organisational decision-making and the idea of escalating commitment to ineffective courses of action. Decision-makers, they postulated, are inclined to persist with ineffective actions when their identities depend on it:

"….the *failure* to persist with a prior course of action- even one that is ineffective- may disturb the individual's (or organization's) identity to a great extent; to avoid this unsettling state of affairs, decision makers may instead choose to persist in pursuing their prior- though no longer functional- course(s) of action." (Brockner et al. 1986. Pg.111. Original italics)

They referred to this pattern as one of "entrapment" by the implications of one's own identity. To test this pattern, they devised two experiments in which college students were given tasks with successive stages and where, to continue the task, a stake had to be placed at each stage. When experimental groups were told that the task was a valid test of perceptual abilities, mathematical reasoning and social perception (experiment 1) or skill (experiment 2), they were significantly more inclined to escalate the stakes they made at each stage when they were given negative feedback about their performance. This was compared to control groups who were informed that the task was a test of highly doubtful validity (experiment 1) or a matter of luck (experiment 2).

In a similar study, Dietz-Uhler (1996) focused upon escalating commitment in political decision-making. Working with a large sample of psychology students, she set up an experiment in which participants enacted roles as members of a town council. In enacting town council meetings, participants had to make decisions about a playground project and were given successive information about its progress. The experimental groups were addressed in such a way as to encourage collective membership and identification with the simulated town council. The comparison groups were given no such encouragement and addressed as individuals.

The experimental groups were significantly more likely to escalate their commitment to the playground project by allocating more resources to it despite steadily accumulating information about its poor progress. For Dietz-Uhler (1996), this provided support for her hypothesis that social identity (defined in terms of group belonging) is associated with escalating commitment to ineffective courses of action.

These aforementioned experimental studies provide some general support for the notion that identities are at stake in certain situations. They lend some credence to Becker's idea of a side bet and its relevance to identity. And they give some plausibility to self-obligation as a useful concept in explaining persons' actions: whereby persons are obliged to act in ways that are consistent with their identities. However, these studies, along with Becker's formulation of commitment, were not generated out of direct and detailed inquiry into areas of everyday life. So there is a lack of detail about how identity side bets, or

identity entrapment, actually 'work' in particular circumstances. There is little or no account of variation on the theme of self-obligation in terms of how identity stakes are formed, when side bets are voided, and how one identity relates to another. Attention is paid to the confining nature of identity commitment but not to any possibility of its potential for generating new actions and new identities. This latter criticism also applies to a conceptualisation of identity commitment as a kind of 'narrative production'.

Identity commitment produced through narrative

Jones (2005) studied personal stories that were available on the internet and that concerned bipolar affective disorder. He made a brief but critical reference to some of the lifespan psychology literature on identity exploration and commitment that is reviewed in this chapter. This literature, he argued, employs a concept of identity commitment as something that persons 'have', a kind of psychological attribute. Rejecting what he saw as psychological essentialism,[2] Jones (2005) focused instead on the idea that identities are 'produced' by texts:

"The study concerns how personal stories function to produce "identities"; more specifically, how texts construct conditions for their authors' ownership of the experience being narrated." (Pg.299)

Jones analysed 23 texts posted by 12 individuals and he examined the various representations of experiences of bipolar affective disorder. He

[2] As a criticism, this has a certain substance when levelled against a tendency to categorise 'identity status' in terms of 'types'. But, whilst this typological tendency emerged from Erikson's work, the overall tenor of his ideas was dynamic and multi-layered. This point was made in an earlier section but bears repetition. See Erikson, E. H. (1968) *Identity, Youth and Crisis*, Norton, New York.

suggested that persons' stories were shaped through certain genres- like 'an ordeal adventure story' or 'struggle with, and victory over, the villain'- and through certain 'myths' (in the sense of fundamental cultural truths) like 'normality' and 'otherness'. Furthermore, Jones (2005) argued that these stories served to commit their authors to particular identities:

"In common with each other and the other sampled texts, the stories commit their implied authors to social-moral positions or identities in relation to the illness." (Pg.315)

These identity commitments, he suggested, are significant for how persons act in their world:

"An identity commitment is not a personification, not an image of "person," but an implicit condition for the person-to-world *relation*." (Pg.316. Original italics)

But Jones did not consider how identity commitment is significant for this "person-to-world relation". Instead, his analysis was limited to the proposition- left largely unexplored- that persons are committed *to* identities *by* stories.

In taking this analytic path, Jones was guided- maybe committed- by a broad and fashionable theoretical tradition in which concepts like 'story' and 'text' are heavily emphasised. This emphasis variously involves attention to how stories are constituted through metaphors, genres, plots, and other conventions (Berger 1997); to the cultural or ideological dimensions of stories and other 'texts' (Barthes 1973, Narayan and George 2003); and to the

significance of stories for the 'making of the self' (McAdams 1993). Furthermore, this preoccupation with stories is reflected in narrative research in the fields of physical illness (Frank 1995) and mental illness (Olofsson 2001, Fredrikson and Linderstrom 2002) as well as accounts of how to understand persons with severe mental illness (Kirkpatrick 2008) and provide therapy for persons in emotional distress (White and Epston 1990).

However, there are limitations to an approach in which 'stories' are accorded such conceptual pre-eminence. For one thing, a focus on 'the story' can draw attention away from what persons might be 'doing' when they tell or write a story and from what they do other than tell stories. In literary studies, this tendency is most dramatically represented in Roland Barthes' account of the 'death of the author' in which he claimed, most essentially, that writing is for readers (Barthes 2006). The meanings of texts, he argued, are constituted by persons that read them and so there is little point in looking for such meanings by reference to authors.

It is this kind of point that seemed to guide Jones (2005) in his analysis of internet texts. In a vague way, he suggested that, through reading their own stories, persons were committed by what they wrote about themselves. But he neglected to analyse or consider what they were doing as authors of their own stories. In this way, he overlooked a range of analytic opportunities. For example, here is a quotation from one of the personal stories he analysed:

"The great thing is that I no longer address my illness very much since my medication has been so successful!!!" (Jones 2005. Pg.306)

Putting aside Jones' emphasis on 'the story as a story', this datum can be analysed in detail. First, it is a report of a change in relation between "I" and "my illness": one in which "I" does not "address my illness" as much as in the past. In making this report, the person is 'doing an evaluation' in saying that this changed relation is a "great thing". This evaluation rests upon a comparison of a present that is preferred to a past. In conceptual terms, this links to the notion of 'temporal self-evaluation' which is a focus for extant theorisation (Albert 1977) and research in the context of schizophrenia (Dinos et al. 2005).

Second, this temporal evaluation is itself suggestive of a self-relation in which *I* made a judgement in relation to present and past *Me's*. Conceptually, self-relations are emphasised in symbolic interactionism (most especially by Mead 1934, Blumer 1969) and so this perspective might prove useful in analysis of further data. Another self-relation is possibly implied by the reference to "my illness". In referring to illness as 'mine', there is some indication that the person identifies with illness and designates himself or herself as ill.

Third, the positive change in relation- between "I" and "my illness"- is attributed to the effects of medication. This attribution serves to evidence a claim about the personal benefits of medication. Such evidence might be significant for the storyteller in that he or she is making or re-making this pharmacological benefit as a truth for himself or herself (another self-relation). If this self-truth is being reproduced then the statement can be understood in terms of commitment to a prior identity as better off for medication. The person

is not- or not only- committed *by* a story he or she is telling but *to* a story through a committed relation *with* a particular self-conception.

Fourth, a question is raised about the person's other actions in relation to medication. If, for example, he or she adheres faithfully to medication then this can be understood in terms of fidelity to a self-conception as pharmacologically advantaged. This then becomes another aspect of identity commitment as it relates to this particular case.

The point here is not to suggest that there is a right way to analyse the data in Jones' study nor to reject the value of narrative approaches. But it does appear- and the aforementioned datum was simply used to exemplify this- that Jones (2005) missed out on some useful analytic opportunities because he was captured by a preoccupation with stories rather than identity commitments.

In addition, Jones (2005) failed to acknowledge that his account of identity commitments- whilst it is distinctive for its narrative emphasis- is nonetheless generally consistent with the work of Becker (1960) and others that is examined in the previous section. Identities are depicted as narrative productions which function as a kind of side bet that obliges persons along certain pathways of action. In this sense, then, Jones' work is part of a broader class of conceptualisations that share an emphasis on the obligatory and limiting nature of identity commitment. But, there is at least some work that attends to identity commitment- when conceptualised as self-obligation- as an aspect of new patterns of action.

Commitment begetting commitment

In a study involving 236 marathon runners of wide ranging age and ability, Horton and Mack (2000) were interested in the effects of athletic commitment on other 'role identities'. Using several measures of sport commitment and a life roles inventory, they found no association between high scores of athletic identity and neglect or under-development of other identities. Also, persons- with high scoring athletic identity compared to those with low scores- reported significantly greater numbers of friends who were runners. They made friendships through running.

Going back to Becker (1960) and his side bets, these friendships could be viewed as part of a developing athletic commitment. Friendship can be regarded as one of the stakes that persons have in running and this is part of what obliges them to continue running. Equally though, if persons find friendships through running, there is a sense in which commitment to running might contribute to the potential for the realisation of an identity as a friend. Indeed, it is possible that persons oblige themselves to make friends with other runners out of commitment to running. As runners who go to athletics clubs and race meetings, they may consider sociability as a requirement of themselves. On this basis, a running identity provides a stake in continuing actions as a friend but also contributes to the realisation of friendship identities.

Stating this as a formal theoretical possibility, commitment *to* one identity could imply commitment *by* that identity to another one. Commitment could beget another commitment. This is the gist of a case study by Neuhouser

(1998) on commitment to the identity of 'mother' among women in a squatter settlement in north-eastern Brazil. Of interest to the author was the prominent role women played in community mobilisations and political activism related to housing. Superficially, this role seems inconsistent with traditional Brazilian notions of *marianismo* which confines women to family and home spheres. But, according to Neuhouser (1998), it is precisely this confinement that explains what was a gendered form of political activism.

To explain this more specifically, in one community mobilisation, a group of women conducted an "invasion" of an area of land and hastily built shacks before police arrived. They resisted attempts by police to remove them and, when their makeshift homes were torn down, they rebuilt them under cover of darkness. The city authorities issued legal injunctions against them but the women ignored orders from the courts. Eventually, the city authorities relented and the squatter settlement was allowed to remain.

The women received little support from men although many did have male partners that subsequently moved into the settlement once it was established. For Neuhouser (1998), a significant aspect of this situation was gendered access to positive identities. In this poor neighbourhood, women had little opportunity to derive positive identities from paid work and it was commonplace for girls to become mothers in their early teens. They had little choice other than to take on the obligations of motherhood and this was perhaps the only socially valued role that was available to them. By contrast, men were

better positioned to derive positive identities from work as well as through sexual prowess and soccer.

It was in this context that the invasion occurred. The invaders were women with children who had no homes and very little income. Without homes, they could not provide for their children's needs. Neuhouser (1998) argued that it was their identities as mothers that committed them to political action. They 'had to' get homes for their children and the costs of failing this obligation seemed greater than those associated with the threat posed by the police and city authorities. By contrast, men were not implicated in an 'all or nothing' identity commitment and so were less inclined to risk direct action. Neuhouser (1998) summarised his explanation in the following way:

"Motherhood was such a salient identity for women in Caranguejo. To sustain it, they mobilized and paid the costs of participation. Women were committed to this identity because extreme poverty meant that they had no acceptable alternatives. They engaged in collective action because they were faced with a choice between mobilization and forfeiting their claim to be mothers. Men also lacked the resources to be fathers, but because acceptable alternative identities were available, they were less willing to pay the costs of mobilization." (Pg.335)

Neuhouser (1998) argued that cultural norms specified what was needed to perform identities as mothers and structural factors obstructed access to the necessary resources. Identity commitment explains how these women actively dealt with this interface between culture and socioeconomic structures. Yet it

was also cultural and structural factors that constrained women's identity options and thereby accounted for the extent of their commitment as mothers. Their commitment as mothers was greater than that of men as fathers because they had scarce alternative options for the realisation of valued identities.

But there was another important point about identity commitment. When Neuhouser (1998) interviewed women who were active in the invasion, they suggested that their activism was associated with changes in how they regarded themselves. They said that they became more independent of men and valued their local status- partly respectful and partly begrudging- as 'strong women' and 'crazy women'. They contrasted themselves with men who had 'done nothing' for their children and who lacked the courage or will to take on the authorities. In other words, there is a sense in which these persons were 'different women' for what they did. So they were not only obliged and confined by their identities as mothers: their actions as committed mothers were a stimulus for new identities as women.

In summary, Neuhouser's study is consistent with literature in preceding sections in which identity is depicted as a kind of stake that obliges persons in their actions. But, this study is distinctive for incorporating cultural and material contingencies in an analysis of a real-world situation. In addition, identity commitment is depicted not only in terms of self-obligation but also as a potential generator of self-transformation. It is this kind of extensive conceptualisation of identity commitment- as sustaining and transforming, as

limiting and freeing- that is emergent from the current study in the context of psychosis.

CIA agent or mental patient?

In introducing the theory of *identity commitment* that is emergent from the present study, it is worth beginning with an examination of an account which concerns a particular person. As part of a large phenomenological study of recovery and schizophrenia, Davidson (2003) reported on a particular interview with Kyle. This man heard voices telling him he was a professional spy and he continued to believe these voices despite the efforts of 35 different psychiatrists who sought to treat him over a period of seven years. During this time, he rejected the notion that he was mentally ill, refused antipsychotic medication and avoided participation in any kind of therapy programmes. But, in working with his 36th psychiatrist over a period of another seven years, Kyle came to 'accept' a diagnosis of schizophrenia and the associated treatment. When asked by his research interviewer why it took so long to accept a psychiatric diagnosis, Kyle replied:

"I had to be a CIA agent or a mental patient. Which would you choose?" (Davidson 2003. Pg. 145)

There are a number of points that can be made here. For one thing, two identities are posited as antithetical and one of them had to be true. From his perspective, Kyle could not be a secret agent *and* a psychiatric patient, he "had to be" one or the other. Therefore, in regarding himself as a CIA agent, he was committed to *not* regarding himself as mentally ill. Given this self-regard, he

was obliged to refuse antipsychotic medication and repudiate a psychiatric diagnosis.

In addition, through consistently rejecting an ascription of mental illness, Kyle stayed faithful to a conception of himself as a secret agent. This enactment of fidelity- together with the 'either/or' relation of the two identities that were 'available'- meant that Kyle kept himself real as a spy. He was keeping true in a double sense: in faithfulness to a particular conception *of* himself and in reproducing the truth *to* himself of that conception. These are matters of commitment. Fidelity to a particular self-conception is an aspect of *identity commitment* and self-truth has a compelling quality. In Kyle's case, the truth of his spy status bound him to a course of refusal and repudiation. At the same time, this truth was not only reproduced through negation. Kyle heard voices telling him that he was a member of the CIA and that he had an important role to play in the 'cold war' against the Soviet Union through participation in thought broadcasting experiments. These voices and this mission were credible for Kyle and they were evidence of the truth of himself as a spy. Much of his time was spent in the solitary pursuit of this mission when he was preoccupied with efforts to broadcast his thoughts and to keep this secret from others. So, in keeping true (to) a spy identity, Kyle faithfully adhered with the positive obligations with which it was associated.

Moreover, Kyle seemed to suggest that he was drawn into this identity commitment by the relative attractions of espionage compared to mental illness. It was more alluring to be a spy than a mental patient and this allure was part of

what bound him to a conception of himself as a secret agent. There is a suggestion that Kyle could 'get along better' with a preferred spy identity and this was a factor in 'sticking with it' for so long.

Examining another aspect of this point, Kyle's identity preference is explicable in social terms. With the ironic question "Which would you choose?" he intimated that he viewed himself in accord with how others would view themselves given the same option. He assumed that others would rather be a spy than a mental patient. Therefore, he seemed to suggest that spies are generally more highly regarded than mental patients and so he implied that his identity valuations are consistent with those normally made by others in the social world in which he resides. So, Kyle partly explained his identity preference by reference to valuations shared with others.

Yet, Kyle did eventually come to view himself as mentally ill and so his commitment- to and by *Me-as-spy*- was not sustained. In accounting for this change, Kyle described a cumulative pattern that occurred over several years. According to him, it started when the 36th psychiatrist told him that he had schizophrenia and this was consistent with what he was previously told by the 35 others:

"I started to think that not all 36 of them could be wrong…It wasn't like they knew each other or anything." (Davidson 2003. Pg.144)

From here, Kyle started to wonder whether he was wrong about himself and actually mentally ill rather than a spy. He described "experiments" in which he noted what happened when he 'listened to' (in the extensive sense of hearing

them and treating them as credible) his voices and compared this with when he listened to his psychiatrist. When 'taken' with his voices, he noted that he felt important, stopped taking medication, disengaged from activities that normally interested him, lost jobs and accommodation, and was eventually incarcerated in hospital. When he listened to his psychiatrist, he noted that he took medication, maintained an apartment, kept in work, spent time with friends, related better to his family, and started dating. Nonetheless, he also said that he felt less important as a mental patient and this accounted for his difficulty in believing his psychiatrist as well as the extensive time taken to identify with this belief. This sense of diminished importance is emphasised by Davidson (2003) in his analysis of this case but he went no further in accounting for Kyle's changing self-identification. Yet such analysis can be extended by reference to *identity commitment*.

Through maintaining an apartment, keeping a job, relating with friends, getting on better with relatives and starting to date, it is possible that Kyle was committing to, and was committed by, relevant self-conceptions (as apartment dweller, employee, friend and so on). Indeed, it is difficult to see how such achievements were consistently possible without *identity commitment*. Furthermore, according to Kyle, these achievements were predicated upon listening to his psychiatrist and believing he was mentally ill. In others words, the realisation of these other identities were contingent upon an acceptance of mental illness. Therefore, continued realisation of these identities bound Kyle to a psychiatric identity. His eventual loss of commitment to and by a spy

identity seems explicable by reference to this developing and binding relation between a self-designation as mentally ill and other self-conceptions. He could only keep true (to) self-conceptions as apartment dweller, employee and so on by keeping true (to) *Me-with-schizophrenia*. A new pattern of *identity commitment*- characterised by a binding combination of mutually sustaining self-conceptions- progressively displaced the prior pattern that sustained *Me-as-spy*. This seems to offer some explanation of how Kyle was engaging to, and engaged by, a psychiatric identity.

In summary, this examination of Kyle's case provides some illustration of *identity commitment* and how it is fundamental to matters of self-relation. Also, it signals some of the key theoretical points that are associated with the present study and provides a basis for an overview of the emergent theory.

Overview of the theory

In the context of psychosis, there are three related modes of *identity commitment*: *keeping true (to) self-conceptions*, *struggling through with Me's*, and *engaging to identities*. These modes are explored in the following three chapters but are worth some introduction (also see diagram on Pg.99).

Keeping true (to) self-conceptions

A constitutive feature of *identity commitment* is that persons stay faithful to particular self-conceptions. They stay true to themselves. This self-fidelity is associated with obligation: with things that persons must and must not do. And meeting such obligation is necessary for the continuing truth of a

self-conception. It is a way that persons evidence themselves to themselves. It is both a proof and a reproduction of a self-truth.

On this basis, persons are implicated in a dual relation of truth. They stay true- in the sense of faithful- to themselves and they keep their identities true in the sense of self-evident. It is this *keeping true (to) self-conceptions* that accounts for consistent lines of action in respect of particular identities. For example, it accounts for how persons enact themselves as religious, as committed family members, as autonomous agents, and so on. In the context of psychosis, this pattern of *keeping true (to) self-conceptions* informs an understanding of how persons often deal with issues like suicide avoidance, the idea of mental illness, involvement with psychiatry, and endurance in the face of suffering.

Furthermore, these relations of self-truth are significant for how persons deal with threats to the actuality of *Me's*. When the truth of identities is somehow threatened or compromised, this implicates persons in a second mode of identity commitment: *struggling through with Me's*.

Struggling through with Me's

In the context of psychosis, *keeping true (to) self-conceptions* is commonly difficult. The truth- to oneself- of *Me's* is threatened or lost through the actions of others, experiences of self or lack of resources (bodily or interpretive). In the face of these threats or losses, persons often endeavour to sustain or regain their identities. They resist encroachments on their identities, they 'keep going' out of fidelity to self-conceptions, they give way without

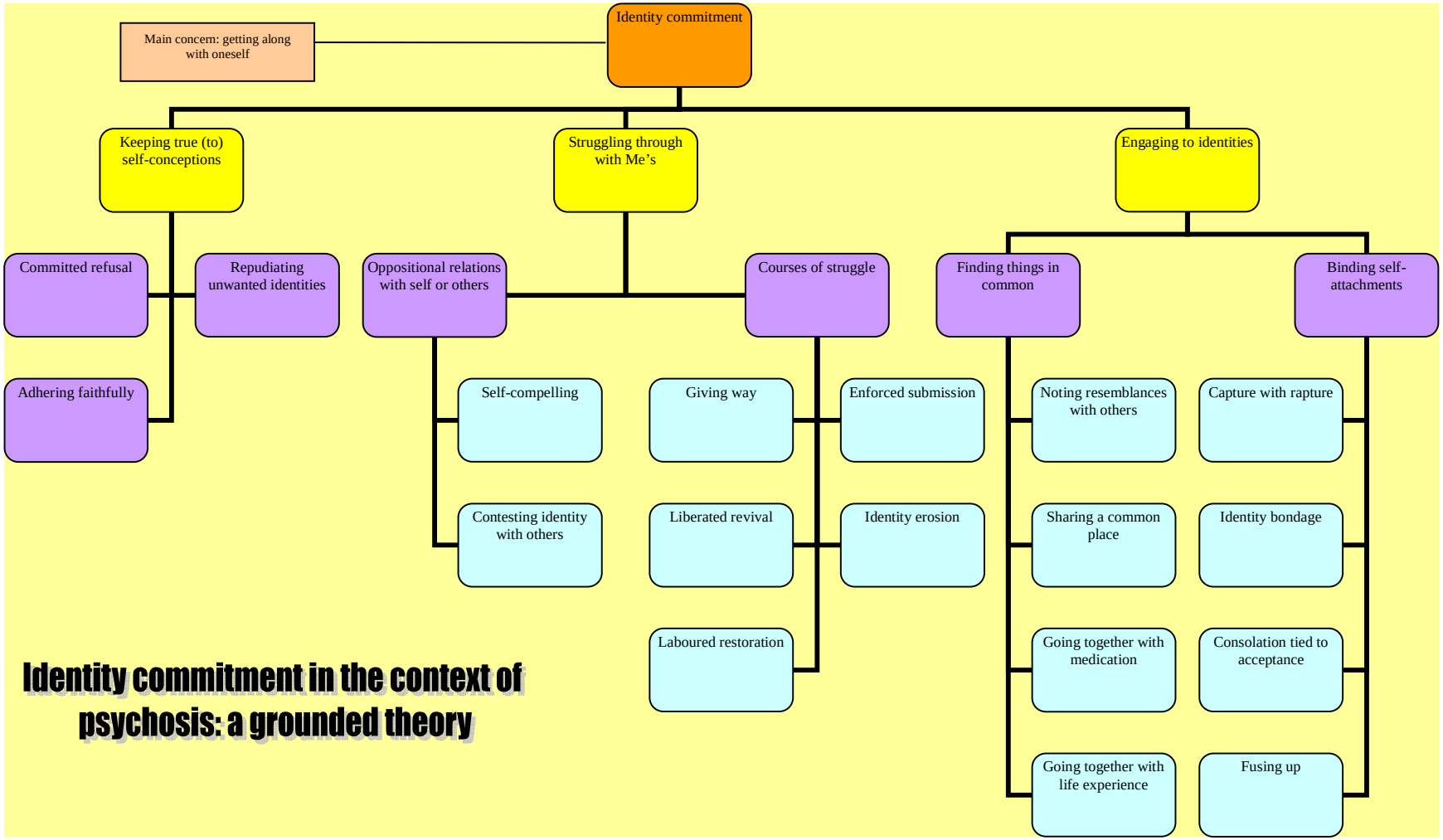
giving up, or they 'make comebacks' through retrieving *Me's* that were lost. In each of these circumstances, persons are *struggling through with Me's* in some sense.

Such struggle has various sequelae. It may end with a kind of victory in which the truth of *Me* is established and persons' endeavours are justified. Alternatively, *struggling through with Me's* can be displaced by an alternative pattern of *identity commitment* in which persons relate to themselves in new patterns. This links to a third mode of *identity commitment*: *engaging to identities*.

Engaging to identities

In the context of psychosis, persons get implicated in patterns of self-relation from which it is difficult to escape. Through *engaging to identities*, they are bound into various kinds of self-attachments. In part, this occurs because persons note a similarity between a particular notion and themselves- they judge themselves as 'like that' and this is a factor in identifying themselves as 'that'. When persons establish the truth of an identity in this way, they are bound into some sort of relation with it. At the same time, establishing such truth is influenced by matters of preference. The relative attractiveness of identities is an important factor in their realisation and in the extent to which persons subsequently get along with themselves. And such attractiveness is also significant for changes in the 'terms of engagement' between persons and their self-conceptions, for changes in the configuration of binding identity attachments.

In the following chapters, these modes of *identity commitment* are examined in more detail.


Identity commitment
Main concern: getting along with oneself
Keeping true (to) self-conceptions
Struggling through with Me's
Engaging to identities
Committed refusal
Repudiating unwanted identities
Adhering faithfully
Oppositional relations with self or others
Courses of struggle
Self-compelling
Contesting identity with others
Giving way
Enforced submission
Liberated revival
Identity erosion
Laboured restoration
Finding things in common
Binding self-attachments
Noting resemblances with others
Capture with rapture
Sharing a common place
Identity bondage
Going together with medication
Consolation tied to acceptance
Going together with life experience
Fusing up
Identity commitment in the context of psychosis: a grounded theory

CHAPTER FIVE

KEEPING TRUE (TO) SELF-CONCEPTIONS

Introduction

Keeping true (to) self-conceptions is a mode of *identity commitment* that is characterised by a dual relation of truth. Persons are true *to* themselves in the sense of faithful. In this sense, *keeping true (to) self-conceptions* refers to ways in which persons enact their faithfulness through actions that are consistent with particular identities. These actions are associated with a sense of personal obligation: of *having to* act in particular ways to be a particular *Me*. However, these actions are not only acts of self-fidelity. In remaining true *to* themselves, persons are realising truths *of* themselves. On this basis, *keeping true (to) self-conceptions* refers to what persons do in sustaining and reproducing *Me's* as true in the sense of actual and real.

In this chapter, three variations of *keeping true (to) self-conceptions* are considered in turn. The first is *committed refusal* whereby persons consider certain actions as anathema to their identities and *not-for-Me* so they remain true to and for themselves through refusing such actions. The second is *repudiating unwanted identities*. Here, persons establish certain identities as *not-Me* and again stay true through acts of rejection. Persons reproduce the truth of what they are by reference to what they are not. The third variation of *keeping true (to) self-conceptions* is *adhering faithfully*. This involves actions that are directly affirmative of particular identities and consistent with the positive self-obligations that derive from them. It involves persons in knowing

they really are a certain kind of person because they do things that such persons do.

Committed refusal

Persons, with experience of psychosis, are inclined to define certain actions as 'things they will not do.' These definitions are associated with being a certain kind of person: to be this kind of person involves *not* doing certain things. This is because these things are considered antithetical to *Me* and are, therefore, actions that are *not-for-Me* in a fundamental sense. This is a basis for *committed refusal*. Persons reject certain actions because they represent invalidations of *Me* and have to be renounced for the sake of *keeping true (to) self-conceptions*. Alternatively, and more simply, persons refuse certain actions because they regard themselves as incapable of such action. They define themselves as 'just not that sort of person' and this commits them- at least for the time being- to *not* doing something. In both these cases, through rejecting what is *not-for-Me*, persons make the truth of themselves as both an ongoing enterprise and recurring accomplishment.

Suicide is a common focus for *committed refusal*. For example, Josiah is a 29 year old man with a diagnosis of schizophrenia. When interviewed, he recounted some awful times associated with hearing voices. At one point, he was living in a hostel for homeless people:

"I was boxing myself in the head and everything. Jumping out of the bed in the hostel and giving myself a box in the head to get the voices to shut up you know….. It was just the pain I was in you know….."

He had similar experiences during a brief stay in prison:

"When I was in prison as well. I was hearing voices then, in my cell in the prison you know. I was banging my head off the prison door and stuff you know…..I would go to sleep and I'd wake up hearing voices. The only time I got away from voices was when I'd go to sleep. Even in my dreams, they were there. When I'd wake up, they were there again."

When asked how he endured these experiences, Josiah replied:

"I didn't think of suicide at all…..I think suicide is a bad thing so I don't think about suicide…. the Church says it's wrong to kill yourself and you should keep going."

So Josiah responded to a question about enduring by saying what he would not do: he would not commit suicide. And he related this to his Christian belief. As a Christian, he should refrain from suicide and "keep going." In other parts of the interview, he made it clear that his religious faith is important to him and he prefers to be a devout Christian.

A similar point was made by Bernard, a 67 year old man with a diagnosis of bipolar affective disorder. Like Josiah, he avows a *Me-as-devout-Christian* and this is a preferred identity. He said that his religious practice is useful in structuring his life and he derives considerable consolation from the words of priests when he suffers with depression. Years ago, he did briefly consider drowning himself by jumping in the River Liffey but ruled this out as a serious possibility. Bernard said that, from a religious point of view, suicide is wrong and therefore not something he could seriously consider.

For both Josiah and Bernard, then, there is an association between religious commitment and non-suicide. Christian devotion carries obligations which include refrain from suicide. Suicide is antithetical to *Me-as-devout-Christian* and so, to be this preferred *Me*, suicide is something that cannot be done. By rejecting suicide, Josiah and Bernard stayed true to themselves as Christians and sustained the truth of themselves as Christians.

Bernard and Josiah both gave another reason for eschewing suicidal action. They said they could not commit suicide because of their families. In this respect, their accounts were similar to that of several other persons who were interviewed as part of the present study. For example, Sarah is a 37 year woman with a diagnosis of schizophrenia. She does not really accept this diagnosis and, when asked to put her difficulties in her own words, she replied:

"People not believing what I'm saying when it's actually true…I'm being stalked every day and in the night-time in my sleep."

Sarah believes that she is stalked by three persons who break into her family home, steal things like jewellery, monitor her movements, and whose motives are perfidious yet perplexing. She is convinced they mean her harm but she does not understand their reasons. Sarah seems to remain consistent in this belief but, from her perspective, it is dismissed by her family who see it as part of her mental illness. And it is 'treated' by psychiatrists who prescribe her more medication and even admit her to hospital when she talks and gets upset about it. As a consequence, she is reluctant to talk about what she 'knows' but, for her, this means that she has no recourse against her persecutors because she

cannot enlist the aid of those who might be helpful. Furthermore, it is extremely upsetting to her that others are willing to attribute to illness that which she knows to be actually true.

In the light of these experiences, Sarah said there were times when she considered killing herself. At one particular juncture, she was attending a day centre and felt bullied. She spoke with her twin sister:

"I went to her and said "I want to end it all" and she said "don't do it.""

For Sarah, her sister's words were important because they reminded her of what her suicide would do to her family. She thought about the grief her death would cause in her family and she specifically felt a responsibility to her three-year old niece:

"I have to be around to see her grow up."

On this basis, Sarah accounted for her non-suicide and considers it unlikely that she will kill herself in the future.

For Sarah, then, caring for relatives involves not inflicting grief upon them. The infliction of grief is antithetical to *Me-who-cares-for-my-family*. Through refusing suicide, Sarah thereby enacts her obligations to herself as well as her family. She stays true to herself and reproduces the truth of herself.

Yet persons may define suicide as *not-for-Me* on the basis of a different kind of committed self-relation to that just discussed. This is illustrated by Susannah Kaysen in *Girl, Interrupted* (Kaysen 1995). In this well-known autobiographical account of psychiatric hospitalisation, she compared herself with Polly, a fellow patient who set herself on fire with petrol:

"Why did she do it? Nobody knew. Nobody dared ask. Because- what courage! Who had the courage to burn herself? Twenty aspirin, a little slit alongside the veins of the arm, maybe even a bad half hour standing on a roof: We've all had those. And somewhat more dangerous things, like putting a gun in your mouth. But you put it there, you taste it, it's cold and greasy, your finger is on the trigger, and you find that a whole world lies between this moment and the moment you've been planning, when you'll pull the trigger. That world defeats you. You put the gun back in the drawer. You'll have to find another way.

What was that moment like for her? The moment she lit the match. Had she already tried roofs and guns and aspirin? Or was it just an inspiration?

I had an inspiration once. I woke up one morning and I knew that today I had to swallow fifty aspirin. It was my task: my job for the day. I lined them up on my desk and took them one by one, counting. But it's not the same as what she did. I could have stopped, at ten, or at thirty. And I could have done what I did do, which was go onto the street and faint. Fifty aspirin is a lot of aspirin, but going onto the street and fainting is like putting the gun back in the drawer.

She lit the match." (Kaysen 1995. Pg.17)

In this passage, Susannah admired the bravery of someone that commits to an irreparable act of self-destruction. But this is part of a distinction she made between herself and another person: Polly is courageous in a way that

Susannah is not. For Susannah, suicide was *not-for-Me* because she lacked the positive qualities that are necessary. From her own perspective, she was not brave enough.[3]

Linking with this idea, several interviewees in the present study gave a lack of courage as one reason for abstaining from suicide. Two of them, Bernard and Joe, used exactly the same form of words to make this point: **"I don't have the bottle."**

In these cases, suicidal action is associated with courage. Persons render suicide as *not-for-Me* through a kind of self-deprecation: they do not have 'what it takes' to commit suicide. On this basis, persons are not obliged to live on out of commitment *to* a self-conception. Instead, they are committed *by* their conception of what they lack. It is 'having no bottle' that obliges them to refrain from suicide and to live on although it should also be acknowledged that this can be accompanied by commitments *to* particular identities (as religious, responsible family member, and so on) as the cases of Bernard and Joe (who also cited family reasons for suicide avoidance) illustrate.

So, suicide can be a focus for committed refusal in the context of psychosis. But there are a range of other actions that persons commonly refuse on a committed basis.

[3] There is a similar and memorable passage in *The Bell Jar* where the putatively fictional character of Esther Greenwood admired a Japanese way of suicide in which persons disembowel themselves but contrasts this with her own squeamishness. See Plath, S. (1966) *The Bell Jar*, Faber and Faber, London. Pgs. 132-133. For another autobiographical account, see Elizabeth Wurtzel on how she did not "have the guts" to drown herself despite the appeal of suicide: Wurtzel, E. (1996) *Prozac Nation: Young and depressed in America*, Quartet Books, London. Pg. 127.

For example, Juliet is a 34 year old woman with a diagnosis of schizophrenia. Like others already mentioned, she considered suicide in the past but rejected this option partly because she did not want to inflict grief on her family. Another action she rejects is illicit drug-taking. Here is how she responded to a question about what she thought was happening when she was first admitted to a psychiatric hospital in 1995:

"I didn't know! I was having a nervous breakdown but I didn't know that. I got imbalanced and I was hearing voices. And I was crying. And I was afraid. I was thinking of the past, fights in the past. Thing's I'd done. But I've copped on now. I can't take drugs any more. When I was in my teens, I was out raving and all that. But I don't now."

At another point in the interview, she again referred to a link between drug-taking and her initial psychiatric involvement:

"I took drugs- God, I'll never go near them again- I took drugs and I was hearing voices."

In both these passages, Juliet makes reference to drug-taking as something she used to do but will definitely not do again. In her own words, she has "copped on now." In maintaining a relation with *Me-as-copped-on*, she must not take illicit drugs. From her own perspective, illicit drug-taking constitutes action that is antithetical to this *Me* and so she now refuses it.

Wadi is a 34 year old man- originally from Nigeria- who told a similar story to Juliet in explaining his abstinence from cannabis. And, going back to Josiah who renounced suicide out of fidelity to *Me-as-devout-Christian*, he also

rejected illicit drug use. Although he took pleasure from various illicit drugs in the past, he says he has to abstain from them because they are incompatible with his faith:

"I just had to get off them because of my religious views. I just had to get off them. If you want to be part of the Church, you can't take drugs."

On this basis, and also because like Juliet and Wadi he thinks of drugs as bad for his mental health, Josiah has remained abstinent from illicit drugs for a significant period of time.

But illicit drugs are not the only substances that are a focus for self-obligated abstinence. Martin is a 43 year old man who, like Juliet, thinks of himself as someone that has learned from his experiences and "copped on." He has a diagnosis of bipolar affective disorder and says that he now recognises a number of ways in which drinking alcohol is bad for him. He abstains from alcohol as part of what he called "sticking to the plan" which means doing things that are right for his mental health. Martin much prefers himself when he sticks to the plan and he currently lives out this preference partly through his abstinence from alcohol.

In explaining his abstemious conduct, Martin gave some credit to the staff of a hostel in which he currently resides. In this hostel, there are fairly strictly enforced rules about alcohol and drug use. This encourages Martin in keeping true (to) *Me-sticking-to-the-plan*. And from a psychiatric service perspective, Martin is doing the right thing through his abstinence from alcohol just as the aforementioned persons are doing the right things in renouncing

suicide or illicit drugs. But this pattern of *committed refusal* is not only reflected in actions that meet with the approval of mental healthcare professionals.

Going back to Juliet, she now thinks of herself as someone with schizophrenia who needs to take medication. This is part of what it means to be "copped on." But these self-realisations occurred over a long period of time after her initial contact with psychiatric services. It was five years after her first admission to a psychiatric hospital before she reached a definite view about her need for medication and identity as a person with schizophrenia. In the meantime, she often would not take prescribed antipsychotic medication. This was linked to a concern with weight gain which, for Juliet, is a significant issue of sexual identity:

"Like you know us women, we worry about our weight all the time."

Juliet considers herself more attractive when she is slim and this is important to her: she prefers *Me-as-slim-and-attractive*. When she first came into contact with psychiatric services, she was very slim but soon noted rapid weight gain when she took antipsychotic medication. Indeed, she linked weight gain with both medication and schizophrenia as an illness:

"The first thing I noticed about the medication and myself being transformed into a schizophrenic, it was my weight. I piled on the weight with the medication."

But this weight gain was unacceptable to her and so medication was unacceptable. In addition, she associated the notion of becoming fat with

becoming schizophrenic. On this basis, she stopped the medication and it was a further five years before she reluctantly started taking medication on a regular basis.

So, Juliet regarded medication and a diagnosis of schizophrenia as anathema to *Me-as-slim-and-attractive*. Staying true to this *Me* and, keeping this *Me* true, she renounced medication for a long period of time. A similar pattern relates to Kate Millett who, in her autobiography, accounts for why she stopped taking lithium:

"For seven years I lived with a hand tremor, diarrhea, the possibility of kidney damage and all the other "side effects" of lithium. Then, in the summer of 1980, I decided to go off lithium, thereby severing the control of the authority I had never entirely believed in and had reason to resent. The decision to go it on my own was a gamble for my own reason. For in accepting lithium as a remedy for depression caused by incarceration and diagnosis, I was accepting the validity of both, together with the pronouncement of my incompetence and degenerative insanity; I was confessing to an illness whose other treatments lead to the loss of one's freedom and dignity through confinement." (Millett 2000. Pg.12)

For Kate, personal freedom and dignity were very important. Accepting lithium was an affront to *Me-with-freedom-and-dignity* and this was a basis for discontinuing the medication. In keeping this self-conception true, she had little choice but to renounce lithium.

In summary, *committed refusal* is a variation of *keeping true (to) self-conceptions*. Through refusing particular actions, persons stay true to, and reproduce the truth of, particular self-conceptions. This overlaps with a second variation of *keeping true (to) self conceptions* in which persons explicitly repudiate unwanted identities.

Repudiating unwanted identities

In *committed refusal*, persons renounce particular actions but they also reject particular identities. In the aforementioned example of Kate Millett, this rejection was explicit in that she partly accounted for her refusal of lithium as a rejection of an identity as mentally ill. This signals a variation on the pattern of *keeping true (to) self-conceptions*. Through *repudiating unwanted identities*, persons establish certain identities as *not-Me* and explicitly reject them. These rejections, as in the case of *committed refusal*, both reflect and reproduce truth to and truths of *Me's*.

In *repudiating unwanted identities*, persons make comparisons: between themselves and others; of themselves over time; between themselves and a concept. Through these comparisons, they establish points of difference that substantiate particular identities as *not-Me*. For example, Stephen is 38 years old with a diagnosis of schizophrenia and a history of heroin and cocaine use. He was first admitted to a psychiatric hospital at the age of 20 and, at this time, he refused to believe that he was mentally ill. This was partly because his experiences, when immersed in psychosis, were so believable. He believed that he was a major Dublin criminal and a target for assassination by both the IRA

and the Irish government. Although he was frightened because of this threat, Stephen said these beliefs also had positive implications in that they rendered him as a kind of underground hero. He felt important in his status as a master criminal that attracted the enmity of powerful others.

When admitted to hospital, Stephen initially refused medication and this was linked to his repudiation of psychiatric illness. In addition, Stephen observed that the other patients "weren't like me." This supported his belief that he was not ill. The other patients were different from him and ill so this informed his self-designations as different from them and *not-ill*. Partly through comparison with others, Stephen was able to repudiate an identity as mentally ill (at least for a while) and maintain faithfulness to, and the truth of, an identity as master-criminal.

This is similar to the case of Aine who was an interviewee in the present study. She is 58 years old with a diagnosis of paranoid schizophrenia that she utterly refutes. Aine was forcibly admitted to a psychiatric hospital for the first time in 1995 but she believed, and still believes, that she was a political prisoner. From her perspective, she was aware of a complicated political conspiracy and her psychiatric detention was designed to prevent her from publicly revealing scandalous truths about prominent politicians in Ireland and abroad.

When admitted to hospital, Aine felt out of place and different from other patients:

"Being so well mentally, I was shocked at all the patients that were there….The other patients were scary. There were some of them just lying there with the nurses sitting beside them. And I found it very scary. I thought I'd never get out…..Their mental health wasn't good…I didn't belong there. They were ill and I wasn't."

So, Aine was frightened by other persons in her immediate environment but, at the same time, she was affirmed through comparing herself with them. They were different from her, they were "ill," and she implied they were appropriately located in a psychiatric hospital. These linked elements in her interpretations of other patients enabled her to distinguish herself as different from them, not ill, and wrongly confined. In other words, through comparing herself with others and distinguishing herself from others, Aine maintained her own regard for herself. She was keeping true (to) a conception of herself as wrongly confined and rightly aware of the reality of the situation.

Furthermore, Aine distinguished herself as *not-ill* through a variety of other comparisons. From her own perspective, she does not act in ways that are consistent with a delusional disorder. For one thing, she was able to refrain from conversations with psychiatrists about politics and from "ranting" to work colleagues:

"It felt mad. Talking to a psychiatrist about politics. So I said to myself: "I'm not going to talk with them about that any more." So when I went I just said I was grand. That's how I know it wasn't a delusional disorder. If

it was a delusional disorder, I would have been ranting to people in my job. But I was four years in that job and I never told them."

In this passage, Aine implies that delusional persons are unable to keep quiet about their beliefs and that they tend to 'rant.' In contrast, she was able to keep her beliefs to herself. With this distinction, Aine provided grounds for her self-identifications of non-delusionality.

Employing a similar interpretive approach, Aine also distinguished between herself and her 'official' diagnosis:

"And the last time I was in hospital, I was told I had paranoid schizophrenia. Now I was 55. There's traits in that when you're 15 or 16. I've worked all my life and had two children. I got married and everything. So I don't agree with them…In fact, there's nothing wrong with me."

Here, Aine associates paranoid schizophrenia with teenage onset and a life without marriage, children, and "everything." By contrast, she is in her 50's and has lived through marriage and raising a family. On this basis, she is not like persons with paranoid schizophrenia. This informs her repudiation of psychiatric illness and is part of the way she stays true to, and provides vindication for, her self-conceptions as unjustly treated and aware of 'what is really going on'.

To give another example of *repudiating unwanted identities*, Bernie is a 50 year old woman with a diagnosis of bipolar affective disorder. When interviewed, she rejected the identity of victim:

“I don’t want to be in the victim role. Because I had that for years, living the victim role. So I don’t want to be in the victim role any more, I want to have a life. Just rise above it, you know.”

According to Bernie, she once lived with, and as, *Me-as-victim*. This was in the context of sexual abuse by her father, years of suffering associated with guilt, dominance by her husband, psychiatric hospitalisation after manic breakdowns, distressing side effects of medication, and being discounted by others because of mental illness. But she said that, over time, she became a different person. She said that she became more independent, more in control of her life, more philosophical, more self nurturing, and more self-accepting. In these ways, she managed to “rise above” victim status:

“I’ve climbed the mountain basically. It’s all downhill from here.”

But it is partly in the contrast between a past *Me-as-victim* and a present *Me-above-victimhood* that Bernie repudiates the former identity and stays true to the latter. In contrasting past and present *Me’s*, Bernie does not simply report a change of herself because she also does something to actualise this change. Her temporal comparisons contribute to her realisation of an identity: they help to reproduce the truth of an identity that is ‘above’ victimhood.

In summary, persons establish identities as *not-Me* and repudiate them. This is a variation on how persons remain true to, and sustain the truth of, their self-conceptions. In a further variation of *keeping true (to) self-conceptions*, persons act positively in enacting fidelity to, and the truth of, *Me’s*.

Faithfully adhering

As well as *keeping true (to) self-conceptions* by reference to what is *not-for-Me* and *not-Me*, persons act in ways that are positively consistent with *Me's*. *Faithfully adhering*, then, is constituted through a pattern of actions that positively accord with an established view of self. This is another way of remaining true to, and reproducing truths of, particular identities.

For example, in her autobiography, Kay Jamison wrote about her relationship with lithium which she was prescribed in the context of her diagnosis of manic-depression. For a long time, she conducted what she called a "war with lithium" which she associated with an unwillingness to regard herself as mentally ill and a preference for herself as 'mildly manic.' This war lasted for several years during which time Kay either abstained from lithium altogether or took it erratically. However, over time, she changed her position and committed herself to medication use:

"Having finally cottoned onto the disastrous consequences of starting and stopping lithium, I took it faithfully and found that life was a much stabler and more predictable place than I had ever reckoned. My moods were still intense and my temperament rather quick to boil, but I could make plans with more certainty and the periods of absolute blackness were fewer and less extreme." (Jamison 1996. Pg.153)

In this passage, it is worth noting Kay's reference to the "disastrous consequences of starting and stopping lithium" compared to the "stabler and more predictable place" associated with medication adherence. Through this

comparison, she reproduces a truth of *Me-better-off-with-lithium*. This is linked to taking medication "faithfully" which represents a positive enactment of fidelity to this self-conception.

Of course, persons do not just faithfully adhere to medication and a related view of self. For example, in the case of Bernard who would not commit suicide out of fidelity to *Me-as-devout-Christian*, he goes to Mass three to four times a week and prays regularly. In this way, he sustains faithful adherence to, and makes himself real as, *Me-as-devout-Christian*. Also, Bernard swims and cycles every day, and he is a member of an athletics club. Just prior to being interviewed, he returned from a running holiday in Italy. Probably because of his active lifestyle, he looks fit and youthful for his 67 years. His exercise is important for how Bernard regards himself. He considers himself active and self-disciplined. Through sport, he said that he learned these qualities yet, at the same time, sport is clearly a way in which he realises them. *Faithfully adhering* to an exercise regime is a way of staying true to, and making true, a self-conception as fit and active.

In summary, *faithfully adhering* is a positive variation of *keeping true (to) self-conceptions*. It is a pattern of action in which persons act in positive accord with *Me's* and at the same time conduct relations of truth with themselves. But, in the context of psychosis, self-truths are often tested and this implicates persons in struggle. This is the focus for the next chapter.

CHAPTER SIX

STRUGGLING THROUGH WITH ME'S

Introduction

In the context of psychosis, *keeping true (to) self-conceptions* is often not easy and indeed it can prove impossible. Self-truths are variously threatened or lost because of a lack of resources to sustain them, problematic experiences of self, or the actions of others. On this basis, persons stay true to, keep the truth of, or retrieve the truth of their self-conceptions through endeavour and perhaps sacrifice. Persons are implicated in *struggling through with Me's*.

In this chapter, these struggles for the truth of oneself are examined in considerable detail. First, the locus of struggle is considered. Essentially, persons struggle within two spheres of oppositional relations: with themselves and with others. These two spheres are explained in some depth. Second, various courses of *struggling through with Me's* are explicated. Persons variously keep, lose or regain self-truths. Each of these eventualities is considered in the following sections.

Oppositional relations with self or others

In *struggling through with Me's*, persons are implicated in at least one of two kinds of oppositional relations. The first is associated with conflicted self-relations. Here, keeping true (to) a particular self-conception is rendered problematic through the influence of other *Me's* that are incompatible or antithetical. On this basis, persons struggle with themselves on behalf of a particular *Me*. It is through *self-compelling* that persons conduct this struggle.

In some sense, they 'force themselves' to act in accord with particular self-conceptions

A second common area of contestation in *struggling through with Me's* is relations with others. Other persons can act in ways that contradict or invalidate particular self-conceptions. On this basis, persons are implicated in struggles over identity. In *contesting identity with others*, persons struggle in opposition to others: they strive to actualise identities despite, and in contention with, the contrary actions of others.

These oppositional relations- concerning the truth of oneself- are worth exploring in some detail.

Self-compelling

As mentioned, *self-compelling* refers to persons' actions in 'forcing themselves' to act in particular ways that are consistent with particular self-conceptions. For example, Thomas is a 53 year old man with a diagnosis of bipolar affective disorder. When interviewed and asked to introduce himself, he replied:

"My name is Thomas and I'm a musician and teacher."

This response was an initial statement of an important *Me*: playing and teaching the fiddle is normally central to Thomas' understandings of himself. He said that music is a "barometer" of his well-being. When he does not play well, he takes that as a sign that life is generally not well. He can detect what he calls the "suppressive effects" of psychotropic medication, or his own anxiety, in the "emotion" and "tone" of his music. This can mean that he loses

confidence in his music playing and this affects his public performances. He becomes more apprehensive about, and less accomplished when, playing the fiddle in public. Indeed, in relation to playing music:

"It blocks me at all levels when it's not going well."

Also, when he plays well, this is a sign that life is generally good.

So playing the fiddle is important to Thomas and the same is true of teaching it. He described himself as a perfectionist in his teaching and he blames himself if pupils are not doing well. He finds individual tuition demanding: it is difficult to keep up motivation, pupils do not always turn up, and it can be lonely work. Also, if he believes he is failing as a music teacher, this affects his general confidence and again his public performance of music.

Although prone to anxiety about his performance as musician and music teacher, Thomas nonetheless 'makes himself' teach, and publicly perform with, the fiddle. As part of this, he has "constant conversations" with himself:

"I say to myself: "Come on Thomas, you've got to push yourself forward."…"

This kind of account of *self-compelling* is commonly told. In the context of psychosis, persons often talk about pushing themselves, pulling themselves, and making themselves do things. There is an active *I* (a *Me* once objectified in reflection) that is 'pushing', 'pulling' and 'making.' And there is a recalcitrant *Me* that is 'pushed', 'pulled' and 'forced'. Here, persons are describing coercive relations with themselves.

To illustrate further, Frank is a 62 year old man who was first diagnosed with schizophrenia in 1991 and, when interviewed, said the quality of his life is limited since the death of his wife:

"I don't do much with myself to be honest with you. Since my wife died- six years ago- I'm just living day by day. I get the feeling in my head to take my tablets, to commit suicide, an awful lot."

Frank said that he does not commit suicide because he believes it will prevent him meeting his wife in the afterlife. Out of religious belief aligned with devotion to his dead wife and fidelity to *Me-as-devoted-husband*, he endures what he views as an empty existence.

In enduring this existence, Frank said that he coerces himself on a daily basis. For example, his four youngest (of eight) children still live at home with him although they are all adults. He does the cleaning, makes the meals and washes their clothes but these are tasks that he pushes himself to do:

"If I didn't have to do it, I wouldn't do it…I just have to say to myself: "Get up and get out of that chair. Don't be sitting there, don't be lazy. Get up and do what you have to do"."

Here, there is a theme of obligation tied up with *self-compelling*. Frank 'has to' do the housework and 'has to' chastise himself. When asked why he pushes himself in relation to housework, he replied:

"Because for 34 years, I used to clean up around the house. I used to keep things clean and tidy with my wife…From years ago, I got in the habit of

keeping the place clean and tidy. It gets on my nerves if the place gets upside down. You know, when grandkids come."

Frank has a long established commitment to a clean and tidy house which means he is obligated to *Me-as-house-proud*. It is by reference to this obligation that he accounts for his *self-compelling* acts. Obligation means that he is compelled to compel himself.

Similarly, going back to Thomas, he repeatedly said that he "had to" push himself. He often experiences self-doubt, anxiety, and apprehension about music teaching and public performance. Nonetheless, he compels himself to keep doing these activities and so these are acts of obligated struggle. They are what he has to do in staying true to, and making true, his identities as musician and teacher.

Another example of *self-compelling* is provided by Joe. He is a 47 year old interviewee and said that, in the early hours of every morning, he is drawn to suicide:

"I have a terrible problem in the morning. I wake up and I have to get out of bed. I'd be suicidal. I feel like throwing myself through the window."

Yet he resists this urge and related this to his family commitment:

"I'll keep myself alive as long as my mother and father are alive anyway."

When asked how he manages to resist suicide, he replied:

"I say to myself 'if I did that now, I'd be very sorry' and I have to get a grip of myself and I have to get up, have a shower and a shave, a cup of tea and then I'm myself again."

And:

“I give myself a good talking to. Yeah. I say “pull yourself together, you’re not that badly off, I know you suffer with your nerves but..” (laughs and changes tack). “Suffering with nerves, what nerve?” (laughs and returns to previous tack) “And you’ve been through an awful lot and you should be happy that you got this far.” Then a cup of tea and a few smokes and everything’s rosy again (laughs).”

Here again, as in other cases that were considered in relation to *committed refusal*, non-suicide is related to family commitment and fidelity to *Me-who-cares-for-my-family*. But this fidelity implicates Joe in a struggle with himself. He articulates this struggle with an account of *self-compelling*: he has to “get a grip” of himself, ‘pull himself together,’ and berate himself with a “good talking to.”

So, *keeping true (to) self-conceptions* often implicates persons in *self-compelling*, in forcing themselves to enact an identity. But, the truths of oneself can also be at stake in relations with others and so this too can be a sphere of struggle.

Contesting identity with others

Persons, with experience of psychosis, can encounter situations of conflict with others about themselves. In these situations, other persons act in ways that contradict or contravene persons’ self-conceptions. This is a context for *contesting identity with others*: where *keeping true (to) self-conceptions*

implicates persons in oppositional relations with others and struggles against others for the sake of *Me's*.

For example, after renouncing lithium and repudiating an unwanted identity as mentally ill, Kate Millett clashed with persons around her. Something of this clash is conveyed in the following passage:

"How easy it would be to try this experiment of going off lithium if I alone were involved. If I had kept the secret. But now it is a circus of other people, a controversy, a conflagration. Some of this is my fault; I have not been discreet. In my first joy at being on my own, recovering the free use of my senses, I crowed over it, kicked my heels. I was healthy and sound, had been all along, my mind was whole without disease- they had deceived me into believing that I was a cripple held together with four pink tablets a day, that 1200mg of lithium separated me from hopeless insanity, that only the drug kept me among the living, the free beings outside the jails. But instead, look at me; I have never felt so well, lithe, strong, young. I am swimming like a swimmer again; not a competitor, not even distance- not in that little pond- but a strong swimmer. I have lost weight, have my breathing back again. Even my vision is better, I am less myopic; it may even correct itself and I could see out of my own eyes perfectly again. For that is how the mind and body feel, rejuvenated, healed….And now the joy has disappeared altogether in arguments and quarrels between Sophie and me. At the end of it I feel my back against the wall and the circle forming around me, the accusations of madness. That I am not quite right, that

something had come over me in the last two weeks. Some terrible change. "People would hardly know you," the solemn approach. "You're a little freaked out," the hip diagnosis. And the ones behind my back whispering that this is an attack she's having, she's flipped.

How little weight my own perceptions seem to have. I am the discussed; what do I know, experience, discover? For it was all discovery- so much so that I would postpone drawing only to relish the activity of my own mind, experience my senses after six years of drugs. Lithium slows thought, clouds the synapses, holds it back, quiets it, represses the brain activity in order to prevent manic overexcitement and hyperstimulation- the great bugaboos. Depression is the victim's dread, not mania. For we could enjoy mania if we were permitted to by those around us distressed by it, if the thing were so arranged that manics were safe to be manic awhile without reproach or contradiction, the thwarting and harassment on every side that finally exasperates them so they lose their tempers and are cross, offensive, defensive, antagonistic- all they are accused of being. A manic permitted to think ten thousand miles a minute is happy and harmless and could, if encouraged and given time, perhaps be productive as well. Ah, but depression- that is what we all hate. We the afflicted. Whereas the relatives and shrinks, the tribal ring, they rather welcome it: you are quiet and you suffer. Two perfect circumstances. You should shut up because you talked too much before, you should close down all your capacity because you were boastful and extravagant about them before. And you should endure the

torments of the damned because you have embarrassed them: remember the time you told your best friend to shut the hell up? For that, for those transgressions (ones they commit themselves all the time but never under the onus of madness), you should wither and die inside." (Millett 2000. Pgs.71-72)

In this passage, Kate says a lot about how she views herself: as rejuvenated for renouncing lithium, as potentially productive if manic, as discounted by others because of ascriptions of madness, and as the focus for a cruel satisfaction on the part of others when she is depressed. On this basis, a principal theme of her book is her struggles with others as she sought to stay true to, and reproduce the truth of, her self-conceptions as 'better off' without lithium and capable of deciding her own best interests.

Hospitalisation was one area for Kate's conflicts with others. On one occasion, her sister, friends and a psychiatrist arranged for her to be admitted to a psychiatric hospital when Kate was on a trip to New York. There were two ambulances and six police cars involved in an effort to forcibly 'take her away.' She managed to escape into the street, create a public scene, and convince a passing police officer that her civil rights were about to be contravened. He dismissed the ambulances and police cars and Kate escaped detention. However, soon afterwards, she went on a trip to Ireland and was incarcerated in a County Clare psychiatric hospital after detention by gardai at Shannon Airport. This is how Kate described her initial entry to the hospital:

"I am terrified anew. Locks, there are locks. Once past the door you are finished. And bars on the windows. Hell and forever, this place of darkness. The sound of keys. And the pretense of a hospital. A nurse, thank God, the sight of a woman. But hard. She'll just take your bag and all. I'll just keep it with me. Wouldn't you be more comfortable? Not really. And if you'll just sit there. A spot where I would never sit: too far into the room, too far from the door, the hall. And the sight of her as a witness to whatever He- she refers to him as to a god- might do to me. After a very long time of waiting and knowing that whatever he is, he is master here, in total control of my life, and I his prisoner, hating whatever trappings of office, state, or psychiatry he will wear- he arrives. Young, handsome, bearded. Natty. Vienna transported to Ennis. I still sit in the chair by the door, my purse in my lap- my last possessions: money, cigarettes. He would have me sit nearer, across from his desk. The procedure. To hell with your procedure; it is simply this that I refuse to partake of. Thereby losing points, looking more abnormal. But the claustrophobia, the general terror of being a prisoner in a darkened building in the countryside of what is now a foreign country in the midst of war and turmoil I do not understand, knowing only that I may never be free again, may never come out of here alive- all this makes it impossible for me to move from the door. I look at him and hate him. As much as I fear him." (Millett 2000. Pg.194)

Following her admission, she insisted that she would not take medication and she tried to escape. These actions prompted coercive responses from staff which further reinforced Kate's sense of injustice. A similar story is told by Ron Bassman in his autobiography. On the first occasion that he was hospitalised, he agreed to go to hospital as a way of proving to his family that he was not mentally ill. But when he arrived, his clothes were taken and he was strapped to a bed. When he escaped these restraints, he was sedated and soon transferred to another hospital where he was stripped and put into a seclusion room:

"Waking stark naked in that tiny room was my hospital orientation. The heavy sedative drugs forced into me for my transfer from Newark City Hospital to Fair Oaks Hospital left me with only my imagination to make sense of what was taking place. My confused, frightened vacillation between anger and pleading would seem to be a normal gut reaction to such a bewildering situation, but I assume the hospital treatment team filtered their interpretations of my behavior through the formula they used to treat madness.

My panic and frantic reactions worsened my prospects of getting anyone to listen to me. The staff had a protocol to introduce the mental patient to his submissive role in the power hierarchy of the hospital. Locked in seclusion and heavily sedated, I fought with all my might against giving in to the spirit-breaking power of the drugs. Each time a drug started wearing off and I again began demanding justice, fairness, a

hearing, I would feel a brief surge of hope when the door opened, only to have it quickly dashed by the entrance of two dour attendants and the ominous presence of the nurse waiting in the doorway. The two attendants easily managed by ineffectual thrashing, and with her practiced professional calm, she stuck the needle in my butt and off I would go to a mindless space that I would never remember. It was my first lesson in a hospital curriculum designed to teach passive dependency through aversive training." (Bassman 2007. Pgs.46-47)

At the time of his admission, Ron believed that he possessed special psychic abilities. These beliefs were derided by staff which he experienced as persecution and which he countered with magnification of his own special status:

"What began for me as simple psychic powers were metamorphosed in the hospital crucible- I was touched by God. Searching my mind for some explanation, something to make sense of the incomprehensible. I began to identify with Jesus Christ; I wondered if my persecution, like His, was a sign of my mission. Was I the new messiah? There had to be an explanation to make sense of these trials and ordeals." (Pg.49)

Like Kate Millett, then, Ron was implicated in an identity contest with others. They identified him as mentally ill and he identified himself as psychically gifted, chosen and persecuted. It was on this basis he fought 'with all his might' against the effects of the medication and for some justice. From Ron's perspective, this fight was for nothing less than himself.

In summary, persons can be opposed by, and can oppose, others in disputes over personal identity. Furthermore, as the accounts of Kate Millett and Ron Bassman attest, *contesting identity with others* is very difficult for persons in situations where others are powerfully positioned. In the context of hospitalisation, they were disadvantaged in the face of the coercive capabilities of psychiatric professionals. And prior to hospitalisation, they were disadvantaged in the face of the combined weight of others in their everyday social network aligned with psychiatric professionals and a legal apparatus for compulsory detention. Similarly, going back to the previous section on *self-compelling*, it is often very tough for persons to force themselves into *keeping true (to) self-conceptions*.

Given how hard it can be for persons in *self-compelling* and *contesting identity with others*, there is a question about the sustainability of *struggling through with Me's* and broader questions relating to the course and outcomes of such struggle.

Courses of struggle

The course of *struggling through with Me's* is varied but it is significantly shaped by limits on the sustainability of such struggle. In the context of psychosis, persons are often very aware of these limits and this informs their actions in different ways. For one thing, persons make accommodations, concessions or evasions because 'all-out struggle'- whether with others or oneself- becomes untenable. Nonetheless, through *giving way*, they manage to sustain a degree of fidelity to, and truth of, themselves.

However, *giving way* may not be possible or only tenable for a period of time. Persons may be forced to capitulate to the power of others or to the force of their own suffering. Through this *enforced submission*, they are compelled into actions and situations that are anathema to their self-conceptions. Their identities- to which they formerly remained true and which they kept true- are negated and lost.

Yet, this negation and loss of self-conceptions is often temporary. Once compulsion- whether by others or one's own suffering- is removed or eased, persons submit no more. When they no longer have to give in, they resume *keeping true (to) self-conceptions* that were temporarily lost. They retrieve the truth of their identities through *liberated revival*. However, this may not be the end of the matter and further *enforced submission* commonly follows at some point. Indeed, a cyclical pattern of *enforced submission* and *liberated revival* can persist over long periods of time.

Struggling through with Me's can involve an alternative course of identity loss and retrieval. Here, persons experience a reduced or eradicated capacity for attesting to the truth of particular self-conceptions. They lack the resources for *keeping true (to) self-conceptions* and experience *identity erosion* to the extent that they consider themselves profoundly diminished. To themselves, they are no longer the persons they once were and this loss is experienced- at least for a time- as irredeemable.

In this case, where persons retrieve the truth of prior self-conceptions, it is through an arduous and protracted course of *laboured restoration*. Persons

slowly rebuild the truth of an identity through *self-compelling* and through accumulating the necessary bodily and interpretive resources.

These various *courses of struggle* deserve further examination.

Giving way

Giving way is a form of action that involves concessions, evasions or accommodations that are a way of *keeping true (to) self-conceptions* in the context of personal struggle. It is something to which persons resort in circumstances where 'all-out' struggle is unsustainable or untenable.

When persons experience their struggles with others as unsustainable, *giving way* entails covertly *keeping true (to) self-conceptions* and evading overt identity contests. For example, returning to Aine who believed she was a political prisoner when in a psychiatric hospital, she stopped talking to doctors and nurses about this. She said that she realised the pointlessness of such talk but also that desisting from it was helpful in gaining discharge. In other words, Aine suggested that she got out of hospital not because she changed her beliefs but because she stopped talking about them. Generally speaking, she continued this policy and this probably explains why her key worker designated Aine as "recovered" when identifying her as a potential candidate for participation in this study.

So, by not trying to convince psychiatric professionals what she knows to be true, Aine seems to manage their impressions of her. Another way she does this is by taking medication even though she does not believe it has any value. She said that her mother pays close attention to her medication adherence

and that she would be re-admitted to hospital if she refused it. Furthermore, she resents all of this:

“The whole thing undermines you. You’re not your own person. You have people telling you how to run your life. Doctors and nurses telling you how to run your life.”

For Aine, then, part of keeping true- as competent and as fully aware of political scandals- involves keeping quiet about what she knows and going along with psychiatric treatment. It is in these senses that she is *giving way*. And whilst this does help her to remain true to and maintain the truth of herself, it nonetheless has its costs because she resents the control of others.

A similar pattern is associated with Sarah’s situation. As mentioned in the previous chapter, she believes she is stalked by others but this is disbelieved by her relatives and psychiatric professionals who attribute her beliefs to schizophrenia. On this basis, she does not talk about the stalkers because this tends to lead to higher doses of medication or hospitalisation. Also, she takes medication even though she believes it has no value:

“I don’t think it does any good really. It doesn’t help.”

Like Aine, she associated her adherence to antipsychotic medication with the threat of hospitalisation. Sarah takes medication to avoid hospitalisation and to “keep the doctors and nurses off my back.” Again, as in the case of Aine, *giving way* has mixed implications. Sarah sustains a view of herself- as correct about what is going on- but still has to live with being discounted by others. As already mentioned, she refrains from suicide in

keeping true to *Me-who-cares-for-my-family* and she lives a life of lonely endurance. When asked how she puts up with this situation, she replied:

"**I don't have any say in it, basically. I just have to keep going."**

The cases of Aine and Sarah give some indication of one of the conditions under which persons tend to give way in identity contests. From their own perspective, they are implicated and disadvantaged in power relations with others. *Giving way* is a way of managing this power relation. For Aine and Sarah, this involves staying quiet about what they know and complying with medication regimes. This way, they avoid admissions to hospital that psychiatric professionals can impose upon them without surrendering their views of themselves.

Returning to Kate Millett who was forcibly admitted to a County Clare psychiatric hospital, *giving way* involved the use of deception. She informed her admitting psychiatrist that she would not take medication but this is how she described the first medicines round she encountered on the ward:

"Didn't I tell the doctor with the little beard last night that I would not take drugs, that this was my constitutional right? If she calls my name I will repeat my little formula from the American Civil Liberties Union. Not that that will do me any good, but it's a spell, a ritual, something you must say to have said it. So when I hear my own name called in this place and the beefy face of the boss nurse is staring me down, I mumble my excuses and then wilt before her ringing command. "Swallow that right now." "What is it?" "Your medicine." "Would you explain what it is called?"

"Prescribed." "No, I mean what is the substance, what chemical?" "None of your business." "How can I swallow something when I do not even know what it is?" "Swallow." I pretend to swallow. There is really nothing else to do." (Millett 2000. Pgs.204-205)

In this situation, Kate did not openly defy the commands of the "boss nurse." But she did not want to take the medication because to do so was anathema to her view of self as competent and autonomous. Caught between compulsion by others and the obligations associated with *Me's*, she pretended to take the medication but did not swallow. In keeping true (to) *Me-as-autonomous*, there was "really nothing else to do" other than give way, but not give in or give up, through surreptitious non-swallowing.

So, Kate appeared to do as she was told but actually evaded doing as she was told. Subsequently, she was caught hiding her medication and she was also apprehended when she tried to escape. On this basis, she was placed under tighter supervision and could not evade taking the medication. However, like Aine and Sarah, she did evade the identity implications of compliance. She did as she was told but maintained a view of herself as unjustly treated and a commitment to *Me-as-autonomous*. This is conveyed in the following passage:

"You accommodate, you learn what to avoid, whom to placate. And the pull to be solid with the oppressed, the moral imperative toward solidarity, meets the pull toward making yourself agreeable with the guards. Yesterday I discovered that there is a little kitchen available to the patients who wash dishes. The staff kitchen really, but if you are good and smile a

great deal and are very pleasant, there is real coffee there. This must be the coffee they gave me that first night- when was it? How long?- you must know; you must always know the date. You must count the days and keep a record in your night table. If you no longer know how long you have been held, how long you have been imprisoned, how will you ever get out or help yourself? What will you say when you are asked? Suppose that help came and you were unable to tell them when you were taken, the day of your arrest- it would dissolve all this horror into nothing. Forget it- make up to this bully of a nurse and admire the coffee, the glass jar of instant coffee. Would she make me some? Would she really? Or could I make it myself? Oh, I'd love to. "You can come here again if you are good." "But sure I am always good": the brogue to amuse them. "Ah but ya take walks now, don't ya, Katherine?" "Nothing but a wee small walk it was," this with the grin of an eight-year old. "And a great mistake it was, too," I add, perfectly serious, swallowing my own meaning while they take theirs." (Millett 2000. Pg.238)

Here, Kate remained as aware as ever of her oppression, but described accommodations to the regime that were exercises in impression management. A similar account of accommodations is given by Mark Vonnegut who was admitted to a psychiatric hospital in the late 1960s as a 'hippie' diagnosed with schizophrenia:

"I was back to being polite, the well-tempered paranoid. I didn't have much choice. If I wasn't polite, they could stick me with those needles or

put me back in that little room or take away my visitor privileges or any number of other things…..There was a fair amount to be polite about. There were silly rules about where I could and couldn't be. I had exhibited some fairly alarming behavior, but still the lag between my being trustable and their trusting me was a bit long at times. It seemed to take them forever to believe that I was capable of keeping clothes on or not being combative or able to go anywhere without an orderly watching over me. At several points I was on the verge of saying, "Come on. That's not really necessary any more." But I never did, mostly because they always seemed to catch on sooner or later, but also because I didn't particularly want to be reminded of what a problem I had been.

The big thing I was polite about was what a bunch of fascist no-goodnik stupid creeps they were. Spiritual mud puddles. Tight-asses. Their straightness made a laser beam look like an indecisive snake with a broken back. They utterly lacked poetry or even slight sympathy for anything vaguely poetic. Not so much as a glimmer of anything you could call curiosity about anything. Insight? Forget it. These were beyond a doubt the dullest, least inspired people I had ever run into.....So there I was, subject to the whims of fascists. I didn't find much to challenge the idea that these people were indeed part of a no-goodnik oppressive machine of some sort. My only hope was to be polite. As soon as I wasn't a patient any more, I could be as stupid as they were and get away with it. For the time being, however, I had to be supergood." (Vonnegut 2002. Pgs.189-190)

In being polite and "supergood," Mark evaded identity contests with powerful others whilst at the same time preserving his oppositional perspective that was, in part, associated with his self-conceptions as a hippie. This combination of impression management and self-preservation is what constitutes *giving way* to others. Another example is provided by Bernie who was admitted to a psychiatric hospital after a manic breakdown. When asked how she came to be discharged, she replied:

"Well, I suppose I conformed….If you're wise, you know you have to conform to get out of there. It comes back to whatever mental problem you may have, you won't take people's ability to cop on, you know what I mean. That doesn't go with mental illness, you know what I mean. You know what I'm trying to say to you, people still have their senses."

Like Mark Vonnegut, Bernie said that she enacted her "best behaviour." She kept her temper even though she found aspects of the hospital regime to be demeaning and she deliberately suppressed other emotional expression like laughter because she was aware this could be construed as "manic." Unlike Mark Vonnegut, though, Bernie continued to police her own actions beyond discharge. She believed that her relatives and other persons in her network were inclined to attribute her actions to illness even when, with regard to others, the same actions would be considered normal. This particularly applied to the expression of emotion and so, for a long period, Bernie managed her emotional self-presentation in the face of the surveillance of others. She concealed her

disagreement with others over abnormal and normal feelings, over psychiatric identification as against *Me-with-normal-feelings*.

As a final example of *keeping true (to) self-conceptions* through *giving way* to others, Karl Snyder wrote in his autobiography about how he was prescribed antipsychotic medication by a psychiatrist but refused to take it. In response, the psychiatrist threatened to stop seeing him:

"I eventually decided to follow his recommendation, but my decision was based on a delusion that They would stop following me if They thought I was crazy- if I took the medicine, I would seem to be crazy, and They would have no need to follow me anymore. The surveillance would stop." (Snyder et al. 2007. Pgs.83-84)

This is a striking illustration of a resourceful interpretation that is part of *giving way*. Karl believed that the CIA and FBI were keeping him under surveillance. During his initial psychiatric involvement, he could not believe that his perceptions were inaccurate. Rather than displace self-conceptions- oriented to capability in knowing what is happening to him and persecution by others- with a psychiatric identity, Karl accommodated medication-taking to his prior views of self. Medication could end surveillance by secret agents and yet the reality of this surveillance could be preserved. In this way, for the time being at least, Karl gave way to his psychiatrist but sustained truth to, and the truths of, himself.

In all of these cases, persons gave way to others in some way. But they also gave way to themselves in the sense that they did things- like take

medication, pretend to take medication, be polite, and so on- that they would rather not. This was part of dealing with two sets of conflicting requirements- those enforced by others and those required as part of *keeping true (to) self-conceptions*. Yet a similar pattern can apply more primarily to relations with self because persons can experience *keeping true (to) self-conceptions* as difficult to sustain regardless of whether others are involved.

For example, Josiah talked of the difficulties posed by keeping true (to) *Me-as-devout-Christian*. For a period, he was going to Confession several times a week, attending Mass as often as possible and studying scripture. Maintaining this level of commitment became onerous and Josiah was inhibited in doing other things. At the time of interview, he said that he was "taking a break" from the full rigours of faithful adherence. He was still reading religious newspapers and studying a course in religion but had not attended Mass for four weeks.

Bernie used exactly the same phrase of "taking a break" in the context of her family and domestic commitments. At one point, she experienced her own need for household cleanliness as a kind of tyranny that ruled her life. Yet, at the same time, she said that she always had a "zest for life" which meant she could forget about cleanliness for a while when she was socialising with friends. More recently, she says that she learned to care for herself and this involves time away from domestic and maternal responsibility. She loves reading because "…there's huge escapism in that," she deliberately spends time away from the house and deliberately does things 'just for herself.' In these

ways, she takes a break from faithfully adhering to *Me-as-housewife* and *Me-as-mother*.

So, through taking a break, Josiah and Bernie evade infidelities to themselves. They do not betray and abandon established identities. Rather, they manage the rigours of self-obligation by reference to a temporary release. They give way on their commitments but do not give up on them.

In summary, *giving way* is a means of reconciling a power disadvantage with the preservation of self-truth. To a varying extent, it allows persons to 'get along' in their self-relations even when they cannot fully 'be' themselves. However, *giving way* is not always tenable or sustainable. In the context of psychosis, there are occasions when persons are forced into submission.

Enforced submission

In the context of psychosis, persons are commonly forced to abandon *keeping true (to) self-conceptions*. They are obliged to act in ways that are antithetical to their identities and make it impossible to keep *Me's* true. This involves a fundamental sense of defeat and acts of *enforced submission*.

An illustration of *enforced submission* is provided by Elyn Saks. In her autobiography, she described her first psychiatric involvement when she was a student at Oxford University. After an initial consultation, she was seen by a group of psychiatrists. One of them suggested that she should attend a Day Hospital:

"Terrified (and angry, both at the suggestion and his manner of speaking to me), I refused outright. I wanted help, not incarceration. I looked at the door behind him; it led out. Out.

"It's a day hospital, Miss Saks. You would be able to go home and sleep in your own bed at night."

"No," I said flatly. "I don't belong in a hospital. I'm not crazy. This isn't the right place for me."

He was undeterred. "It is our opinion that you need the support and help of a day hospital." The other doctors were looking at me as though I were a specimen in a jar.

"I'll be fine," I insisted, "as long as I can see a psychiatrist once or twice a week."

"That would not be enough," Russell said firmly. "You really need to come into the day hospital."

"No way!" I said, springing out of my chair and running as fast as I could out of the room, and out of the hospital. I kept waiting to hear the sound of footsteps behind me, their angry voices, someone yelling, "Stop that woman!" But it didn't happen. I'd left them behind.....That night was terrible. I lay awake in a pool of sweat, unable to sleep, a mantra running through my head: *I am a piece of shit and I deserve to die. I am a piece of shit and I deserve to die. I am a piece of shit and I deserve to die.* Time stopped. By the middle of the night, I was convinced day would never come again. The thoughts of death were all around me; I realized then that they

had begun the summer before, like a small trickle in a creek where I had gone wading. Since then, the water had been steadily rising. Now it was deep and fast and slowly threatening to cover my head.

The next morning, haggard and beaten, I managed to call the hospital and reach Dr. Smythe. "I'm glad you called," she said. "Please, come in as soon as you can."

That lonely night had served its purpose. No one had locked me up against my will. I entered the hospital voluntarily." (Saks 2007. Pgs.57-58. Original italics)

Elyn had a strong conviction that she should not need psychiatric treatment, that she should not go to a psychiatric hospital and that she should be able to deal with her own problems through acts of will. She viewed psychiatric treatment as anathema to an established and preferred *Me-with-willpower*. But, in the above passage, she signalled that she had no choice but to give in and go to the Day Hospital. She could suffer no longer and, as she said, she was "beaten" when she contacted Dr. Smythe. Even though she "entered the hospital voluntarily," this was in the sense that she was not forced by others. Her submission was nonetheless forced by the suffering associated with thoughts of death.

Subsequently, Elyn agreed to in-patient admission and a psychiatrist tried to convince her to take antidepressants:

"I refused. "People ought to get better because they work at it, not because they take some pill," I said…..The idea of putting a pill in my mouth

disgusted me. Just as disgusting was the idea that I'd somehow become so weak of character that I needed a drug to get better." (Saks 2007. Pgs.63-64)

She continued to renounce medication but was then disturbed by her own gaunt, unkempt appearance when she looked in a mirror. At this moment, it seemed to her that she was faced with the stark choice of medication or death. Elyn submitted to medication.

This pattern of *enforced submission* is also illustrated in Kate Millett's autobiography. As described in a previous section, she stopped taking lithium and she was recurrently *contesting identity* with others. When incarcerated in an Irish psychiatric hospital, she had to give way in the face of enforced treatment but still managed to sustain a view of herself as fundamentally competent. Subsequently, some Irish friends managed to secure her release into the supervision of a sympathetic Dublin psychiatrist and she was freed to return to the United States. Like when her friends, family and a psychiatrist sought her incarceration in New York, Kate emerged with intact self-conceptions after contesting her identity with others. However, on her return from Ireland, this keeping true to herself was quickly rendered untenable.

After two months back in the United States, Kate felt defeated by debt and a general sense of failure. Desperate and depressed, she went to a psychiatrist with whom she had past involvement:

"It all seems the same to him. He must have hundreds of patients, and the six months I haven't seen him appear to have quite erased me from his

mind. Sitting before him, I feel erased. A defector surely, but in returning a prodigal as well, proof of the pudding. He's not sympathetic, merely recriminating. As if accusation after accusation of madness, misconduct, bizarre behavior, were cure in itself. I want a prescription, not a lecture. My illness now is not mania but depression- he should direct his indictment to the other one, the manic. She would have been delighted in answering these charges, contradicting him, demanding he prove it. The self I am now wouldn't bother to cavil, is too tired and humbled and broken, too sick to fight back.

Capitulate and get a prescription. I was mad to stop taking lithium, yes, manic as they say. There's no point in arguing it; it no longer applies." (Millett 2000. Pg.260)

In 'capitulating', Kate was willing to take lithium and accede to an ascription of mania. And in this *enforced submission*, she viewed her defeat as complete with its implications that she was fundamentally wrong about herself:

"Tame I am, defeated. No longer the crone of Ireland raving at them all. Forget her- that way lay madness. From now on it will be your eternal disgrace that you said this or did that, the words filtering back to you in accusing voices, your follies defined in their tones, demonstrated in the tired disgust of their very manner of breathing as they deliver the withering quotations. What they went through: the anxiety over you, the embarrassment of you. The problematic one day to the next while you were off in a foreign country and getting into God knows what trouble. Or at

home and endangering the farm, ruining the summer for the apprentices. Spending like a fool, wasting time and money and energy; wasting everything.

All over now: Foreman's (her psychiatrist's) voice commands you to surrender, not only the present but the past. "You were wild, you were wacko, you were high as a kite."…" (Pg.264)

It was "all over now" for the identity Kate had struggled for. In the face of necessity imposed by desperation, she acceded to what her psychiatrist commanded and renounced what she once insisted was true of herself. And she took the lithium, slowly recovered and managed to gradually pay off her debts.

After a fashion, Kate's capitulation was the end of the story because it was the focus for the final chapter of her autobiography. However, she added a postscript and, in doing so, illustrated and actualised a common pattern of identity retrieval: *liberated revival.*

Liberated revival

When loss of identity is associated with capitulation, persons commonly experience defeat to the extent that *enforced submission* continues. As they are released from enforcement, persons resume their commitments to and by conceptions of themselves (to) which they formerly kept true. In this *liberated revival*, they are like wrestlers who submit because they are inescapably locked by their opponents but restart combat once they are let go. Their surrender is complete and yet temporary: they are finished by, but only for the duration of, the force exerted upon them.

Returning to Kate Millett- who surrendered to her psychiatrist, lithium treatment and ascriptions of mental illness- this pattern of *liberated revival* is illustrated in the postscript to her autobiography which began as follows:

"I wrote *The Loony Bin Trip* between 1983 and 1985. The last section was written first, in a hangover of penitence and self-renunciation, that complicity with social disapproval which is depression. Now, when I reread it, I find something in it rings false. True, it describes depression: the giving in, the giving up, an abnegation so complete it becomes a false consciousness. But typing it over I want to say, Wait a moment- why call this depression?- why not call it grief? You've permitted your grief, even your outrage, to be converted into a disease. You have allowed your overwhelming, seemingly inexplicable grief at what has been done to you- the trauma and shame of imprisonment- to be transformed into a mysterious psychosis. How could you?" (Millett 2000. Pg.309)

Here, Kate addressed her past self as a *Me-who-gave-in* but she clearly no longer identified her present self in those terms. She went on to explain her surrender:

"I could not bear to be the only one anymore. I could not pit my truth against so many, against the power of science, nor could I live without other people. I surrendered my understanding, lost myself trying to survive and accommodate. And I went on taking lithium. It seemed a condition of parole: if I stopped taking it and were found out I might be

confined again. A sort of Pascal's bet: I was terrified that without the drug I could plummet again." (Pg.309)

So Kate continued taking lithium for several years but this was reluctant compliance rather than faithful adherence. In the above passage, she conveyed a sense of continuing duress imposed through a combination of the force of others and the "power of science" as well as fear of re-incarceration and depression. Nonetheless, she did not capitulate forever and eventually stopped the lithium again. By this stage, she was active in the service user movement and had the encouragement of "comrades" as she described them. So she was released from the relative powerlessness that comes from isolation combined with pressure from others. She gradually reduced the dosage of her lithium but did not tell her friends, family or psychiatrist. As part of her *liberated revival*, she was *giving way* and avoiding identity contests rather than continuing to give in.

Kate waited a year after completely discontinuing the lithium with no untoward effects. It was only then that she told any of her immediate friends and family. At the time of the publication of the second edition of her book in 2000, she remained off medication and clear of involvement with psychiatry. She concluded her postscript with a note of vindication:

"The psychiatric diagnosis imposed upon me is that I am constitutionally psychotic, a manic-depressive bound to suffer recurrent attacks of "affective illness" unless I am maintained on prophylactic medication, specifically lithium. For a total of thirteen years I deadened my mind and

obscured my consciousness with a drug whose prescription was based on a fallacy. Even discounting the possible harm of the drug's "side effects," it may seem little consolation to discover that one was sane all along. But to me it is everything. Perhaps even survival: for this diagnosis sets in motion a train of self-doubt and futility, a sentence of alienation whose predestined end is suicide. I have been close to that very death, remember its terror and logic and despair. One struggles to forgive the personal betrayals, just as one must come to analyze the forces that hemmed one in. But it is essential not to forget. In the remembering lies reason, even hope and the saving faith in the integrity of the human mind." (Pgs.310-311)

Here then is another end to Kate Millett's story. It marks a return to self-conceptions- as essentially sane and competent- that she initially fought to sustain and then surrendered. And this *liberated revival* proved enduring.

So, Kate Millett ended the telling of her story with an account of *liberated revival*. But, just as persons can retrieve identities in this way, this is commonly not the end of the story and is often succeeded by further *enforced submission*. Returning to Elyn Saks whose suffering forced her submission to psychiatric hospitalisation and treatment, she recommenced her university studies upon discharge and again excelled as a student. With this restoration of her everyday existence, she discontinued her medication and once more repudiated a psychiatric identity. Freed from her suffering associated with immersion in psychosis (or at least from the extremes of this suffering because she did still experience intrusions of psychosis), she recommenced her

committed relations to *Me-with-willpower* that was antithetical to self-attributions of mental illness.

However, six months later, Elyn was again hospitalised and was forced to capitulate in the same way as on the first occasion. Again, she was discharged, returned to her studies and another *liberated revival* ensued. After graduating with distinction from Oxford University, she returned to the United States and studied law at Yale. Again, she suffered terribly with psychosis and was forcibly admitted to, and treated in, a psychiatric hospital. She gave in but then again resumed in actualising *Me-with-willpower* and her opposition to psychiatric involvement. This cyclical pattern continued and, in its midst, she built a successful career becoming a Professor of Law in California. After a number of years of varying degrees of psychiatric involvement, her psychiatrist/analyst (Dr. Kaplan) told her that her diagnosis was schizophrenia and she should accept it:

"Kaplan was asking me to surrender. That's the way I heard it, and that's the way it felt, deep inside my core. Asking, hell- he was *telling* me to surrender. I'd never surrendered to anything in my life. If the doctors up to this point were right, wasn't I supposed to be in an institution by now? Virtually every single expert, at one time or another, had suggested that this was my destiny. If I had ever truly believed them, if I had ever surrendered to their version of me (instead of doggedly hanging onto *my* version of me), I'd still be crawling around the tunnels under the Warneford, burning my arms and legs with a lighter and waiting for devils

to blow the world up by using my neurotransmitters in some explicably evil way.

But I didn't believe them, and look where I'd ended up: a lawyer, a scholar, with multiple academic degrees and honors, the promising beginnings of both a publishing career and a teaching career. I was living on my own, making friends, feeling the warm California sun on my back every day and being grateful for it. So- surrender? Stop fighting? I couldn't." (Saks 2007. Pg.248. Original italics)

In this passage, Elyn makes it clear that she preferred, and was committed to, her version of herself to that suggested by psychiatrists. As a 'fighter,' she was obligated to never surrender and this was justified by her considerable achievements accrued through 'fighting.' Nonetheless, her struggles to sustain *Me-with-willpower* were repeatedly defeated by the awfulness of psychosis. Elyn's suffering could not be willed away and so no amount of fighting could avoid *enforced submission*.

Hence, Elyn was implicated in a cyclical pattern of *enforced submission* and *liberated revival* for a number of years. Her surrenders were always temporary and her fighting comebacks always ensued. In her case, this pattern was related to her preference for a strong, autonomous- rather than psychiatric-identity. But this kind of pattern can also relate to identity preferences established as part of immersion in psychosis. Returning to Kay Jamison and her "war with lithium," she took her medication when she was suffering but not

once she was recovered. Part of the issue was that Kay's experiences of mania could be exhilarating and therefore difficult to give up:

"The intensity, glory, and absolute assuredness of my mind's flight made it very difficult for me to believe, once I was better, that the illness was one I should willingly give up. Even though I was a clinician and a scientist, and even though I could read the research literature and see the inevitable, bleak consequences of not taking lithium, I for many years was reluctant to take my medications as prescribed. Why was I so unwilling? Why did it take having to go through more episodes of mania, followed by long suicidal depressions, before I would take lithium in a medically sensible way?

Some of my reluctance, no doubt, stemmed from a fundamental denial that what I had was a real disease. This is a common reaction that follows, rather counter-intuitively, in the wake of early episodes of manic-depressive illness. Moods are an essential part of the substance of life, of one's notion of oneself, that even psychotic extremes in mood and behavior somehow can be seen as temporary, even understandable, reactions to what life has dealt. In my case, I had a horrible sense of loss for who I had been and where I had been. It was difficult to give up the high flights of mind and mood, even though the depressions that inevitably followed nearly cost me my life.

My family and friends expected that I would welcome being "normal," be appreciative of lithium, and take in my stride having normal

energy and sleep. But if you have had stars at your feet and the rings of planets through your hands, are used to sleeping only four or five hours a night and now sleep eight, are used to staying up all night for days and weeks in a row and now cannot, it is a very real adjustment to blend into a three-piece suit schedule, which, while comfortable to many, is new, restrictive, seemingly less productive, and maddeningly less intoxicating. People say, when I complain of being less lively, less energetic, less high-spirited, "Well, now you're just like the rest of us," meaning, among other things, to be reassuring. But I compare myself with my former self, not with others. Not only that, I tend to compare my current self with the best I have been, which is when I have been mildly manic. When I am my present "normal" self, I am far removed from when I have been my liveliest, most productive, most intense, most outgoing and effervescent. In short, for myself, I am a hard act to follow." (Jamison 1996. Pgs.90-93)

So, Kay gave in to lithium treatment when she was suffering “suicidal depressions” but, once recovered, she did not give up a preference for herself as manic. When she was not acutely suffering, she viewed *Me-as-normal* as inferior to *Me-as-manic*. The loss of mania was too great and it was partly on this basis that she renounced lithium treatment at least until she re-experienced suffering.

Liberated revival, then, has varying sequelae. It can precede a sustained return to prior identity commitments and *keeping true (to) self-conceptions* as in the case of Kate Millett. Or it can itself be succeeded by further *enforced*

submission as in the case of Elyn Saks and Kay Jamison. Where there are recurrent cycles of surrender and revival, this commonly persists until persons engage to new identities or engage identities in new ways. This is explored in the next chapter but, more immediately, there is a variant of identity loss to explore that is part of an alternative course of *struggling through with Me's*: *identity erosion.*

Identity erosion

Identity erosion occurs as persons experience a severe depletion of resources that are necessary to sustain relations of *keeping true (to) self-conceptions*. These resources are primarily *bodily*- referring to the extent to which persons can summon physical capacity and bodily energy- or *interpretive* referring to the availability of 'symbolic objects' from which persons can derive meanings that relate to the truths of themselves. When there is a continuing depletion of resources that were formerly summoned in keeping (to) particular self-conceptions, identities erode and persons judge themselves diminished when such identities were valued. Such *identity erosion* is prolonged and- at least some of the time- seemingly permanent.

A pattern of *identity erosion* is illustrated by reference to Terry. He is a 49 year old man, diagnosed with schizophrenia, who was first admitted to a psychiatric hospital in 1994 and then every year for the next five years. He is married for the past twenty five years and has two daughters. Prior to his first hospital admission, Terry kept up fairly continuous employment despite alcohol-related problems. He is an ex-soldier and was a painter and decorator.

These aspects of Terry's biography are significant because his family and work status are very important to him. He always wanted to be a good father and husband and he always wanted gainful employment. They were self-conceptions (to) which he kept true. But, in 1994, Terry said that he "went insane." This began when he witnessed a man walking down a backstreet and looking suspicious. The same day, it was reported in the news media that loyalist paramilitaries were trying to plant a bomb in Dublin. The whereabouts and appearance of the man suggested to Terry that he was involved in an attempted bombing and he reported this to gardai.

Subsequently, he believed that the Loyalist Volunteer Force or Ulster Volunteer Force was targeting him for assassination because of the information that he passed to gardai. He also started to believe that the television and radio were communicating directly with him and that his flat was a place of evil. Just before his first admission to hospital, he threw his wife down the stairs because he thought she was the devil. When gardai arrived in response to this incident, Terry fought with them, he was struck with batons and he sustained broken ribs. He was then incarcerated in a locked psychiatric ward and quickly realised that he had attacked his own wife. Indeed, he thought he had killed her and said that he was "stricken with guilt."

Terry quickly recognised that he did not kill his wife but he still felt guilty for hurting her. Also, he soon realised that he was on a psychiatric ward and that, rather than persecuted by malign agents, he was suffering with mental illness. For Terry, this was a considerable relief at the time. It was preferable to

regard himself ill than in imminent danger of death. And he credited antipsychotic medication with helping him to realise these new self-truths. He believes that it was medication that helped him realise that his ideas of persecution were “unreal.”

So psychiatric hospitalisation and medication were resources that Terry employed in realising a new identity: as mentally ill. However, whilst it was preferable to be ill rather than persecuted, the subsequent identity implications were problematic. When Terry was discharged, he was taking high doses of medication and this was physically debilitating. With little energy, he spent much of his day lying on his couch at home. Also, it seems that this lethargy was associated with demoralisation. For Terry, productive activity was essential to an identity not just as a working man but also as a family man. ‘Doing something useful’ and ‘earning a living’ were part of it what it meant to be a proper husband and father:

“I was useless, no good to anybody. Not to my wife, not to my daughters, not to anyone.”

It seemed to Terry that, because of mental illness, he could no longer meet his obligations and he could see no prospect of meeting them. This lack of prospects was seemingly confirmed by recurrent immersions in psychosis and psychiatric hospital readmissions.

Hence, Terry was diminished in his own eyes for an inability to realise identities as husband, father and productively employed person. These *Me’s* were lost to Terry for the inaccessibility of resources to sustain them. Lacking

physical energy and often stiff because of side effects of medication, he lacked the bodily capacity to 'get moving.' With a mental illness that signified (to Terry) irrevocable disability, there were no prospects for identity retrieval.

In short, then, Terry's identities- as productive, as a decent husband and a good father- were eroding away as he lacked access to resources to sustain them through recurrent experiences of psychosis and psychiatric treatment. As part of this *identity erosion*, *identity commitment*- to and by conceptions of himself as father, husband and worker- was largely impossible.

A pattern of *identity erosion* is also illustrated by Bernie in the context of her experiences of hospitalisation. When interviewed as part of this study, she talked about her first admission to a psychiatric hospital:

"Being in hospital. I suppose the first thing that is hard is when they take everything away from you. You know all your jewellery or anything you could harm yourself with. It's quite, it's very demeaning. I found it very demeaning. But then I can understand why this has to happen. I think that there should be a psychiatrist that talks to you right when you get into hospital. For a little while. Rather than a nurse stripping you of everything. Do you know what I mean?"

So the hospital admission procedure involved taking objects away from Bernie such as jewellery and clothing. These objects, and their removal, symbolised something important to Bernie. Their removal was "demeaning" in that there was an implicit message about danger that she might pose to herself. She was not to be trusted with her own safety. Furthermore, she felt 'stripped of

everything' because her jewellery and clothing were taken away. She normally used these objects as part of *adhering faithfully* to her identity as a woman: she employed them in staying true to herself and reproducing the truth of herself. Their removal, then, denied her access to resources for *staying true (to) self-conceptions*.

Bernie went on to talk about other aspects of her hospital experiences. A general theme in her account was that she felt- to use her own words- "completely discounted" by professionals and her family. Here is one example:

"I think the most demoralising thing for me was when my family came up- my brother and sister- and they discussed with the doctor how they felt how I felt. It was all these people talking to the doctor about me. And I never getting a chance to express myself….It's very belittling you know. It's very belittling. Even if you are psychotic, or bi-polar, or whatever else, your brain still works….And I think that's what's forgotten."

In this passage, Bernie implies that she was normally a participant in decisions about herself and that she normally expressed herself in interactions with others. Such participation and self-expression were part of how she maintained self-conceptions as competent and responsible: they were resources she employed in sustaining this identity. When these resources were unavailable to Bernie, it was "belittling" and "demoralising."

Furthermore, from Bernie's perspective, all of this had longer term consequences. She felt ill-equipped to return to her responsibilities once she was discharged from hospital:

"And then eventually I got out completely but it was very hard when I came out because I'd been in hospital for three months, thirteen weeks exactly. I had to start back cooking, I had had a holiday for thirteen weeks. Well we won't call it a holiday but I was away from home so I had to start back from scratch, you know what I mean. And the roles would have been reversed. My husband was the housekeeper at that stage. And he was the mother to the kids. So my roles were reversed completely so I had to get it all back. But I didn't. It was September when I came out, the end of September, and the washing machine broke in the middle of November, the end of November, and that just put me over the edge. And I went back into hospital again over Christmas…"

Denied the means to sustain an identity as capable when in hospital, Bernie no longer regarded herself in these terms when she was discharged. Hospitalisation provided the conditions for a profound erosion of her sense of capability and so she could not simply resume everyday living with her prior responsibilities. She needed to "start back from scratch" but instead was immediately expected "to get it all back." This was all 'too much' and it was in this context that she experienced crisis and readmission.

In summary, then, persons can experience an erosion and loss of identities that is occasioned by the depletion of bodily or interpretive resources that were formerly employed in *keeping true (to) self-conceptions*. However, this does not mean that identities are necessarily irretrievable in this context but such retrieval does imply a course of struggle: a project of *laboured restoration*.

Laboured restoration

With *identity erosion*, persons lack the resources necessary to sustain prior *identity commitment*. Therefore, *liberated revival*- prompted by the removal of duress- is not possible. Instead, retrieving *Me's* is a difficult and protracted enterprise of *laboured restoration*. This enterprise involves *self-compelling* where persons 'make themselves' act in ways that are consistent with particular self-conceptions and gradually re-accumulating the resources that can sustain particular self-truths.

Returning to Terry, it will be recalled that he could not sustain the truth-to and of himself as husband, father, and productive person- because of the demoralising effects of repeated immersions in psychosis, psychiatric hospitalisation, particular significations of mental illness and drug treatment. This meant that, in his own eyes, he was profoundly diminished as a person.

However, Terry's medication regime was eventually changed and he started with Clozaril. He rated this as helpful and was never again readmitted to a psychiatric hospital (his last admission was in 1999). He suffered less in the way of dystonic side effects but still lacked energy and interest. Nonetheless, in 2003, he secured a part-time job as a caretaker and then went on to other work and employment retraining.

In accounting for this change in the structure of his daytime activity, Terry talked of the initial difficulties which involved effort and tiredness. He found it difficult to summon the energy to go to work and the effort of getting

through the day was “exhausting.” In response to a question about how he managed to make this effort, he replied:

“I dragged myself to work every day and I forced myself through each day.”

When asked to explain how this was possible, he said:

“I needed something to talk with my wife about at the end of the day. I’d had nothing to say to her before I started work again. And I needed somewhere to go, something to do with myself. I was sick of lying around.”

So, Terry reported acts of *self-compelling* that he explained by reference to marital obligation and the necessity of ‘doing something’ and ‘going somewhere.’ On this basis, dragging himself to work can be understood as a committed effort to restore *Me-as-good-husband* and *Me-with-purpose.*

Over time, Terry found it progressively easier to go to work and maintain activity. His efforts seemed to progressively add to, rather than exhaust, his capacity for physical endeavour. And as Terry sustained regular structured activity, he said that his relationship with his wife and daughters improved. He took more interest in their lives and did have more to talk with them about. He did more jobs around the house. These were ways in which Terry was again *faithfully adhering* with a family and work identity and so they were also ways in which he re-established particular self-truths. At interview, he expressed a high level of contentment with himself, his family, work and life in general. He seemed restored to the identities whose loss he once lamented.

This pattern of *laboured restoration* is also illustrated by reference to Bernie. After her second discharge from hospital, she continuously doubted herself and everyday tasks represented formidable challenges. The task of taking her children to and from school was especially formidable. Bernie knew there were other mothers who were aware of her hospitalisation and she believed they judged her negatively. Each time she went to the school, it felt like she was running a gauntlet of disapproval. This overlapped with medication-related problems:

"I had a problem in that the tablets I was on didn't agree with me. So I had the shakes and I had a restlessness in my feet so I couldn't stop walking. So one day in the schoolyard I was shuffling and a mother said to me "Bernie, you're shuffling." And I had a horror when I was in psychiatric hospital of people shuffling, you know shuffling up and down the ward. So I thought to myself "am I going to be like this for the rest of my life?" I should have opened up straight away and said that these tablets are affecting me but I hadn't the confidence in hospital to do that, you know."

For Bernie, the "shuffling" was a visible sign of her status as a former psychiatric patient and she felt ashamed. As she indicates in this passage, shuffling also reminded Bernie of persons she observed in hospital that were themselves shuffling because of side effects of medication. These persons had long histories of psychiatric involvement and Bernie imagined her own fate as long-term incarceration. In shuffling like them, Bernie feared that this was a sign of also sharing their broader destiny and this made it difficult for her to

envisage recovery. Furthermore, the shuffling was associated with a restlessness that literally meant she could not rest:

“I remember one night, a few nights I couldn’t go to sleep, it was five o’clock in the morning and I was just shuffling around the bedroom, shuffling around the sitting room and I just couldn’t go to sleep.”

Despite this adversity, Bernie ‘kept going’ through the ordeal of taking her children to and from school:

“The kids. You just have to keep going for their sakes. There was no pleasure in it though. It was just dark, going from A to B. Like a fish in a bowl.”

Unlike her sense of personal capability that was profoundly eroded by hospitalisation, she was still capable of keeping true to herself as a caring mother albeit with difficulty. Over time, going to the school became less of an effort and it seems possible that her successful endurance was a factor in the long-term restoration of the truth of *Me-as-capable*. In *identity commitment* to and by a self-conception as caring mother and living the truth of this self-conception, it is plausible that she was starting to build the means to attest to her own ability. At the same time, going to the school got easier because she started to ‘go easier on herself.’

Professional help was a factor in this change. Bernie attended family therapy with her husband and the useful contribution that she made to the family- especially in caring for her children- was an emergent theme of the sessions. She identified this recognition of her role as a source of confidence. In

this regard, conversations with her community psychiatric nurse (CPN) were also helpful:

"I would have beaten myself up when I came out of hospital, I wasn't really able to do the housework. I actually had no interest in doing housework. My husband was doing it but she (the CPN) said to me: "Bernie, all along before you went into hospital you were doing everything" and I needed somebody to say that to me, you know what I mean. So it's OK if there's a time in your life when you're not able to do it. You shouldn't be beating yourself up just because somebody else had to take over."

This contributed to an enduring shift in self-relations:

"I'm gentle with myself now, I'm gentler with myself. I have no interest in what other people think of me."

This gentleness involves refrain from self-criticism and less sensitivity to the judgements of others. Going to the school disappeared as a problem because Bernie said that she no longer cared about the disapproval of other mothers.

Furthermore, in building this self-relation of gentleness, Bernie 'looked after' herself. She engaged in activities that were pleasurable for her. Her concentration improved over time and this developed in tandem with increased reading:

"Now I have wonderful concentration and I read. I absolutely love reading and that is my space and that is my time out. And I would read any book

and every book I could get my hands on. And there's huge escapism from that."

After leaving the children to school, Bernie ceased to regard housework and responsibilities as imperatives but started a routine of going to a café for a cup of coffee. This represented something that was 'just for her.' But paradoxically, through pressurising herself less about what she should be doing, she was able to do more. Through prioritising herself, she was less inclined to doubt and criticise herself. And with less self-doubt and criticism, she was able to attend to matters like housework at her own pace.

In dealing with the problem of housework, she was also initially assisted by the appointment of a Home Help:

"I found her a great help. Just the fact that I had somebody else who was going to be there. Because at this stage, I had cut off with all my friends, I had cut off with my best friend so I had nobody. I was starting from scratch and I wasn't getting any support from my husband. But just having one person coming in- three times a week she used to come- and she was helping me. That would have helped me for a year, she came for a year."

In practical terms, housework was less of a daunting burden for being shared with someone else. And this assistance meant that Bernie had time to adjust to household tasks before she was 'on her own' in doing them again. Perhaps just as significantly, there was something symbolically important about

the idea of “somebody else who was going to be there.” This in itself seemed to be helpful.

Furthermore, Bernie said that she ‘built herself up’ with confidence through reminding herself of her own abilities:

“I was always reminding myself, always reminding myself of what I can do- you need to after you’ve been in a psychiatric hospital. I mean I love when the kids have holidays, it breaks the routine and it’s lovely and it’s rest time. And then they were going back in September and I thought “Oh God” but then I just said to myself “I did it last September and the September before so I’m going to manage this September.” Talking to yourself, giving yourself that bit of confidence: “I did it before so I’ll do it again.” It’s all confidence.”

Here again, Bernie describes a relation with herself that helped in rebuilding her sense of capability.

On top of these developments, Bernie spoke up about her problems with medication and her psychiatrist modified her regimen. She now suffers none of the side effects that she found distressing.

By reference to all of this, Bernie said that her suffering is ‘behind her’ and she expressed confidence in her capacity to deal with whatever emerges in the future:

“The future? I suppose I’ll be rearing my kids. Then I’m confident enough, I don’t know what my marriage will be like, whether we’ll stay together or finish up. But I’m quite happy with myself, with my own company. Once I

have a friend or two, I will always do something to help other people, so I really have no worries about my life."

Bernie partly associated this confidence with how much she suffered in the past and her belief that things could never be as bad again:

"Nothing could be tougher than what I've been through so I don't have fear….That's very liberating."

In summary, then, it seems that Bernie retrieved the truth of herself as a capable person. This retrieval took a significant period of time and in the context of adverse circumstances. She endured this adversity, capitalised on resources that were available to her (especially help from other persons) and changed her patterns of self-relation. In so doing, she committed to and was recommitted by a relation with *Me-as-capable.*

Finally, persons do not necessarily make a transition from *identity erosion* to *laboured restoration.* In the context of psychosis, persons may not be able to retrieve certain identities and this implicates them in new patterns of identity engagement. This question of *engaging to identities* is the focus for the next chapter.

CHAPTER SEVEN

ENGAGING TO IDENTITIES

Introduction

In the context of psychosis, persons commonly get engaged to self-conceptions which they subsequently keep true and to which they stay true (at least for a time). They become implicated in patterns of relations with themselves that are not easily ended: they are committed *to* these relations and committed *by* them.

In this chapter, *engaging to identities* is explored in some detail. First, the notion of *finding things in common* is considered. This refers to how persons find similarity between themselves and an idea that can be employed in considering themselves. These discoveries of similarity are an essential though not sufficient aspect of *engaging to identities*.

Second, the question of *binding self-attachments* is examined. This refers to patterns of self-relations *to* which, *through* which, and *in* which persons are committed. These patterns constitute persons' 'terms of engagement' with particular identities.

Finding things in common

Finding things in common with a particular notion is an aspect of *engaging to identities*. In establishing themselves as 'like that' (in the sense of 'I am like that') or establishing 'that' as 'like me' (in the sense of 'that is like me'), persons identify similarities between what a particular conception means

to them and what they mean to themselves. Detecting such similarities is a necessary, though not sufficient, element in identity engagements.

In the context of psychosis, there are several related and overlapping ways in which persons find things in common with particular conceptions: through *noting resemblance to others*, through *sharing a common place*, through *going together with medication*, and more broadly through *going together with life experience*.

Noting resemblance to others

Finding things in common with others is often important as persons newly engage with a particular conception of themselves. This involves *noting resemblance to others* through comparisons with them.

In the context of psychosis, a common focus for *noting resemblance to others* is psychiatric diagnosis. For example, John is a 59 year old man who was interviewed as part of the present study. He was very definite that he suffers from mental illness and schizophrenia in particular but this was not always clear to him. In 1979, he "took a breakdown" following problems at work and what he described as a life "living on the edge" that incorporated heavy drinking and gambling. He was not sleeping, started to 'hear voices' and he was fearful that he would be killed by the IRA. After John smashed a window in Dublin city centre, the Gardai took him into custody and then brought him to a psychiatric hospital.

At this time, John was aware that something was wrong:

"I knew I was unwell but I didn't know what it was."

Whilst in hospital, he was treated with what he described as heavy doses of largactil and he quickly recovered. When discharged, John felt in "marvellous health" and he stopped taking medication. It seems that he experienced a *liberated revival* and he returned to his former lifestyle. But he shortly became "unwell" again and was readmitted to hospital.

For several years, John went through periods of "living on the edge" that incorporated heavy drinking and gambling, competitive football at a high level, and little rest. These periods were followed by immersion in psychosis, hospital admission, and treatment with medication. When restored to himself, John returned to his 'hard-living' existence. Over time however, John learned about his illness:

"No one ever told me straight I had schizophrenia. I learned that from people I met in the hospital and at day centres."

In observing and conversing with other persons in psychiatric facilities, he discovered that some of them 'heard voices' and 'had schizophrenia.' John considered himself 'like them': he heard voices like them, he was treated with the same medications and he attended the same facilities. Furthermore, John inferred (correctly from a professional perspective because he was diagnosed with schizophrenia) that he was like them in his diagnosis, that he too had schizophrenia.

So, John was *noting resemblance to others* and, in so doing, he was finding compatibility with the meanings of 'schizophrenia.' Through *finding*

things in common with others who personified schizophrenia, John was engaging to a new self-conception.

The discovery of commonalities with others- in the context of psychiatric diagnosis- is also illustrated in the autobiography by Elyn Saks. As already mentioned, she was strongly committed to a view of herself as strong and independent and this involved the repudiation of a psychiatric identity. For many years, she was implicated in a cycle of *enforced submission* and *liberated revival*. Eventually however, Elyn began to find things in common with persons who were diagnosed with mental illness. For example, she attended a self-help group for persons diagnosed with mental illness and a common theme in the group was members' attempts to stop medication:

"Yet another member of the MDDA group had tried and failed to stay off her medication. Yes, yes, she felt better now she'd taken her pills. "But I think maybe it just wasn't the right time for my body chemistry," she said. "I'll handle it differently the next time I try."

That night, talking to Steve on the phone, I said, "I know the illnesses are different, and the meds are different. But you know, I'm beginning to think there are some interesting parallels between what I'm trying to do and what the people in group are trying to do."

"Gee, ya think?" Steve said. I could almost hear the smile on his face.

"Oh, shut up." " (Saks 2007. Pgs.251-252)

Elyn observed the struggles of others as they tried to give up on medication and noted some similarity with her own struggles. But furthermore, she saw a certain futility in others' efforts to avoid both medication and the implications of their illness. This gave her cause to reflect upon her own refusal to accept the idea of herself as mentally ill and in need of medication. If others were 'like her' in repudiating mental illness and refusing medication, perhaps she was also 'like them' in living out a pattern of *identity commitment* that was ultimately futile. In *noting resemblance to others*, Elyn countenanced the possibility that she should accept the idea of herself as mentally ill.

However, in the context of psychosis, it is not only illness-oriented conceptions that are the focus for *noting resemblance to others*. This point is exemplified by Ron Bassman in his autobiographical account of oppressive experiences associated with psychiatric hospitalisation and of subsequent recovery. Part of this recovery involved making a comeback from *identity erosion* through *laboured restoration*. Through two hospitalisations, Ron said that he became submissive, despairing and listless but gradually his energy, concentration and confidence returned in the wake of his second discharge. Work played an important part in this recovery and he went on to successfully complete a Doctorate in Psychology. According to him, this achievement played an important role in his retrieval of self-respect.

Ron subsequently worked as a psychologist and, for a period, he kept quiet about his past experiences as a psychiatric patient. At the same time, he was uncomfortable about this avoidance of disclosure and did not want to "turn

his back” upon his own life history. On this basis, though with some anxiety, he first publicly disclosed his psychiatric history as part of a discussion at a professional conference. Following this, he met with persons from the psychiatric service users/survivors movement. He shared his experiences with one particular activist:

"Rae belonged to a community of people who were connected by experiential understanding- an understanding honed in the crucible of painful self-disintegration and abuse, where the anger of the psychiatric survivor still burns but is governed by wisdom and compassion. For the very first time I met a person who truly understood and shared my experience. Before the evening was over, we knew and trusted each other. I came to Rae seeking advice. I found a remarkable, charismatic woman who introduced me to the psychiatric survivor community. I quickly realized that I actually had been a long-time, inactive member. I left her house that night with an armload of books and articles. She gave me the name of a woman survivor to call when I arrived in St. Louis. After meeting Rae, I learned that I could go just about anywhere and find psychiatric survivors, peers in any city, people who by virtue of their psychiatric experiences are loosely networked throughout the United States and other countries.

Whenever I could, I visited with Rae and always left with a new armload of books. Most of the works had never made it into the mainstream publishing market. The "fugitive" books, as she called them,

made me aware of many talented, psychiatrically labeled people, my brethren who were fighting to create change in an oppressive, exploitative mental health system." (Bassman 2007. Pg.164)

Ron found so much in common with members of this community of psychiatric survivors that he regarded them as his "brethren". This was part of realising that he was a "long-time inactive member" of the movement. Also, it was part of engaging to an identity as a psychiatric survivor and activist.

In summary, then, *noting resemblance to others* is an important way of engaging to a new self-conception. But finding commonality with others is influenced by matters of location and place. It is in certain places that self-comparisons occur and this is often significant.

Sharing a common place

Going back to John, he noted his resemblance to other persons he met in psychiatric settings. It was in a psychiatric hospital and in day centres that he met others who personified schizophrenia. Therefore, John was provided with opportunities to interpret himself in new ways partly because he was *sharing a common place* with such persons. A similar point relates to Elyn Saks in the self-help group and it is of general significance. To a varying extent, opportunities for comparisons with others are influenced by their location. Particular settings- especially institutional ones- structure opportunities for self-comparisons and for finding commonalities with others. Furthermore, such settings carry their own symbolic significance. When situated within them, persons encounter, or are confronted by, opportunities to compare themselves

with the significations associated with their location. Through *sharing a common place* with such significations, persons can be more inclined to find things in common with them.

These points are illustrated by reference to Terry whose immersion in psychosis, *identity erosion* and *laboured restoration* were considered in the previous chapter. Perhaps surprisingly, Terry said these aspects of his life story did not really reflect the most fundamental problems in his life or his biggest challenges. Instead, Terry identified alcoholism as his most significant problem. Though he does not currently drink alcohol and has not done so for some years, he attends Alcoholics Anonymous (AA) three times a week, acts as a sponsor for another member and places considerable significance on being part of what he calls "the Fellowship of AA".

Terry said that he learned to regard himself as an alcoholic through AA. For a long time, and long before the start of psychosis, Terry knew that "something was wrong". He drank a lot of alcohol and there were times when life seemed empty and he contemplated suicide. He recounted a point when he sat on the steps of the River Liffey after drinking all night and thought about jumping in. On occasions, Terry saw his General Practitioner and was diagnosed with depression yet he remained vague about what was wrong. But when he attended AA, he heard the stories of the other members. In the small details of their lives (such as the physical problems they experienced and the impact of their actions on relatives), Terry recognised himself and came to

define his problems as like those of other drinkers. He engaged to a self-conception as alcoholic.

Clearly, this aspect of Terry's life story is consistent with the previously cited examples of *noting resemblance to others*. But it is also noteworthy that Alcoholics Anonymous is generally understood as an organisation 'for alcoholics'. This in itself raises a question for persons when they first attend AA meetings: a question of whether they belong there. Before his first meeting, Terry was told that he would hear the stories of others who were 'like him'. At the meeting, different persons told different stories but they were each integrated by a common theme of alcoholism. And the meeting was organised to enable the telling of such stories.

So there was a situational context for Terry's initial engagement to an alcoholic identity. It was a place symbolically linked to alcoholism, inhabited by self-identified alcoholics and with structured opportunities for *noting resemblance to others*. Through *sharing a common place*- with connotations of alcoholism and with others who are alcoholic- Terry was at least enabled, perhaps encouraged or even directed, to find things in common with alcoholism.

In the context of psychosis, persons frequently share a common place with connotations of mental illness and with persons diagnosed with mental illness. An obvious example of such a place is a psychiatric hospital and this is illustrated in Dan Behrman's autobiographical account of mania and depression where he described his initial experiences of a psychiatric ward:

"Once my parents are gone, I walk the long hallway back to the patients' lounge. The television is blaring, and all the nuts are sitting around it in a semicircle. I focus on their faces instead of the television. Lena is staring out the window watching the traffic go by. Michael is peeking through his hands at the television. Amanda is fidgeting with her bandages. Bob, my roommate, a schizophrenic in his fifties, is sitting off to the side mumbling something about the CIA. By degrees I realize the extent of my illness. I'm not sure what I was thinking before, but this place isn't Canyon Ranch. I'm not here for herbal wraps, mud baths, or five-mile hikes. After thirty-three years it hits me that there's something really wrong with me. I have a mental illness." (Behrman 2002. Pg.230)

In this setting, Dan was confronted with two realities. This was a place for persons with mental illness and it was a place in which he was resident. So he and mental illness shared this place in common. This was a factor in the realisation "by degrees" of the extent of his illness and that there was "something really wrong" with him. For Dan, then, *sharing a common place* with mental illness was an aspect of engaging to a self-conception as mentally ill.

Of course, this is not to argue that persons necessarily find things in common with mental illness- or any other conception- by *sharing a common place* with it. In Chapter Five, there are references to persons- like Aine and Sarah- who kept true (to) versions of themselves that were antithetical to mental illness despite several hospitalisations. Furthermore, persons do not necessarily

associate psychiatric hospitals with mental illness. This point was raised by Mark Vonnegut in his description of his first admission to a psychiatric ward:

"Well, so here I am in a mental hospital. It took a while for it to sink in. In a way, I knew it all along. Simon and my father had talked about it and I had been able to pick up on some of what they were saying. The nurses and orderlies, the little room, the needles in the ass, it all added up: mental hospital.

It took a while before I was able to pay much attention to the fact. I was all taken up with voices, visions and all. I vaguely knew I was in a mental hospital but it wasn't any different from being anywhere else. Where I was was beside the point.

Little by little, with the help of massive doses of Thorazine in the ass and in my milkshakes (which was all they could get me to eat), little by little it started mattering to me where I was and what was going on…..Little by little it sank in. It was all on the level. This was a real mental hospital with real doctors and nurses. It wasn't some weird put-up job designed by my father or anyone else.

Then the only weird thing about this hospital was that I was a patient here. Everything else made sense. All the other patients fit nicely into my idea of what mental hospitals were about. They were all victims one way or another…..They had been dealt lousy parents, lousy jobs, lousy marriages, lousy friends, lousy educations…..What was my excuse? What more could I have possibly asked from life?" (Vonnegut 2002. Pgs. 185-187)

So, once he realised he was in a psychiatric hospital, Mark dealt with the question of what he was doing there. At this point, he associated 'craziness' with victimhood and, on this basis, reasoned that he was 'out of place'. Nonetheless, Mark did subsequently find things in common with, and get engaged to, a self-conception as mentally ill. This highlights the need to incorporate factors- other than the fact of being in a particular place or in the presence of other persons- into an account of *finding things in common* with a particular conception. In the context of psychosis and engaging to a psychiatric identity, one of these factors is persons' relations with medication.

Going together with medication

Medication is often an important focus for *identity commitment* in the context of psychosis. As noted in previous chapters, psychotropic medication is commonly an issue in *committed refusal*, *adhering faithfully, enforced submission* and *liberated revival*. And persons' relations with medication are also often a focus for *finding things in common* with the meanings of mental illness and an aspect of engaging to psychiatric identities. More specifically, in taking psychotropic medications, persons consider whether 'it works' for them. If it does work in some sense, this can prompt persons to find something in common with mental illness. Medication is a principal treatment employed in psychiatry and so it 'goes together' with mental illness. Therefore, as persons discover that they and medication 'go together', they realise commonality with mental illness and this *going together with medication* encourages an engagement to a psychiatric identity.

This is illustrated by David Boyles in his autobiographical account of psychosis. After immersion in psychosis, hospitalisation and treatment with medication, he was unsure about whether he was truly mentally ill. As a test, and with the agreement of a doctor, he weaned himself off medication:

"For some strange reason I wanted to see if I truly had this "problem". I was down to 1mg. of Risperdal, and 250mg. of Depakote, and 50 mg. of Zoloft. I was to wean off the Zoloft first, according to the Doctor. After just a couple of weeks of weaning down to 25mg. and then stopping, I noticed the differences. I had a hard time getting up in the mornings for work. I became a very grumpy person. And drinking too much came back into play (I substituted the alcohol with the absence of the Zoloft, without realizing it). I thought I could adjust to the irritability and continue on with the weaning off with the next medication, Risperdal. How wrong I was.

During this time frame I was on .5mg. of Risperdal, *every other day*, with the 250 mg. of Depakote.

Ruminating thinking started back up. I was constantly over-analyzing the creation story of Adam and Eve in Genesis from the Bible. I began to think about God too much and whether he existed or not. And I had a hard time reading. I would get a lot of headaches too....When I would be over at my girlfriend's sister's home, I was back to constantly bringing up topics of God and the Bible. I was drinking a lot again to try and make myself feel better when we were all together. Then we went to bed that

evening. I was having strange, uncomfortable sensations in my head. I guess at that point I realized I was relapsing and needed my medication...." (Boyles 2004. Pgs.53-55. Original italics)

David went back on the medication:

"The differences came immediately. The first time I noticed feeling better was an afternoon with my girlfriend, at her sister's home. We were all together and I suddenly realized I was not obsessing about God, the Bible, and anything religious. She told me that it had already been mentioned that they noticed the differences in me, and that I was doing better. Getting back on the Zoloft at 50 mg., initially gave me some side effects. So I went down to 25 mg. and I felt better. The Zoloft works for me on the obsessive thinking and the depression at the same time. What a wonderful medication it is. Risperdal is the anti-psychotic medication that keeps me from being delusional and not hallucinating. Depakote is the mood stabilizer that keeps me from becoming hyper-manic, which would start with elation and then escalate." (Pg.56)

Through this and other such experiments, David noted an association between his well being and medication. He was worse without medication and better with it. For him, this constituted evidence of his mental illness: the effectiveness of medication attested to the actuality of a psychiatric disorder.

Through his medication experiments, David found something in common with the meanings of mental illness. As an idea, he associated mental illness with pharmacological treatment: they 'belonged together.' On this basis,

to discover that medication worked for him- that he and medication also 'belonged together'- was to realise something in common with the idea of mental illness. This was a condition for more thoroughgoing commitments to a conception of himself as mentally ill. Towards the end of his book, he declared:

"This condition is a biological-chemical imbalance in the brain. *I felt it, so I know.*" (Boyles 2004. Pg.81. Original emphasis)

At this point, David is fully engaged to a notion of mental illness: he is bound with it. His own experience now attests to a truth of mental illness and mental illness is 'a fact' about himself that he accepts:

"When I look back on it now from nearly three years ago, of the diagnosis, it all makes sense. It has taken this time for me to accept the facts, listen to the Doctors, and test my medications, to realize that I have a mental condition/illness." (Pg.75)

So, David came to realise the truth of mental illness by reference to himself and the truth of himself by reference to mental illness. Through this bi-directional truth-making, David is committed to a psychiatric identity. This commitment emerged, in part, from his experiments and his experiences of *going together with medication.*

To provide another example of *going together with medication*, Stephen was interviewed as part of this study and, as mentioned in Chapter Five, he was admitted to a forensic psychiatric hospital when he was 20 years old. When hospitalised, he believed he was a master criminal and refused to believe he was mentally ill. Also, he refused medication which was then forcibly administered.

He continued to repudiate the idea of being mentally ill and sustained this resistance by reference to his differentness from other patients on the ward. At interview, Stephen also attributed his repudiations to the undesirability of mental illness. He said that he viewed mentally ill persons in negative terms and so:

“I definitely didn’t want to be one of them.”

However, Stephen said that he ultimately “had to accept” that he was mentally ill. Part of the reason was that “the medication worked.” He felt “more stable” when taking medication and believes that it probably worked directly on the way he was thinking.

So, like David Boyles, Stephen discovered that he and medication ‘went together’ and this linked him to mental illness. He shared this in common with mental illness. A similar experience was reported by Elyn Saks. For years, she was implicated in a cycle of *enforced submission*- where she surrendered to medication- and *liberated revival* where she rejected it. But when she tried a new drug called Zyprexa, she noted that she was less bothered by intrusive psychotic experience and better able to concentrate. She considered this highly significant for the way she regarded herself:

"The most profound effect of the new drug was to convince me, once and for all, that I actually had a real illness. For twenty years, I'd struggled with that acceptance, coming right up to it on some days, backing away from it on most others. The clarity that the Zyprexa gave me knocked down my last remaining argument....Thanks to the new chemicals coursing

through my body, I experienced long periods of time in which I lived as other people did- with no psychotic thinking at all. The Zyprexa did that.

There's no way to overstate what a thunderclap this revelation was to me. And with it, my final and most profound resistance to the idea I was mentally ill began to give way. " (Saks 2007. Pg.281)

So it was partly through *going together with medication* that Elyn eventually got engaged to an identity as mentally ill.

In summary, then, *going together with medication* is a common way in which persons find things in common with mental illness. However, this is a variation of a broader pattern whereby persons find commonalities between a conception and their experiences.

Going together with life experience

Returning to David Boyles and his claim of knowing his condition as a bio-chemical imbalance because he "felt it," this is another way of saying that this explanation of his illness 'went together' with some of his life experience. This hints at a general point about how persons find things in common with particular conceptions. They consider whether and how well such conceptions fit with their experiences. And it is through *going together with life experience* that conceptions can be employed in engaging to new identities.

This is illustrated by reference to Stephen who was mentioned in the previous section and who said that he had to accept he was mentally ill because his medication 'worked'. But this was not the only reason he gave for getting engaged to a self-conception as mentally ill. In addition, he said that a trusted

doctor told him that his brain was damaged through smoking hash and the subsequent use of “hard drugs.” This, the doctor said, was part of the explanation for his schizophrenia. For Stephen, this “all made sense.” He could now see a point of similarity between an important aspect of the diagnosis- that is, an explanation of its cause- and his own biography as a heavy user of illicit drugs. Drug use was salient to both him and schizophrenia.

Therefore, schizophrenia went together with aspects of his biography and this was another factor in Stephen ‘having to accept’ that the diagnosis applied to him. A similar pattern is associated with the development of Martin’s commitments to a conception of himself as vulnerable to depression. Martin was another interviewee in this study and was briefly mentioned in Chapter Five. Over the past twenty years, he was admitted to psychiatric hospitals on six occasions. He was variously diagnosed with, and ‘treated for’, schizophrenia, bipolar affective disorder and depression.

At interview, he said that he always knew the diagnosis of schizophrenia was wrong. He associated this knowledge with comparisons between himself and others he met in hospital with this diagnosis. In Martin’s words, they were “much worse than me…much madder than I was.” This perceived difference- between him and others who (to him) personified schizophrenia- attested to the incongruity of this diagnosis. Martin could find nothing in common with the meanings of schizophrenia and this meant he was not going to engage to notions of himself with schizophrenia.

Martin did, however, identify himself with a diagnosis of bipolar affective disorder and this was identified by his community mental health nurse as his 'official' diagnosis. This diagnosis is associated with problematic variations in mood and this is something that, for Martin, fits with his own experiences. He shares this in common with the diagnosis. However, 'depression' was the key word that Martin employed in talking about past difficulties and in defining his illness. He said that, ever since his childhood, there were periods when he felt sad, lonely, like there was nothing to live for and suicidal. Several suicide attempts led to hospitalisation. For Martin, these aspects of his past experiences are consistent with 'depression'. What is more, he said that his father was recurrently depressed and spent time in psychiatric hospitals. Martin reasoned that he probably inherited depression from his father, that it was a question of genetic transmission. Furthermore, Martin identified antidepressants as medications that were most helpful and saw this as further confirmation that he really does 'have depression'.

So Martin discovered that he 'went together' with what depression signifies to him. It is associated with misery and suicidality and these are aspects of his past experiences. It is inheritable and Martin's father was depressed. It is an illness treatable with medication and Martin experienced the benefits of such medication. At least partly by reference to these commonalities, Martin got engaged to a self-conception as constitutionally inclined to depression.

Further illustrating this pattern of *going together with life experience*, Wadi is a 34 year old man with a diagnosis of schizophrenia and he was interviewed as part of the present study. Nine years ago, he immigrated to Ireland from Nigeria and this was when he first 'heard voices.' At first, he was unsure about what was happening to him and he considered a spiritual explanation:

"I didn't know what was happening. I thought it was God. I am Muslim and I didn't used to pray much. Like I don't pray like the way it's been said, I don't pray five times a day. I don't do that at that time. So I thought maybe because I'm not doing that, maybe that's the reason why the voices are disturbing me. So basically, I started to pray five times a day and reading the Koran. Reading the Koran and all that. I find the voices are more calm when I pray and read the Koran."

He also wondered whether the voices were conducted by his dreadlocks and about the relevance of separation from his family:

"I used to think it was something to do with not having my family here. I used to think like if you are alone, you are lonely, and then you hear them."

So Wadi did not initially think of himself as mentally ill. But, in 2002, he was imprisoned after he was attacked in the street by a group of youths and picked up by Gardai who subsequently identified irregularities in his immigration arrangements. He spent two months in a prison cell whilst his residency situation was examined. At this point, the voices "got worse":

“I started to feel my head was painful. I can hear voices in the pipe and then I can hear my sister talking…And I keep hearing them, they keep coming to me. And I never tell anybody there because I think maybe they will probably think I’m not well. But I don’t really know what stopped me from telling them. I never think it’s harmful. I thought maybe it’s OK, that’s how everyone is, everyone hears voices like that.”

Wadi was given medication and, at one point, kept in solitary confinement in a padded cell.

Eventually, he was released but he had nowhere to go. He saw a social worker who told Wadi that he was unwell and who suggested admission to a psychiatric hospital. He agreed and it was at this point that he really started to think of his experiences in terms of mental illness:

“I started to think of it as an illness in the hospital. I thought if people can see that in me and say I’m not well, then it is an illness.”

Wadi did not find it difficult to accept the idea of illness:

“I could accept what people were telling me because I felt it inside of me, that I wasn’t well. I felt ill.”

This ‘feeling ill’ is linked to physical pain when Wadi hears voices:

“Sometimes the back of my head is sore. It’s physically painful.”

Here again, then, there is a discovery of commonality between experience and illness. To feel physically unwell was to share something in common with a signification of illness. When others told Wadi that he was ill, it

was therefore not difficult for him to view this as plausible, especially in the context of a hospital setting.

In summary, then, *going together with life experience* is part of a broader pattern whereby persons find things in common with particular conceptions. This is a necessary aspect of *engaging to identities* but does not sufficiently account for such engagement. Such engagement is not just a matter of 'going together' and *finding things in common* with particular conceptions. It also involves patterns of self-relations characterised by *binding self-attachments*.

Binding self-attachments

As part of *engaging to identities*, persons bind with themselves in distinctive patterns of self-relation. Through *binding self-attachments*, they connect to particular identities or they combine and inter-relate various self-conceptions. And such attachments or combinations have a binding quality in the sense that they involve obligations and requirements as well as a degree of inescapability.

Furthermore, attraction is an important factor that accounts for variation in *binding self-attachments*. In the context of psychosis, persons are attracted by certain identities and this in itself is a factor in attaching to them. However, persons do not only attach to identities that are attractive and wanted. There are circumstances in which persons are 'caught' and confined by identities to which they are decidedly averse. In this case, then, the unattractiveness of an identity accounts for at least some of the suffering involved in being 'stuck with it'. Yet

persons do not simply suffer forever from their ties to unwanted and unattractive identities. Often, they discover consolations in such identities and get engaged to self-conceptions that are appealing 'given the circumstances'. Or persons manage to join or blend an 'acceptance' of an identity that was unwanted with other self-conceptions that are appealing. In so doing, persons fuse particular self-conceptions into a new synthesis or a mutually sustaining combination.

More specifically, through *binding self-attachments*, persons are implicated in at least one of four patterns of self-relations. These are *capture with rapture, identity bondage, consolation tied to acceptance* and *fusing up*. Each of these patterns is worth elaborating.

Capture with rapture

Persons can be attracted by the possibility of new identities and such attraction can be a factor in binding them to self-conceptions once they are realised. In other words, the allure of an identity is a potential factor in engaging to it. Where this allure is especially powerful, there is potential for *capture with rapture*. Here, persons are drawn into *identity commitment* through the appeal of particular self-conceptions and very good feelings associated with their realisation. These feelings include joy, exhilaration and even ecstasy. Related to this pattern, persons readily find things in common with conceptions that are highly attractive, even fantastical, in some sense. And this *capture with rapture* can be associated with immersion in psychosis.

For example, returning to David Boyles' autobiography, he described initially positive experiences of psychosis:

"My views and feelings about living changed for the better. I was having what I labeled a *spiritual awakening* for how good it felt to "understand" a little more about what I never thought through thoroughly.....When my emotions started to amplify, I immediately labeled myself as being "blessed"." (Boyles 2004. Pg.4. Original italics)

David became "euphoric" at the profundity of his new-found spiritual and philosophical insights. Then he "found God" in a moment of revelation:

"Now I had been "touched by God"; and already being euphoric, it was wonderful. I went down to the beach one afternoon and just stood there on the rocks and observed "life". I was "one with life". Everything made sense. I became so elated that I almost started to cry. And right in front of the others nearby. I wanted to scream out loud- "Isn't life beautiful?" " (Pgs.6-7)

So David sensed the presence of God, he could "understand" more, he was struck by the beauty of life, and he was euphoric. It was on this basis that he conceived of himself as "blessed." This fitted with his experiences- he shared things in common with the significations of 'blessedness'- and there was clearly enormous appeal in *Me-blessed-by-God*. Such allure was at least an aspect of getting bound up with this self-conception, in this *capture with rapture*.

A similar pattern was reported by Thomas who is a 53 year old man with a diagnosis of bipolar affective disorder. As described in Chapter Five, he is a musician and music teacher and these roles are important to how he views himself. But there were occasions in the past when he abandoned them altogether. This was in the context of immersion in psychosis, an experience that Thomas found positive in many respects:

"Psychosis leads you to a place that is very comfortable. You feel everything just makes sense at that moment in time."

When he was 'in this place', Thomas heard "internal voices" of God and a spiritual guide. They instructed him on the "correct path" that he should take. He also heard other voices that made him attractive promises about what will happen in the future and informed him of special gifts that he possessed. In particular, they told him that he had powers of healing and profound insight. These were messages that he was disposed to believe and he experienced positive self-feelings:

"I felt that euphoria that makes me feel good about myself."

Furthermore, Thomas followed the directions of these various voices. On one occasion, they told him that an ex-girlfriend wanted to marry him and that he should propose. So he purchased an engagement ring but she declined his proposal. Prior to his most recent hospitalisation, voices instructed Thomas to give up his music to devote himself to a career as a psychiatrist. He wrote to all his students and informed them that he would no longer teach them. He had no notion of undertaking medical education because, in his mind, he already

possessed the necessary healing skills. All this seemed like a good idea at the time but it meant that Thomas deprived himself of his own income. It also meant that his relatives became worried and they alerted psychiatric professionals. With their involvement, he was admitted to a psychiatric hospital.

On his most recent psychiatric hospital admission (he was discharged only three weeks prior to the interview), psychiatrists questioned his claim that he had special healing powers:

"They asked me, "How are you healing these people?" I couldn't explain myself. The confrontation broke me down. And I was having drugs for the psychosis and it brought me back to reality. I suddenly am faced with my manic self and it all comes crashing down."

As Thomas discovered *Me-as-manic*, he was diminished through the twin realisation that this identity was inferior yet 'more real' than the one established when immersed in psychosis. *Me-as-manic* became the reality of living with himself and *Me-as-healer* was invalidated. But this was a short-term reality because it was experienced "like a landslide" and Thomas became depressed. With the recognition of what he did as manic- like sever contact with the music students that were the source of his income and a focus for his work- Thomas negatively judged himself. He was distressed by the loss of *Me-as-musician/teacher*, a loss that seemed potentially irrevocable.

At the time of his interview, Thomas was starting to retrieve his identity as a musician and teacher. He was finding this difficult because he was

apprehensive about approaching his former students, fearful of rejection and anxious about again playing music in public. Nonetheless, he was teaching again and he was planning to publicly perform. He seemed engaged in a project of *laboured restoration*. But a key point here is how he viewed all of this in retrospect. At interview, he made a direct link between the attractions associated with psychosis and his tendency to believe in them. He compared his voices to the Sirens of Greek mythology that lured sailors to drowning or shipwrecked destruction with the beauty of their songs. Likening himself to these sailors, he said that his voices conveyed messages that were so alluring that he lost awareness of potential dangers. He was captured by the rapture of himself as a gifted healer and it was on this basis that he was bound with this particular identity.

So, in the context of psychosis, there are circumstances in which *binding self-attachments* are associated with the intense appeal of an identity. But, as Thomas' story suggests, *capture with rapture* can mean a short-term- though not easily terminated- identity engagement. Indeed, his story points to another pattern of binding self-relations: *identity bondage*.

Identity bondage

In contrast to *capture with rapture* and its associations with the strong appeal of new identities, an alternative way in which persons bind with *Me's* is associated with imposition and confinement. Here, persons find things in common with a conception and identify with it but this self-identification is experienced as both inescapable and unwanted. Self-conceptions are

experienced as inescapable for being true and unwanted because of their troublesome implications like the loss of prior *Me's*. Persons are therefore impounded by their own self-truths and the distressing implications of these truths. They are chained to oppressive, burdensome self-conceptions in a relation of *identity bondage*.

Thomas' story, outlined in the previous section, is one of shift from *capture with rapture* to *identity bondage*. Once he was confronted by others and with the effects of medication, he experienced no choice but to know himself as manic. The 'facts' were compelling and they diminished him: he was no longer a healer and was instead mentally ill. There was no escaping the truth of this unwanted and depressing self-realisation. A similar pattern related to Patrick who is a 54 year old man with a diagnosis of schizophrenia. For about eight years, he believed that he was Archangel Michael and "a superior being." During this period, he concealed this supernatural status from others and deliberately misled them. When interviewed as part of this study, he said:

"It was like I was a spy if you like. I was trying to prevent people from knowing what I was doing…It was a general way of living…"

In response to a question about whether this was an exciting life, he replied:

"Oh yes. I was very happy. I thought it was great. I felt great doing this."

So, captured with rapture, Patrick was bound to *Me-as-divine-being,* a very special identity. But, despite his self-concealment and following the promptings of his mother, Patrick first saw a psychiatrist in 2000 and was

admitted to a psychiatric hospital in 2002 for four months. Patrick's admission to hospital was "voluntary" in the sense that no laws of compulsory detention and treatment were invoked. However, Patrick said that a psychiatrist made it clear to him that he would be compulsorily detained if he did not agree to admission. On this basis, Patrick acceded to hospitalisation.

Once admitted, Patrick said there was no change to his "mindset." He continued to believe in his supernatural status and he compared himself with other patients:

"I thought I had the whole thing worked out…I didn't see that I had a problem with schizophrenia or depression for that matter…I used to look at the other patients in the hospital and wish them well. There was nothing wrong with me. I was different from them."

Through contrasting himself with others in the hospital, Patrick was *repudiating unwanted identities* and keeping true (to) his divine status.

After discharge, Patrick pretended that he was taking medication:

"I wasn't too happy about taking medication. In fact, I stopped taking it but I told them that I was taking it."

Hence, in his relations with psychiatric professionals, Patrick was inclined to *giving way* but not giving up his identity. However, about eighteen months after discharge from hospital, he was struck with a sudden realisation:

"I had an insight that I actually had a psychosis. For about eight years, I thought I was Michael, the Archangel. I thought I was some kind of a superior being. You know, a greater being. Greater than other people and

all that…I also thought I was the Holy Spirit. For about six months before the insight, I also thought I was the Holy Spirit."

Patrick experienced what he repeatedly called "the insight" at a defined moment: it happened one morning as he gazed into his shaving mirror. At this moment, he experienced a transformation- an epiphany- in the way he viewed himself. Once he realised that he "had a psychosis", his divinity was invalidated: it was rendered false, it was no longer *Me*. He could not be psychotic and divine because these identities were antithetical to each other. Engaging to *Me-with-psychosis* necessarily spelled the end of *Me-as-divine-being*.

So "the insight" meant a whole new world for Patrick and this was hard to take:

"I found myself in a completely new world, a world that I couldn't cope with. I realised that I had psychosis and I didn't know what to do with myself. I found the going very tough. I just wished the whole thing would end…. When I did enter the real world, I found it all too much to take. I couldn't take it. Basically, I felt suicidal. I felt the whole thing was too much for me."

Patrick experienced a crisis that was partly to do with a lost self-conception as a divine being:

"I was a much lesser person than I thought I was. I'd thought I was a perfect being in the world I was living in. And I didn't have to change anything. I didn't have to try to live in any other way than I was."

Patrick felt diminished and overwhelmed by his entry into what he described as “the real world”. He did not want to be psychotic but, after “the insight”, he was compelled to regard himself as such. There was no escape from this self-truth once it was realised and so, for a time at least, he was trapped in the suffering associated with his fall from divinity and his unpreparedness for a world in which he was a person like others. At this time, he was trapped in a relation of *identity bondage*.

Before moving on to another example of *identity bondage*, Patrick’s sudden realisation- of himself as psychotic- is worth some examination. “The insight” happened in a moment but Patrick had experience of psychiatry. He was a former patient of a psychiatric hospital, he was attending out-patient appointments with psychiatrists, and he was engaged in an employment training programme alongside other persons with psychiatric diagnoses. It was at least partly on this basis that he could access and employ psychosis as a concept in regarding himself. Furthermore, he related to other persons on his training programme. Prior to this, he remained largely detached from others and this was associated with a sense that he was a superior class of being. But, over time on the programme, he was drawn into relations with others:

“It brought me out to realise that I had to make some sort of effort if I wanted a friendship. I realised that friendship was a two-way thing.”

So, Patrick’s insight occurred in a context in which he was familiar with psychiatric concepts and relating to others who were diagnosed with psychiatric illness. And he started to want friendships with these other persons. It was in

these circumstances that he found things in common with a psychiatric conception and engaged to an identity as psychotic. This does not explain the suddenness of his identity conversion but does render it somewhat intelligible.

Returning to the more general pattern of *identity bondage*, both Patrick and Thomas suffered through bondage to self-conceptions of mental illness and the loss of fantastical *Me's* associated with psychosis. But immersion in psychosis can itself involve such bondage. Going back to Lori Schiller and her autobiographical account of hearing voices, she often could not escape their persecution. They shouted at her, they abused her and they urged her to commit suicide. She heard them often and anywhere. She could not ignore them because they were so intrusive and because they were so real. Often, she was convinced that other persons must be hearing the voices because they were so clearly audible. So the evidence of Lori's own senses meant there was no getting away from a self-truth of persecution, from an identity as a victim of the voices.

Furthermore, Lori could find no other viable way of accounting for herself and her experiences. On her first admission to a psychiatric hospital, she was resentful of staff's efforts to convince her that she was mentally ill:

"All the time I was in hospital they told me I was sick. They told me I was psychotic with hallucinations. I hated these two words. I knew they were not true. Psychotic meant like the movie *Psycho* and Norman Bates, and the Bates Motel. That was scary and sick. That wasn't me. I wasn't a *Psycho*-tic woman with a butcher knife.

And hallucinations? Another word that enraged me. Hallucinations meant that you were seeing something or hearing something that didn't really exist. But when I heard the Voices screaming at me, they were real. When the doctors and nurses challenged me, told me that I was out of reality, and hallucinating, I hated them. What made me the psychotic one? What about all those judgemental people? What made them the experts?" (Schiller and Bennett 1994. Pg.90)

For Lori, then, psychosis carried associations of maniacal homicide and she could find nothing in common with that. And hallucinations meant that the evidence of her senses was discountable and that she could not discern what is 'really real'. This suggestion was offensive to her and, in repudiating it and contesting her identity with hospital staff, she was keeping true (to) a conception of herself as mentally competent. All the same, this bound her to the truth of persecution by voices. In committing to a mentally competent identity, Lori was also tied to one as persecuted. This, informed by the compelling evidence of her senses, was the nature of her *identity bondage*.

In summary, then, one variant of *binding self-attachments* is characterised by suffering associated with an unwanted identity to which persons are chained. However, persons often do escape from *identity bondage* over time. They work out new identity engagements and new forms of *binding self-attachments*. One pattern for such self-engagement is *consolation tied to acceptance*.

Consolation tied to acceptance

In the context of psychosis, persons can settle for identities that are not desirable but with which they can realise some comfort. This involves 'making the most of things' through deriving consolations from identities that are otherwise unwanted. But this is *consolation tied to acceptance*. Persons are bound into realising 'as much as they can make' *of* themselves through settling for less than they want *for* themselves.

A readiness for *consolation tied to acceptance* was illustrated by Fiona who was interviewed as part of the present study. She is 34 years old with a diagnosis of schizophrenia and a ten-year history of psychiatric treatment. In 2007, she was admitted to a psychiatric hospital and stayed for almost twelve months. When she was interviewed, it was three months after her discharge and she was awaiting results of diagnostic tests that were instigated when she was resident in hospital. This was because she experienced some kind of 'absences' from which she could not be immediately roused, she developed a speech impediment, and the nature of her hallucinations were potentially suggestive (to medical staff) of an organic brain syndrome rather than a functional mental illness. Fiona was definite about her own preference:

"I would love it if it were something physical because I'm ten years with mental illness. It's not that I want something wrong with my brain but it would be better….There's less stigma against it and I might be able to come off the medication. I don't want to take the drugs."

So Fiona welcomes the idea of brain disease but not because it is desirable in itself: far from it. Instead, she is attracted by the identity pay-offs of physical illness. It is not that she wants brain disease so much as she does not want to be mentally ill. In seeing the appeal of brain disease, Fiona envisages a 'way out' of an unhappy relationship with herself as mentally ill. Because of this prospect, she is enthusiastic about what would otherwise be undesirable. She is ready for *consolation tied to acceptance*: she is willing to accept an unappealing identity in return for the consolation of getting rid of one to which she is even more averse. For her, these are satisfactory terms of identity engagement and, on this basis, Fiona 'consents' to a proposal of brain disease.

A less firmly established- but nonetheless significant- tendency towards *consolation tied to acceptance* is illustrated by Joe. He is 47 years old and, when interviewed as part of this study, he emphasised his positive qualities as a gifted, thoughtful and "deep" person:

"I have a sharp mind, you know. There's not much that I miss really, you know, about what happens. They know that up there in that hospital about me, you know."

And:

"I'm not a bad person: I'm a sensitive, talented, gifted man who knows himself."

And:

"Guys don't come any deeper than me. You don't come across anyone like me. I'm very rare, you know."

In recurrent statements like these and in the conviction with which he expressed them, Joe was insistent that he was a man with exceptional qualities. But he was also insistent that the quality of his life is poor and that much of his adult life was miserable. He suffered with mental illness, he was recurrently admitted to psychiatric hospitals and, most grievously, he was "scarred for life" through incarceration in a forensic psychiatric hospital. For Joe, these two self-truths- of rare gifts and a miserable quality of life- were difficult to reconcile:

"**It's a poor quality of life I'm living. It's a poor quality. I'm not depressed but I'm confused. I'm very confused. What life did to me, you know. Such a good bloke, such a good mixer, you know. A talented guy. All these things going for him. Good looking bloke, you know. An awful lot going for him and he suffers all this."**

Joe was perplexed by how it is possible that, despite his positive qualities, life turned out so badly. Yet, in the interview, he also realised some consolations of an unwanted identity as mentally ill. This was evident in his consideration of his psychiatric diagnosis:

"I'm not paranoid, I don't get paranoid. I don't hear voices either, you know. As yerman said, he was right that psychologist, "you have the smart man's illness." I have the smart man's illness, that's what it is you know. I suppose that people that know themselves as well as I do, they're able to say that about themselves you know."

For Joe, the "smart man's illness" is bipolar affective disorder and he also made reference to creative individuals and comedians with this diagnosis.

Given his own creativity and smartness, Joe can find more in common with the meanings of this diagnosis than with schizophrenia (he was diagnosed with both of these disorders at different points). As bad as his life has been and as much as he would prefer a life without mental illness, he finds some consolation in the idea that his illness is associated with valued qualities. Indeed, he views his particular diagnosis as a kind of affirmation of these qualities: as confirmation of his own creativity and smartness.

Furthermore, Joe takes a certain comfort from the idea that he is blameless for mental illness and he compared himself favourably with persons he considers more responsible for their problems:

"I've seen some alcoholics and junkies and I say to myself "I'd handle their trip." I see people queuing up for methadone and all that and I think "what a fucking waster. I didn't ask for this fucking illness but this fella inflicted it on himself." And if I was that way, I know I'd beat the hell out of it. I think I'm in a position to say that. I know I'm right too."

Moreover, Joe identified a consolation associated with the vulnerability of being human:

"Like I say, everyone has their limits. Everyone has their breaking points. Anyone can take a breakdown. No one's too strong for that. You know even the smartest men will take breakdowns."

Here, Joe implied that he could not be blamed for his "breakdown" because it is not a matter of strength which he lacks so much as limitation that he shares with all other human beings. In this way, he provides his own solace

but this comfort is tied to a self-truth of psychiatric illness and breakdown. Joe realises the consolation of blamelessness through accepting the truth of an unwanted psychiatric identity. But there are degrees to such acceptance and, in Joe's case, it is only partial. He still suffers with a sense of unfairness and the idea that- with his particular qualities- he does not deserve much of what happened to him. On this basis, he is only partially implicated in *consolation tied to acceptance* and so only seems to derive scant comfort from his self-attributions of blamelessness as well as the link between his diagnosis and valued qualities.

A fuller realisation of *consolation tied to acceptance* is illustrated by Bernard. He is 67 years old and was mentioned in Chapter Six in the context of *self-compelling*. During his interview that was part of this study, Bernard was like Joe in associating mental illness with blamelessness. In talking about his diagnosis of bipolar affective disorder, he said:

"It is just like a normal illness and it is not my fault."

Bernard said that his illness was perhaps associated with brain chemistry, probably hereditary and definitely "God-given". On this basis, he said that he is never embarrassed by his illness, he never concealed it and he has no reason to feel inferior to others because of it.

Yet, this is not to suggest that Bernard absolves himself of moral responsibility in relation to his illness. He is not responsible for his illness but said he is responsible for how he lives with it. He "does his best" to push himself when he is "not well" (a term he employs to refer to depression).

Through this *self-compelling*, he goes to self-help groups, he attends Mass more regularly and he stays active. And he takes a certain pride in the level of efforts he makes as well as the extent to which he enacts a moral obligation to try. This moral obligation is emphasised at Recovery Inc., a self-help organisation, and Bernard's membership provides opportunities to find things in common with other persons who associate self-worth with personal effort.

For Bernard, then, mental illness is an inescapable reality that was imposed upon him. But this renders him irreproachable and, at the same time, he takes pride in 'doing his best' given the adversity of his personal circumstances. Through *consolation tied to acceptance*, he accepts the unwanted imposition of a psychiatric identity for the consolations of blamelessness and honourable endeavour. His positive self conceptions- as beyond reproach and 'trying his best'- are therefore bound to one as mentally ill. This is the nature of his *binding self-attachments*.

Another kind of consolation- associated with acceptance of notions like psychosis and mental illness- relates to the reality of persons' experiences. Notions of mental illness can be employed- especially in retrospect- in discounting certain experiences as 'unreal'. This is comforting when those experiences were distressing or harrowing. In the previous chapter, Terry's initial admission to a psychiatric hospital was described where he felt relieved when he realised he was mentally ill because this meant that he was not really a target for demons or loyalist paramilitaries, his wife was not really the devil and he had not really killed her. So there were some powerful consolations

associated with the acceptance of a self-conception as mentally ill. Admittedly, Terry's relief was temporary and he could find little comfort- at least not for a long time- in the subsequent implications of mental illness. Nonetheless, consolation is what he initially found through accepting himself as mentally ill and the associated invalidation of his experience when immersed in psychosis.

This kind of consolation is of more enduring significance to Michael, a 64 year man who was interviewed as part of this study. For a long period of his life, Michael used to hear voices:

"It was uncanny, it was an uncanny thing. I'd be sitting there and suddenly this voice would read the riot act to you. It's uncanny. And you'd say to yourself "who are you, are you the police?" They might say "yes", I can't remember exactly. It was a long time back Mark. And you'd get "yes we're the police and we're going to get to you". All this kind of stuff Mark. It was dreadful, dreadful."

On a daily basis, he heard voices like this and it was "dreadful" because they interfered with his life and he often believed the awful things they said. However, in retrospect, he views these voices as "symptoms". When asked whether 'schizophrenia' is a word that he would use to describe his problems, he replied:

"Oh yes I would yes. Because I seem to have, what's the word, the symptoms of it, the voices and that yes. The symptoms of it…. That's something I definitely have."

For Michael, regarding these voices as symptoms of schizophrenia means they were not ‘really real’ in the way he once thought. This means, for example, that he now realises that he was never actually accused by the Gardai of heinous crimes. Happily for him, Michael no longer hears voices and he attributes their demise to the helpful effects of Clozaril. However, he said that he still experiences some “paranoia”. As an example, he talked about a group of young persons who assemble in a courtyard beneath his apartment. Michael sometimes thinks he can hear them from his apartment (he lives very high in a high-rise block) and that they are shouting abuse at him. But by reference to the idea of himself as paranoid, he doubts his own perceptions and often dismisses them as misguided.

In these ways, Michael realises certain comforts in his schizophrenia and paranoia. Through accepting these as conceptions of himself, he invalidates past self-truths of persecution and renders his current experiences less amenable to persecutory interpretation. Indeed, this pattern of *consolation tied with acceptance* was integral to the story that Michael told of his whole adult life. At interview, he told a story of suffering accompanied by ‘small comforts’ (like the solace of prayer, the pleasures of music and occasional trips to a café with his community mental health nurse), of disappointments accompanied by recognition of how he could be much ‘worse off’ (like persons that are homeless, suicidal or victims of torture). It was not an account of victory in suffering but of ‘taking the little one can’ in a context of adversity.

But persons do not easily settle for consolations. *Consolation tied with acceptance* is only a viable pattern of self-relation where persons experience limited identity options and the inescapability of an unwanted identity. And such inescapability often takes time to realise. This is illustrated by reference to Juliet who was mentioned in Chapter Six in connection with her *committed refusal* of antipsychotic medication. She associated medication, and 'being schizophrenic', with weight gain and this was anathema to *Me-as-slim-and-attractive*. But, in keeping true (to) this preferred identity as an attractive woman, Juliet suffered a recurrence of immersion in psychosis and felt really unwell:

"I was very, very sick. I thought the TV was talking about me, people on the radio. I don't even want to talk about it. It was horrible, really embarrassing….I was really bad. I couldn't walk. I was really, really sick. And I couldn't get out of bed. I couldn't hold a cigarette properly. I was really, really bad. Because I was neglecting myself- I was drinking. I was drinking alcohol and not taking my medication. Not eating properly. I was only about six or seven stone, you know. That was the worst dose of schizophrenia I had. It was much worse than when I first got sick."

This happened eight years ago and, looking back on these events, Juliet said they were directly attributable to her non-adherence to medication. She was subsequently admitted to a psychiatric hospital and treated with medication which she since kept taking. She now regards adherence to medication as a

necessity because it prevents a recurrence of immersion in psychosis. But there is a serious drawback:

“The only thing is I was never this size. I was much slimmer. The medication piled on the weight. I was about eight stone. I’m twice that now which is horrible.”

Juliet would prefer to not take medication because of the “horrible” weight gain it occasions. Because of medication, she regards herself as relatively unattractive compared to the past but she is bound to this unattractiveness by her wish to avoid a recurrence of suffering with immersion in psychosis. After suffering terribly with psychosis and associating this with non-adherence to medication, Juliet experiences no real choice other than to accept the weight gain for the very significant consolations of relapse prevention and normal living:

“If I’m on medication for the rest of my life, well and good. But if I’m not, even better. But if I am, I’ll just live with schizophrenia and live a normal life. I’ll take my medication every day and go to work every day. Do things to help myself and push myself sometimes.”

So, Juliet learned some hard lessons over time about a link between her suffering with psychosis and *committed refusal* of medication. It is in this context that she lives with, and to a large degree accepts, the physically unattractive implications of medication for the consolations of stability and normal living. On this basis, she is bound with conceptions of herself as unattractive through *consolation tied to acceptance*.

In summary, then, *consolation tied to acceptance* is a pattern of self-relation in which persons are bound with an identity which, in itself, is unwanted or undesirable but, through accepting such an identity, they derive self-conceptions that are comforting. This consolation helps persons to live viably, or at least to live, with themselves. Yet, in the context of psychosis, persons do not necessarily settle for living with less than they want. They also find ways of becoming more than they were.

Fusing up

In the context of psychosis, persons commonly realise a conception of themselves as enriched or elevated. Despite or perhaps because of their suffering, they regard themselves as 'more than', and not reduced by, identities or experiences that are unwanted in themselves. Persons draw on different self-conceptions and link or blend them together. Through *fusing up* these 'elements', they realise *Me's* that are 'greater than before' in some sense.

For example, Gary is a 41 year old man who is diagnosed with schizophrenia and who, when interviewed as part of the present study, said:

"In the last few years I got my act together and now life is better than it's ever been."

For Gary, a key element in this success story is antipsychotic medication. He contrasted his current adherence to medication with the past when he refused to take it or took it erratically. He associated this past non-adherence with recurrent admissions to a psychiatric hospital, "relapses" of his illness, and a generally miserable life. On the other hand, Gary linked his more

recent adherence to medication to remaining out of hospital, ability to sustain employment, harmonious family life, a circle of friendships, and a generally decent life. Furthermore, Gary said that without medication:

“I would probably have been on a psychiatric ward forever or committed suicide."

So Gary made two kinds of comparisons. There was a temporal comparison in which he contrasted a present medicated self with a past unmedicated one. And there was a comparison of destinies in which he contrasted a medicated self with the imagined fates of an unmedicated self. In making these comparisons and drawing these distinctions, Gary established a truth of himself as ‘better off’ for medication: a truth that commits him to *adhering faithfully* to his prescribed treatment.

In addition, an important aspect of this self-truth was its implications for other *Me’s*. For Gary, it is possible to realise several preferred identities- relating to family, work, and friendships- as *Me’s* because of the benefits attributable to medication. He sustains a combination of engagements with valued identities and this is part of what binds him to *Me-needing-medication*.

Moreover, Gary links his need for medication with his diagnosis of schizophrenia: he believes he needs medication because he has schizophrenia and he learned to identify with schizophrenia- in part- because he needs medication. For Gary, the truth of his schizophrenia is incontestable and yet he gives it little attention. Weeks can pass when he hardly ever thinks about his illness. He attributed this to getting on with life: working part-time in a cinema,

attending Club House, meeting friends and doing things around the house. None of these things involve a preoccupation with illness and he values this.

Furthermore, Gary developed an account of accumulated wisdom. Medication was part of this account and how he learned about its benefits. Alcohol was another part and how he learned to avoid it. Suicide was a third aspect. He once took an overdose and remembers regaining consciousness, feeling ill and wondering whether he would die. At that point, he realised that he did not want to die and hoped that he would be saved. Subsequently, there were occasions when he contemplated suicide but refrained from any attempt because he knew that a change of mind was a possibility. Instead of attempting suicide, he sought professional assistance and found this helpful. On subsequent suicidal occasions, he reminded himself of this helpfulness and assured himself of the possibility of remedy. This in itself, he said, helped him to stave off suicidal impulses.

So, Gary has learned that he can change his mind when he wants to die, that medication helps, and that he is better not drinking alcohol. He defines himself as wiser with experience and this informs his perspective on the future. He hopes that he will not become ill again but he knows from experience that he will 'get through it.' And he partly attributes his currently much improved situation to his own accumulated wisdom.

Overall, then, Gary seems to realise several valued identities: as a relative, as an employee, and as a friend. *Keeping true* (to) these identities appears to occupy much of his time in everyday living and living with himself.

This means that he often pays little attention to *Me-with-schizophrenia* but nonetheless he links this identity with his faithful adherence to medication. Furthermore, he predicates his realisation of valued identities upon his commitments to ones as mentally ill and in need of medication. And he considers himself better off for recognising the mutually sustaining nature of these identities as well as wise for establishing such recognition. Through *fusing up* various identities in mutually sustaining relations, he renders himself 'better and wiser than in the past'.

A similar story relates to Lori Schiller. As part of the introduction to her book, she declared victory over the voices that were the source of her suffering for many years:

"Sometimes these Voices have been dormant. Sometimes they have been overwhelming. At times over the years they have nearly destroyed me. Many times over the years I was ready to give up, believing they had won.

Today, this illness, these Voices, are still part of my life. But it is I who have won, not they. A wonderful new drug, caring therapists, the support and love of my family and my own fierce battle- that I know will never end- have all combined in a nearly miraculous way to enable me to master the illness that once mastered me.

Today….I have a job, a car, an apartment of my own. I am making friends and dating. I am teaching classes at the very hospital at which I was once a patient." (Schiller and Bennett 1994. Pg.7)

Like Gary, Lori developed an account in which she progressively- although haltingly for long periods- realised she 'had schizophrenia', that medication was helpful and that these realisations were a basis for engagement with other identities. In turn, she viewed her engagement with other identities as justification for her realisations about schizophrenia and medication. Through *fusing up* these identities as mutually sustaining- through binding them together in reciprocal realisation- Lori attests to her own victory. She is bound to an acceptance of illness and medication but this acceptance is bound to other identities as worker, as friend, as independent and as capable. In this way, she realises a kind of paradox: she is obliged to accept illness and medication but, in doing so, she is more independent and free to live out preferred identities. And this independence and freedom is part of what obligates her to accept medication.

This integration of confinement with freedom was also relevant to Elyn Saks' new pattern of identity engagement after many years of *enforced submission* and *liberated revival*. As mentioned in a previous section, she eventually realised herself as mentally ill through *going together with medication* and realising beneficial effects from Zyprexa. But this self-realisation was not simply attributable to her evaluations of medication. In the past, she noted that medication was useful yet stopped taking it. Although she found Zyprexa particularly helpful, her evaluations of this drug were also part of a changing set of self-relations. For many years, Elyn viewed mental illness and taking medication as antithetical to her self-conceptions as capable and

self-reliant. To her, an acceptance of mental illness represented an invalidation of these self-conceptions which she repeatedly reasserted following *enforced submission*.

But, when benefiting from Zyprexa, Elyn was drawn by what she called "the riptide analogy". Riptides are sea currents that are near to shore and too powerful for even the strongest swimmers to resist. In resisting riptides by trying to swim against them, persons are commonly exhausted and then drowned. But capable sea swimmers know to 'go with the flow' of a riptide: to allow themselves to be carried by it. When swimmers surrender to the current in this way, it propels them beyond itself and they are liberated from it. For Elyn Saks, this was a powerful metaphor through which she both represented and realised her acceptance of mental illness:

"Ironically, the more I accepted I had a mental illness, the less the illness defined me- at which point the riptide set me free." (Saks 2007. Pg.281)

Like Gary and Lori Schiller, Elyn found that her acceptance of herself- as mentally ill and in need of medication- enabled her to live more of a life. She was able to work more productively and with less interference, to train as a psychoanalyst, and to sustain a loving relationship.

So, Elyn was *fusing up* a formerly rejected identity as mentally ill with established ones as capable and self-reliant. This was a synthesis of what she once regarded as antithetical. Surrender to mental illness became the capable thing to do and allowed her to be more capable and self-reliant as well as engage to new identities. Her account is ultimately one of victory in surrender.

In the context of psychosis, however, *fusing up* does not necessarily involve an acceptance of mental illness. This is illustrated in Ron Bassman's autobiography. As mentioned in the discussion of *finding resemblance to others,* Ron qualified as a psychologist and he said this helped him to retrieve his self-respect after the demoralisation of two admissions to a psychiatric hospital. But he was left with some disquiet:

"The future offered possibilities, but I could not help worrying about how long it would be until some haunting questions again demanded attention. Was returning home as a doctor enough to prove my competence and allow me to enter mainstream normalcy? Would I be able to abandon my search for meaning by just chalking it up to an adolescent identity crisis? In order to remain safe, did I have to turn my back on what I had experienced? And what about my obligations to the people who were- and are- going through similar experiences?" (Bassman 2007. Pgs.141-142)

Ron went on to get married and have a son, develop an interest in Tai Chi, participate in and benefit from psychodrama as well as helping others in his work as a psychologist. He valued this aspect of his work but found it constraining when he worked for an agency. Also, he avoided disclosure of his psychiatric history because he worried about the potential ramifications for his career. At the same time, he was uncomfortable with what he saw as this pretence and the idea that he was turning his back on an important aspect of his biography. Eventually, he did disclose his psychiatric history at a professional conference and, from there, encountered a network of psychiatric survivors that

he immediately recognised as “brethren”. As part of this recognition, he realised himself as a psychiatric survivor: as a person who survived oppressive experiences within an unjust psychiatric system.

Associated with a self-identification as a survivor, Ron committed himself as an activist working to redress psychiatric injustice. He worked in psychologist education and was explicitly employed to draw upon his biography as both a professional and a service user. In *fusing up* these identities, he was no longer turning his back on his own life history. Instead, like Elyn Saks, he synthesised two identities- in his case, as a professional and as a psychiatric survivor- that he formerly considered antithetical. This integration is suggested by the sub-title of Ron’s book: “A psychologist’s experience from both sides of the locked door”. However, this is not to suggest that Ron combined his professional and survivor identities in equal measure. For him, the more essential self-truth is that he is a survivor in a community of consumers, survivors and ex-patients (depending on how persons want to self-designate and which he abbreviates as c/s/x):

"When I broke my silence and began introducing myself as a person who had been diagnosed and treated for schizophrenia- a psychiatric survivor- I became an insider in the psychiatric survivor world. As an insider I discovered the distinct difference in meetings when a group was composed entirely of c/s/x and when groups contained even one professional. Genuine expression is inhibited by the presence of professionals." (Pg.179)

From this, it seems clear that Ron regards himself as more of a survivor than a professional. And this is confirmed by his subsequent claim that he feels much more comfortable and 'at home' in meetings of c/s/x than of professionals. Nonetheless, he has a career as a professional which he values and in which he realises himself as 'more than a professional' by reference to his survival of psychiatry. For him, his value as a professional is bound to his status as a survivor. Furthermore, for Ron, *fusing up* does not involve accepting a medical conception of mental illness. Indeed, he continued to repudiate psychiatric categories- as they apply to himself or anyone else- and regards his past 'schizophrenia' as part of a search for identity rather than a constitutional pathology.

In summary, then, *fusing up* refers to self-relations in which identities are linked and blended. Persons are committed through these links in which they render themselves 'greater than' a particular category like mental illness or 'better off' than in the past. And this constitutes the last of a number of patterns of *identity commitment* that were examined over the last three chapters. What remains to be explored is the relevance and significance of these patterns.

CHAPTER EIGHT

EXPLORING THE THEORY

Introduction

To summarise the last four chapters, *identity commitment* is a pattern of self-relation that variously implicates persons in truth-keeping, struggle and engagements with themselves. It is fundamental to how persons get along with themselves in the context of psychosis. In this chapter, this theory of *identity commitment* is explored in five ways.

First, *identity commitment* is explored as an account of resistance. Particular attention is given to resistance to psychiatric identification and the emergent theory of *identity commitment* is considered for its usefulness in accounting for such resistance. Second, *identity commitment* is explored as an account of entrapment in terms of how persons are bound to unwanted identities in the context of psychosis. Third, *identity commitment* is explored as an account of acceptance. Two forms of acceptance- downward and upward- are proposed and some implications considered. Fourth, *identity commitment* is explored as an account of self-comparisons. Particular attention is given to social and temporal comparisons and their place in patterns of *identity commitment*. Finally, *identity commitment* is explored as a dynamic account of constraint and preference whereby both are necessarily implicated in how persons get along with themselves in the context of psychosis.

Identity commitment as an account of resistance

'Poor insight' as an explanation for resistance

In psychiatric research and practice, it is commonly observed that persons- who experience psychosis- deny they are mentally ill even though the truth of their disorder is evident to others (Greenfeld et al. 1989, Pompili et al. 2004, Cooke et al. 2007); that persons refuse prescribed antipsychotic medication even though there is evidence for its effectiveness (Greenhouse et al. 2000, Cheng-Fang et al. 2005); that persons misplace confidence in their own interpretations and beliefs that are false and outlandish to others (Bora et al. 2007, Warman et al. 2007); and that persons are inclined to misattribute 'mine-ness' for 'otherness' (Gallagher 2000, Blakemore and Frith 2003, Fu and McGuire 2003, Parnas 2003, Kircher and Leube 2003, Sass 2003, Sass 2004, Knoblich et al. 2004, Frith 2007).

In each of these areas, persons are considered unable to properly grasp the truth of things and this inability is commonly formulated in terms of 'poor insight'. In addition, poor insight is employed as an explanatory category. It is taken to explain a variety of actions like refusal of psychiatric treatment or involvement, refusal to believe one is mentally ill and opposition to the efforts of psychiatric professionals. In short, from a psychiatric perspective, resistance- by persons diagnosed with psychotic illness- is commonly attributable to poor insight.

There are criticisms of this psychiatric conceptualisation of insight and some argue that it is merely a criterion to judge whether psychiatrically

diagnosed persons regard themselves in ways approved by professionals (Goffman 1968, Dolson 2005). In any case, it is certainly not necessary to invoke poor insight in an explanation of resistance to psychiatric treatment and involvement. For one thing, an alternative account is offered by the theory of *identity commitment* that is emergent from the current study.

'Keeping true' and 'struggling through' as forms of resistance

As illustrated in Chapter Five, the refusal of antipsychotic medication and the repudiation of psychiatric identities constitute acts of *keeping true (to) self-conceptions*. In Chapter Six, examples are cited of persons who resisted psychiatric treatment and involvement and who contested their identities with psychiatric professionals. These were illustrations of *struggling through with Me's*.

In each of these cases, persons' acts of resistance were regarded by others as indicative of poor insight. But persons were acting in ways that were faithful to certain conceptions of themselves. These conceptions were preferable to ones associated with mental illness and treatment. This meant that, for the time being at least, persons could better live with established truths of themselves than alternative versions associated with mental illness. Fidelity to preferred self-conceptions was partly constituted by refusals to act in ways that were associated with antithetical psychiatric identities. This fidelity not only involved staying true *to* established identities but also served to reproduce the truth *of* these identities. For example, in rejecting medication as *not-for-Me* and

repudiating mental illness as *not-Me*, persons were keeping true self-conceptions as competent, independent, strong, and the like.

So, at least in part, self-fidelity provides an explanation as to why persons resist psychiatric treatment and involvement in the context of psychosis. This resistance is explicable in the light of commitment to established identities. Persons are in a committed relation with conceptions of themselves and so they 'have to' stay faithful. On this basis, they are obliged to resist psychiatry and they do so. In some cases, this resistance is enduring over long periods of time, perhaps indefinitely.

However, this theory of *identity commitment* does not only provide an alternative formulation of resistance to that commonly employed in psychiatry. It also brings some sociological assumptions into question about the possibility of resistance in psychiatric contexts.

Identity as a sociological end-product

There are sociological accounts which portray psychiatric identities as predictable end-products of social processes. A seminal example of such an account is provided by Goffman (1968) in a study of 'the total institution' that was primarily based upon observations in an American psychiatric hospital in the late 1950s. In this institution, 'inmates' were segregated from their customary everyday worlds and, for Goffman (1968), this meant that persons were denied access to the roles, activities, and relationships that sustain their selfhood, their prior self-definitions and appraisals. This prior self, especially a creditable self, was 'mortified' through experiences of a context in which

privacy was denied, deferral to staff was required, submission to a routine was mandatory, and usual strategies of self-presentation were undermined. Staff members employed information that discredited persons' efforts to present their self as capable or distinguishable from their current situation as an inmate. Indeed, persons were encouraged to view their current environment as an expression of their self:

"Once lodged on a given ward, the patient is firmly instructed that the instructions and deprivations he encounters are not due to such blind forces as tradition or economy- and hence dissociable from self- but are intentional parts of his treatment, part of his need at the time, and therefore an expression of the state his self has fallen into." (Pg.138)

Furthermore, persons encountered a range of incentives, including the prospect of discharge, to re-define themselves in ways that were consistent with a psychiatric viewpoint. According to Goffman (1968), many persons integrated these re-definitions into a reconstituted self and did not resist them.

Predominantly, the message of Goffman's asylum work was that psychiatric hospitals process personal identities and produce institutionally-sanctioned selves. He made a major contribution to a theoretical tradition in which psychiatric involvement was accorded a determining role in how persons view themselves. Other examples of this tradition are provided by Scheff (1978) with his account of psychiatric labelling, Estroff (1985) with her account of the community segregation and welfare dependency of persons with serious

mental illness, and Lally (1989) with his Goffman-like account of 'engulfment' by psychiatric identities in the context of psychiatric hospitalisation.

Taken together, these sociological accounts convey an impression of persons that are powerless to define themselves once they are implicated in psychiatric involvement. Resistance against psychiatric definition appears to be useless on this basis. However, going back to Goffman's work, it was somewhat contradictory. He actually identified various ways in which persons respond to the mortifications and privilege system of a psychiatric hospital. One of them was an "intransigent line" in which persons flagrantly refuse to cooperate with hospital staff. Goffman (1968) suggested that this response is often (which means not always) temporary. He referred to another pattern of inmate action as "colonization" whereby persons learn to exploit the satisfactions available in the asylum. Still another pattern was "situational withdrawal" and the final pattern of inmate response was "conversion" whereby persons take over the official view of themselves.

In short, identity conversion was actually only one of four patterns whereby persons responded to their social situation as inmates of Goffman's asylum. But this was the pattern he emphasised and analysed whilst overlooking the others. This point was made by Townsend (1976) in a critical commentary on Goffman's work.

So, Goffman (1968) observed resistance to psychiatric involvement but did not account for it. In failing to account for resistance as a variation of inmate action, he contributed to a climate of sociological opinion in which such

resistance was overlooked in favour of an emphasis on identity as an end-product of social or institutional processes. This climate of opinion may, in part, be associated with a rejection of the idea of an asocial individual that can stand apart from the social world. But, the current theory of *identity commitment* offers an entirely social formulation of resistance. For one thing, it is a formulation that receives theoretical support from symbolic interactionism and the idea of a 'social self'.

Symbolic interactionism, identity commitment and resistance

Symbolic interactionism is a theoretical perspective that proved useful to the current study but, at first glance, this may seem like a perspective ill-fitted for an account of resistance. This is because symbolic interactionism can be viewed as a perspective which depicts a self at the behest of others. Mead (1934) argued that self can only become an object for itself through the standpoint of others:

"The individual experiences himself as such, not directly, but only indirectly, from the particular standpoints of other individual members of the same social group, or from the generalized standpoint of the social group as a whole to which he belongs. For he enters his own experience as a self or individual, not directly or immediately, not by becoming a subject to himself, but only in so far as he first becomes an object to himself just as other individuals are objects to him or in his experience; and he becomes an object to himself only by taking attitudes of other individuals toward

himself within a social environment or context of experience and behavior in which both he and they are involved." (Pg.138)

So, Mead (1934) located the origins of *Me's* in a world of others and in a social environment. For Holstein and Gubrium (2000), this implied that persons were socially governed and they identified Mead as a seminal figure in a sociological tradition which depicts "a self at the mercy of the social". They linked Mead to the subsequent development of a labelling perspective in which social responses to deviance were considered the determining factor in the formation of deviant identities (see Lemert 1978, Scheff 1978).

For Holstein and Gubrium (2000), Mead and symbolic interactionism were tainted by associations with a socially-governed self. On this basis, they consigned symbolic interactionism to history and went on to develop what they presented as a more nuanced "postmodern" account of identity that allows for a self that is both actively constructed and locally constrained. But, in so doing, they overlooked the full implications of Mead's social self.

A key point is that symbolic interactionists did not consider self to be social only in the sense of a product of interaction with others. For sure, Mead (1934) argued there could be no *Me's* without others and that persons necessarily employ the regard of others in becoming aware of themselves. But he also argued that self provides its own social experiences through *I-Me* relations. This idea was elaborated by Blumer (1969) in exploring the notion of "self-indications" and in contrasting symbolic interactionism with the view of persons as "responders" to the social world:

"The view of the human being held in symbolic interactionism is fundamentally different. The human being is seen as "social" in a much more profound sense- in the sense of an organism that engages in social interaction with itself by making indications to itself and responding to such indications....Instead of being merely an organism that responds to the play of factors on or through it, the human being is seen as an organism that has to deal with what it notes. It meets what it so notes by engaging in a process of self-indication in which it makes an object of what it notes, gives it a meaning, and uses the meaning for directing its action. Its behavior with regard to what it notes is not a response called forth by the presentation of what it notes but instead is an action that arises out of the interpretation made through the process of self-indication. In this sense, the human being who is engaging in self-interaction is not a mere responding organism but an acting organism- an organism that has to mold a line of action on the basis of what it takes into account instead of merely releasing a response to the play of some factor on its organization." (Pg.15)

As an "acting organism", persons conduct relations with themselves and this implies that they do not simply do as others direct. Instead, their actions are shaped by the reality that they live with themselves through various patterns. One such pattern is characterised by commitment and this is mentioned by Strauss (1969) in a symbolic interactionist essay on self and identity:

"The person who knows his world well, who is familiar with all its pathways, is strongly committed. Committed to what? To a conception of himself as a certain kind- or kinds- of person, who is expected to, and himself expects to, act in certain ways in certain situations. If the situations that arise are not entirely familiar, they are nevertheless somewhat like the old ones and demand similar lines of action.

Commitment, then, will involve conviction as to what is right and proper as well as their converse: what is worth striving for, fighting for, what is to be avoided, abhorred, considered cheap or sinful, and so on." (Pgs.39-40)

For Strauss (1969), then, commitment to certain self-conceptions implies an inclination to 'fight for them' when necessary. It is this inclination that is associated with resistance to psychiatric involvement as it is instanced in this study in the context of psychosis. This resistance is entirely consistent with symbolic interactionist accounts of self and self-relations.

Furthermore, as already mentioned, symbolic interactionism is a theory of *Me's* that are drawn from a world shared with others. When persons resist psychiatric involvement in a dynamic of *identity commitment*, this resistance needs to be understood in terms of their various social involvements and community memberships. They are not asocial individuals fighting against psychiatric domination. At a general philosophical level, this point was explored by Taylor (1989) who criticised the notion of individuals standing alone and apart from the worlds in which they live. Giving the examples of

Socrates who was resolute in his views even when faced with the prospect of a death sentence for them and Old Testament prophets who delivered God's message despite persecution, he argued that such persons are never really 'outside' some community:

"They are still in a web, but the one they define themselves by is no longer the given historical community. It is the saving remnant, or the community of like-minded souls, or the company of philosophers, or the small group of wise men in the mass of fools, as the Stoics saw it, or the close circle of friends that played such a role in Epicurean thought." (Taylor 1989. Pg.37)

In other words, persons' resistance to self-definition in terms of a particular social category is associated with commitment to, and identification with, another social category. In a psychiatric context, this is illustrated by Prior (1995) in a case study of a man who was an in-patient in a psychiatric hospital in Northern Ireland. He spent thirty six years as a patient and was compulsorily detained for a significant proportion of that time. Nonetheless, he continued to reject a definition of himself as mentally ill and took no medication for many years. He maintained a strong religious commitment, attending a local church every day and singing in its choir. In addition, he maintained regular paid work in the local community doing a range of manual jobs. At the same time, he had minimal contact with other in-patients and, for many years, used the hospital largely as a place to sleep.

As Prior (1995) pointed out, this scenario represents a negative case for sociological accounts that emphasise the capacity of psychiatric hospitals to

produce psychiatric identities and for more general claims about the creation of deviant selves (for example, see Lemert 1978). The social status of a detained 'mental patient' was not central to how this man was identified by himself and others that lived in the town where his hospital was situated. Instead, it appeared that his 'core identity construct' was religious and his attributed status (by persons in the town) was shaped by his Christianity and employability as a manual worker. Therefore, he was not excluded from the local community (perhaps partly because it was a hospital town) and was able to resist a conversion to a psychiatric identity.

In the case of this man, *keeping true (to) self-conceptions* and resistance to a psychiatric identity proved a sustainable pattern of *identity commitment*. But, there are variations in the sustainability of such resistance.

The limits of resistance

There are limits on the extent to which persons can sustain resistance to psychiatric involvement and identification. These are detailed in Chapter Six. As persons move towards these limits, open resistance may be untenable and persons resort to resourceful ways of *giving way* rather than giving up their self-obligations. Persons covertly keep true (to) self-conceptions and make some overt concessions to psychiatric involvement. Psychiatric professionals may be entirely unaware of this reality and this can be a part of a wide gulf in perspective between themselves and patients or service users. Also, *giving way* was associated with a good deal of dissatisfaction on the part of participants in the current study. They complained about the injustice or isolation that was

associated with their pretence. This was not a way that they wished to live with themselves or others.

Incidentally, there are interesting questions about the relevance of *giving way* for an understanding of varied contexts of everyday life. For example, in a well-known study of cabin crew on airlines, Hochschild (2003) conceptualised 'emotional labour' in a way that is akin to *giving way*. These staff tended to deliberately present a 'front' to passengers as a way of conforming to a company requirement of smiling, attentive customer service. They maintained this front even in situations where it was antithetical to what they were thinking, feeling and believing. And regarding their actions as a front enabled cabin crew to sustain a distance between their work and themselves: to keep true to themselves and yet act 'falsely' to themselves. For some, however, this emotional labour seemed to carry significant personal costs.

Anyway, getting back to the topic of resistance to psychiatric involvement and identification, *giving way* can be a way of sustaining such resistance over varying lengths of time. Nonetheless, there are situations in which persons are forced to submit to psychiatric treatment and involvement as well as forego a particular identity commitment (*enforced submission*). And there are situations in which persons lack resources to sustain fidelity to particular self-conceptions (*identity erosion*). Whilst persons do often retrieve the truth of prior identities through *liberated revival* or *laboured restoration*, this can be followed by further submissions and erosions. On this basis, resistance to psychiatric involvement and identification can be unsustainable

and persons are confronted with the self-truth of unwanted psychiatric identities (*identity bondage*).

In summary, resistance to psychiatric involvement and identification is explicable in terms of *identity commitment*. This concept provides a basis for understanding resistance in terms of how it is possible, how it varies, when it is unsustainable, and how it is located within wider patterns of self-relations that are intelligible. As such, it carries greater explanatory value than the psychiatric concept of poor insight or notions of sociological determinism. Furthermore, the theory of *identity commitment*- emergent from the current study- offers something to an understanding of a variety of phenomena other than resistance. One of them is entrapment by unwanted identities.

Identity commitment as an account of entrapment

Suffering, psychosis and unwanted identities

In the context of psychosis, it is well recognised that suffering is often related to persons' conceptions of themselves. More specifically, persons can suffer because they view themselves in particular ways: as diminished, persecuted, without positive futures, and the like. On this basis, it is difficult for persons to get along with themselves.

Returning to the topic of insight into mental illness, Cooke et al (2007) undertook a study with persons who each had at least one "distressing positive symptom" of psychosis and were beginning cognitive-behavioural treatment. The researchers identified an inverse correlation between insight and self-esteem. Persons were inclined to view themselves negatively when they

regarded themselves as mentally ill. On this basis, Cooke et al (2007) reasoned that persons may cope with psychosis in a way that promotes positive self-evaluation but poor insight:

"If persons believe that they are mentally well despite disagreements with clinicians ('poor insight'), this might help to maintain positive core beliefs about the self and promote good self-esteem. Therefore poor insight could be viewed as an adaptive response to a diagnosis of a serious mental illness with respect to psychological well-being, although it can have maladaptive effects on other areas of functioning, such as engagement with services and taking medication." (Pg.236)

The idea that 'good insight'- into oneself as mentally ill- is associated with problems of self-regard is emphasised in other studies. Lewis (2004) conducted a review of research literature and identified an association between insight, hopelessness and suicide. In a similar vein, Iqbal et al (2000) identified an association between 'post-psychotic depression' and a sense of entrapment associated with realising oneself as mentally ill in a longitudinal study of persons recovering after psychosis (see also Birchwood et al. 2000).

Now, these studies raise some questions which the authors did not attempt to answer. In circumstances where believing oneself to be mentally ill is associated with entrapment, lowered self-esteem, depression and even suicidality, why would anyone believe this? Why not opt for the more consoling alternative of poor insight?

These questions are also left begging in a grounded theory study by Sayre (2000). Focusing on persons diagnosed with schizophrenia and admitted to a psychiatric ward, she examined how they responded to hospitalisation, psychiatric diagnosis and the "social predicament" of being mentally ill. She found that most of the participants did not accept a psychiatric explanation for their predicament. In theorising their varying "attribution accounts" of hospitalisation, Sayre (2000) identified a core category of "maintaining self-worth". Persons variously explained their hospitalisation in ways that sustained a distance between themselves and the negative social category of mental illness. However, there were two participants (out of a total of 35) who were consistently and harshly critical of themselves. Sayre (2000) did not attempt to relate the core category of maintaining self-worth to these cases and instead disregarded them as minority exceptions without analytic significance. In other words, she failed to explain the full range of variation in persons' attribution accounts.

A similar point applies to another grounded theory study by Hall and Cheston (2002). They examined how attendees at a psychiatric day centre coped with threats to their identities posed by psychiatric diagnosis (not exclusively of psychotic illness) and experiences of mental illness. The core category of their grounded theory was "coping with stigma and rejection" but some of the participants represented themselves in terms of undesirable characteristics. As in Sayre's study, the authors did not reconcile the core category with this pattern of self-representation.

By contrast to the aforementioned studies and grounded theories, the current theory of *identity commitment* does account for how persons are attached to unwanted identities.

Identity bondage, truth and self-obligation

Identity bondage is one variation of *identity commitment* that is conceptualised as part of the current study and examined in Chapter Seven. This refers to a pattern of self-relation in which persons regard self-conceptions as both inescapably true and seriously unwanted.

In the context of psychosis, there are two related ways in which *identity bondage* is realised. The first may seem too obvious but it is nonetheless worthy of consideration. Persons regard themselves as inescapably flawed, diminished, persecuted, and so on because it seems evidently true to them. In addition, this self-truth is compelling and confining: persons are compelled to suffer and unable to escape because of this truth and because there is little or no scope for doubt. They are committed by the truth.

One source of such compelling self-truths is persons' own senses. When immersed in psychosis, for example, there are persons who hear the voice of the devil and see the shapes of demons. At least for a time, the clarity of these perceptions can render them unimpeachable. Their truth seems beyond doubt. In addition, self-truths are discovered through *finding things in common* (detailed in Chapter Seven). Persons find so much in common between themselves and particular conceptions that the 'match' seems undeniable. Realising this match may occur gradually or through a sudden insight.

Furthermore, when *keeping true (to) self-conceptions* and *struggling through with Me's* is untenable or unsustainable, persons often realise a loss of valued identities and a truth of self-diminution.

The second aspect of *identity bondage* is that it can be obliged as part of keeping true (to) other self-conceptions. For example, faithfulness to *Me-as-mentally-competent* implies trust in one's own senses and commitment to the evidence of one's senses no matter how disturbing. This can oblige persons to continue believing in their own persecution rather than discount their own capacity. Therefore, through the mixed implications of fidelity to preferred identities, persons can be committed to the truth of unwanted identities.

With the concept of *identity bondage*, this study goes further in accounting for how persons are confined by unwanted identities than research reviewed in the previous section. Also, there is no precedent for this concept in the extant literature of identity commitment that is reviewed in Chapter Four. Whilst there is a notion that identities commit persons to courses of action and this means they are entrapped or obliged in some sense (Brockner et al. 1986, Dietz-Uhler 1996, Neuhouser 1998), there is no account of how persons get entrapped with identities that are unwanted. In providing such an account, the current theory of *identity commitment* is somewhat distinctive.

Furthermore, the theory of *identity commitment*- associated with the current study- highlights the ways in which persons do often move from *identity bondage* to other patterns of self-relation. In varying ways, these patterns are characterised by acceptance.

Identity commitment as an account of acceptance

Acceptance in a general context

In a number of research contexts, there is a suggestion that 'acceptance' is a positive way of coping with some kind of unpalatable reality. These contexts included living with multiple sclerosis (Pakenham 2006), chronic pain (McCracken et al. 2007), and a relative with schizophrenia (Fortune et al. 2005). In addition, in the field of alcohol misuse, there is a longstanding emphasis- associated especially with Alcoholics Anonymous- on the notion of acceptance of the truth of oneself as alcoholic and the necessity of this acceptance as a basis for recovery (Denzin 1993).

There are also references to acceptance in the context of persons with psychosis. In a study of mood-stabilising treatment for persons with bipolar affective disorder, Greenhouse et al (2000) established an association between 'acceptance coping' and adherence with medication. Also, they briefly mentioned the idea of readiness in relation to accepting mental illness. By reference to an autobiography by Jamison (1996) that was also analysed as part of the current study, Greenhouse et al (2000) acknowledged that there can be pleasurable aspects of bipolar illness that persons find difficult to 'give up'.

This latter point links with studies, cited in the previous section, which suggest that persons are often reluctant or unwilling to accept a diagnosis of psychotic mental illness because of its negative implications for their identities (Sayre 2000, Hall and Cheston 2002). In addition, in the current study of *identity commitment* and as mentioned in the earlier section on resistance, an

unwillingness to accept a psychiatric diagnosis can represent fidelity to alternative, preferred identities. Therefore, a 'refusal to accept' can constitute an affirmation of a self-conception and not simply a negation of an alternative identity.

Furthermore, there is a difference between acceptance of identities and entrapment by unwanted identities. Acceptance of identities allows more room for the realisation of preferred self-conceptions although there is significant variation in the extent of this scope. The current theory of *identity commitment* accounts for this variation and provides some insights into the dynamics of acceptance in the context of psychosis.

Downward acceptance and consolation

In Chapter Seven, *consolation tied to acceptance* is examined as a variation on how persons are bound to particular self-conceptions. This involves realising self-conceptions that are comforting in the context of identities that are constraining and unwanted. But such self-realisations are contingent upon acceptance of such unwanted identities and it is in this sense that *identity commitment* is an underlying pattern. In making the best of things, persons are committed to accepting less than they once wanted for themselves. Also, *consolation tied to acceptance* needs to be understood as a pattern of self-relation. It reflects what persons do to get along with themselves when unwanted identities appear inescapable and, as such, commonly represents a 'next step' after *identity bondage*.

Here then is one dynamic of acceptance that is explained by reference to *identity commitment*. It is a 'downward' form of acceptance associated with making the best of unwanted limitations. In principle, this kind of acceptance generally meets with the approval of psychiatric professionals. It is often viewed as 'a good thing' when persons make the most of themselves in the context of accepting limitations associated with psychosis. However, professionals do not necessarily grasp the full implications of downward acceptance.

Going back to Goffman (1968) and the responses of inmates to a total institution, he identified "colonization" as one pattern of response whereby persons built a relatively contented existence through exploiting the satisfactions available within the hospital system. They accepted their institutional restriction and made the best of it. However, this was not necessarily a form of acceptance approved by staff members who were oriented to inmates' ultimate discharge.

Similarly, Estroff (1985) conducted an ethnographic study with persons who were mainly diagnosed with schizophrenia and engaged in an assertive community treatment programme. In this social situation, persons were paid extra welfare benefits, made friendships with other service users and they were accustomed to asymmetrical power relations with psychiatric professionals. They had few contacts with persons- other than professionals- that were 'not crazy' and they exhibited side effects of antipsychotic medication that emphasised their differentness in everyday settings. In this context, service

users generally accepted their situation and made the most of its consoling features like friendship and welfare payments. However, Estroff (1985) was critical of the way in which welfare, patterns of friendship, medication and power relations with professionals were inter-related factors that served to sustain 'crazy identities'.

A key point here is that, in the context of psychosis, *consolation tied to acceptance* is a pattern that occurs in particular circumstances that offer particular opportunities for the realisation of comforting self-conceptions. These self-conceptions may or may not meet with the approval of others like psychiatric professionals or researchers. But they do reflect the efforts of persons to get along with themselves in the particular circumstances they encounter. Furthermore, there is commonly potential for downward acceptance to be followed by upward acceptance.

Upward acceptance, fusing up and recovery

Fusing up is another variation on the pattern of *binding self-attachments* (see Chapter Seven). Here, persons accept identities that were once unwanted and as part of a mutually sustaining set of self-conceptions. As part of this combination, acceptance is a means to an enlarged life with greater possibilities for the realisation of preferred identities. These identities are sustained by acceptance. At the same time, acceptance is sustained by reference to these preferred identities.

Hence, *fusing up* constitutes an upward form of acceptance. Persons do not define themselves as anyway diminished and instead account for

themselves as ‘better off’ or elevated through their acceptance of an identity that was once unwanted.

This idea of elevation through upward acceptance is relevant to the notion of recovery in the context of psychosis. In the literature of mental health and psychiatry, there is a well established interest in recovery. Seminal figures in this literature are Deegan (1996, 2001), who was herself diagnosed with schizophrenia and subsequently became a psychologist, and Anthony (1993), a psychiatrist. Both of them emphasised the idea of recovery as a process that persons ‘do’ themselves, that is not predicated on the elimination of ‘symptoms’, that involves setbacks, that occurs over time, that involves the discovery of meaning, hope and purpose, and that can be assisted by supportive others.

Following these early contributions to the recovery literature, a variety of authors developed or reviewed ideas about recovery in the context of mental illness (Clinton and Nelson 1999, Repper 2000, Repper and Perkins 2003, McGruder 2001, Turner-Crowson and Wallcraft 2002, Carpenter 2002, Kelly and Gamble 2005) and others followed Patricia Deegan’s lead in writing about their own personal experiences of recovery (Bledsoe 2001, Mack 2001, Deegan 2003). In addition, there were various studies of recovery in the context of psychosis that emphasised various elements like medication, friendship and acceptance from others, experiences of being productive, and openness to beauty and joy (Davidson 2003); reconnection with the broader world (Forchuk et al. 2003); taking self-responsibility, determination, and optimism (Tooth et

al. 2003); finding a way out, accepting life as a struggle, and development of new understanding (Thornhill et al. 2004); and overcoming loss (Henderson 2007).

Although this literature is quite diverse in accounting for recovery, there is no reference to any notions like upward acceptance or *fusing up*. Yet, at the same time, these notions do relate to aspects of the recovery literature. They refer to situations in which persons reach new understandings of themselves as changed for the better, they are not predicated on illness explanations, they succeed previous patterns of struggle and setback, and they do not refer to an end-point but an ongoing relation.

On this basis, the current theory of *identity commitment* is distinct from the extant literature of recovery and yet could make a contribution to it. More specifically, the current theory suggests upward acceptance as a recovery process that reflects ongoing self-relations of *identity commitment* and *fusing up*. Another aspect of ongoing self-relations, and *identity commitment*, is self-comparison.

Identity commitment as an account of self-comparisons

Comparing self with others

When implicated in committed relations with themselves, persons make wide use of self-comparisons. In the context of psychosis, one focus for such comparisons is the standpoints of others. For example, in *keeping true (to) self-conceptions,* persons judge the truth of their own fidelity- as religious, independent, caring family members, as feminine, and so on- by reference to

conceptions that are more generally held. Reproducing truths of oneself involves establishing similarity or 'fit' between self and these generally held conceptions (see Chapter Five). Similarly, when *engaging to identities* and discovering new self-truths, *finding things in common* involves discovering a resemblance between one's own life experiences and a conception encountered in relations with others.

Over time, persons encounter new or changing standpoints and this can mean new possibilities for self-comparison. In a study involving persons attending a psychiatric day centre, Hall and Cheston (2002) showed how some persons changed their views of mental illness through adopting the standpoint of other attendees. On this basis, they adopted a less negative view of mental illness in general and of themselves as mentally ill. Also, persons in the day centre found similarities between themselves and other attendees- they were 'in the same boat'- and this was part of *finding things in common* with a more consoling conception of mental illness.

Here then, persons did not just compare themselves with the standpoints of others but also more directly with other persons. In a study involving women attending a psychiatric drop-in centre, Camp et al (2002) found that the most frequent social (self-other) comparisons were lateral. Persons were largely inclined to note resemblances between themselves and other attendees in a way that is consistent with the aforementioned study by Hall and Cheston (2002). However, 'downward social comparisons' were also common in which attendees appraised themselves as coping better than other attendees or dealing

with less severe mental health problems. For Camp et al (2002), these comparisons served to enable attendees to present themselves in a relatively favourable light. This point might also have emerged from a study by Jackson et al (2009) of 'social identity' among persons who were in-patients on an acute psychiatric unit. The authors were interested in how persons identified with other in-patients but the participants tended to differentiate themselves from other in-patients. This was obviously contrary to researcher expectations because they were interested in identification with an in-group and so they did not really analyse the significance of these self-differentiations.

In any case, in the current study of *identity commitment*, persons commonly made comparative distinctions between themselves and others. For example, this was an important way of *repudiating unwanted identities* as part of *keeping true (to) self-conceptions* (see Chapter Five). By comparing and differentiating themselves from others who personified unwanted identities, persons reproduced the truth of themselves as 'not like them' and 'not like that'. And this was part of keeping true preferred self-conceptions. Another common example related to *consolation tied to acceptance* (see Chapter Seven). Here, persons commonly distinguished themselves from others who were 'worse off' or 'less worthy' in some sense. This was part of a self-relation in which persons established themselves as making the best of things given the adverse circumstances.

So, comparisons with others are an important part of *identity commitment*. This is relevant to the theoretical and research tradition of social

comparison theory in which it is well recognised that persons employ comparisons with others to evaluate themselves, elect to improve themselves, verify themselves, or enhance themselves (Festinger 1954, Buunk et al. 1990, Collins 1996, Mussweiler et al. 2000, Biernat 2005, Buunk and Gibbons 2007, Brown et al. 2007, Greenberg et al. 2007). In the context of psychosis, however, *identity commitment* appears to account for the particular directions and uses of social comparisons.

Comparing self over time

Another kind of comparison relates to oneself in time. This is another area of investigation in social psychology and temporal comparison theory suggests that past-present comparisons help persons to maintain a sense of identity over time (Albert 1977). When persons evaluate themselves as 'better off' in the present that the past, this is called a 'downward comparison' whereas an 'upward comparison' refers to a converse temporal self-evaluation.

In a study of temporal comparisons in constructions of identity among persons with schizophrenia, Dinos et al (2005) undertook a content analysis of transcripts of semi-structured interviews with twelve participants. Persons made extensive use of past-present comparisons even though the interview schedule was more oriented to questions about the future. The majority of temporal comparisons were downward: persons considered themselves better off in the present than the past. However, these comparisons tended to be with a self that was 'more ill' in the past whereas comparisons tended to be upward when oriented to a past 'healthy self' prior to the onset of illness. In other words,

participants tended to evaluate their current self as inferior to a past self prior to mental illness.

Again, as with interpersonal comparisons, temporal comparisons were associated with particular patterns of *identity commitment* in this study. Upward temporal comparisons were associated with *enforced submission* and *identity erosion* (Chapter Six) as well as *identity bondage* (see Chapter Seven). Downward temporal comparisons were associated with *liberated revival* and *laboured restoration* (Chapter Six) as well as *fusing up* (Chapter Seven). Furthermore, the mixed picture of temporal self-evaluations (reported by Dinos et al. 2005) was associated with *consolation tied to acceptance* (Chapter Eight). Hence, it seems that *identity commitment* provides an account of variations in temporal comparisons. Also, temporal self-evaluations are part of what constitutes different patterns of *identity commitment*.

In summary, self-other and temporal comparisons are widely employed in *identity commitment*. They are part of how committed self-relations are sustained and realised but they are also shaped by these relations.

Identity commitment as a dynamic account of constraint and preference

Constrained and obligated selves

In the extant literature of identity commitment that is reviewed in Chapter Four, one thematic emphasis- exemplified in the concept of a 'side bet' (Becker 1960)- is constraint, obligation and limited 'room for manoeuvre'. The current theory of *identity commitment* is consistent with and, in some ways, extends this emphasis. In the context of psychosis, committed self-relations

often mean that persons ‘have to’ act, and view themselves, in certain ways. Indeed, in some instances, persons are entrapped in attachments to unwanted identities.

This idea of an obligated or entrapped self is somewhat at odds with some depictions of self in everyday life. Gergen (2000), for example, argued that a committed self is a modernist conception that is anachronistic in the face of postmodern multiplicity where self-doubt undermines self-truth, certainty gives way to perspectivity, self-categories break down, and pastiche replaces authenticity. To support this analysis, Gergen (2000) used anecdotal data like his observations of a man who propositioned a woman on a plane and then immediately had a telephone conversation with his wife as though nothing had happened. With incontrovertible evidence like this, he pronounced the death, or at least the terminal decline, of commitment!

As a counter-example to Gergen’s claims and by reference to qualitative data that were systematically analysed, Karp (2001) examined matters of commitment and obligation in the context of families and serious mental illness. Contrary to the notion of an unobligated self, he showed how relatives commonly go to extremes in caring for persons with serious mental illness in ways that take an emotional toil but that are borne through obligation. In the language of the current study, they were *keeping true (to) self-conceptions* as caring relatives and this also often involved ‘struggling through’.

In any case, the current study strongly suggests that, at least in the context of psychosis, persons are obligated to particular conceptions of

themselves and in a range of ways. They do not experience the world as a succession of possibilities to be a different person in the way described by Gergen (2000). Instead, they live in a world of constraints associated with commitment.

Furthermore, in the context of psychosis, constraints are not only associated with obligations associated with self-fidelity, with the limits of such fidelity, and with entrapment by unwanted identities. Persons also encounter structural limits on available identity options. This kind of point is explored in an ethnographic study of gender relations in a psychiatric hospital by Leyser (2003). She echoed earlier work on psychiatric institutions in suggesting that incarceration restricts opportunities for the maintenance of certain identities. However, she traced ways in which male residents were able to sustain and assert their gender identities in relations to each other and with female residents. For these men, 'doing masculinity' involved talking about and objectifying women in the presence of a male audience and in a way that established one's credentials as a heterosexual 'regular guy'. It involved 'macho language' that was oriented to proving oneself as superior through common references to other men's 'wimpiness' or homosexuality. It involved 'play fighting' in which men jokingly, and yet significantly, showed their physical strength or capacity to endure physical force. Furthermore, the enactment of masculinity involved touching female residents with varying degrees of sexual suggestiveness but again often for the benefit of a male audience.

So, in a hospital where residents were segregated from the outside world, 'men continued to be men'. Indeed, Leyser (2003) argued that male residents enacted masculinity as an assertion of their normality and as a way to resist attributions of abnormality associated with mental illness and hospitalisation. 'Being a man' served to negate 'being mentally ill' or at least to diminish the implications of mental illness for self.

In this context, then, there were scant interpretive resources to draw upon in realising the truth of any identities other than as a man and as a psychiatric patient. *Adhering faithfully* to self-conceptions of masculinity was the principal, perhaps the only, means available of realising *Me's* they could 'get along with'. Manhood was the same all or nothing affair as motherhood for the Brazilian women who occupied land and built homes in the study by Neuhouser (1998) which was reviewed in Chapter Four.

Anyway, Leyser's study highlights the structural constraints associated with institutional psychiatry and the consequent closure of identity options. However, it is also possible to over-emphasise such constraints. This point is illustrated in an ethnographic study of acute mental healthcare by Quirk et al (2006). Focusing on three psychiatric admissions wards on different hospital sites in London, they observed that membership of these wards was temporary and revolving with rapid turnover of both patients and staff. Patients maintained contact with the outside world: they were regularly visited by relatives and friends, they made frequent outside contact with telephones and especially mobile phones, they procured illicit drugs if they wanted, and they enacted a

number of prior role commitments. Ward staff and patients were on first-name terms, could not be easily distinguished by appearance, and were not separated by great social distance.

Quirk et al (2006) contrasted this situation with Goffman's account of a total institution and argued that the concept of a 'permeable institution' is more consistent with their observations given the continuing, though not unfettered, passage of persons, goods, and communication between the wards and the outside world. One implication of this permeability was that there were few signs that persons were institutionalised and they kept up many of their normal obligations of personhood. In other words, persons maintained access to everyday settings and could sustain fidelity to everyday self-conceptions.

So, institutional psychiatry varies in the extent to which it provides structural constraints upon identity preference and commitment. This was illustrated in the current study of identity commitment where persons were implicated in psychiatric involvement to varying degrees.

Nonetheless, in overall terms, one dimension of 'a committed self'- in the context of psychosis- is encounters with limitation, constraint and obligation. Yet, there is another dimension associated with active preference.

Active preference

As examined in Chapter Four, there is a lifespan psychology tradition in which experimentation, openness and preference are emphasised as a basis for identity commitment. In the current study, there was no support for Erikson's idea of persons as uncommitted to identities, exploring identity possibilities and

then choosing preferred identity options. In the context of psychosis and the current theory of *identity commitment*, persons are always committed in some sense even though there are changes in patterns of commitment.[4]

Nonetheless, active preference is an important part of the dynamics of *identity commitment*. For one thing, preference is part of what generates obligation. For example, in *keeping true (to) self-conceptions*, persons are obliged to act in particular ways which sustain the truth of preferred *Me's*. To a large extent, persons are able to get along with themselves when preferred self-truths are realised (*capture with rapture* is the most extreme example of this reality). In addition, preference can play a role in binding persons to unwanted identities. Persons are obliged to read an unpalatable self-conception as true because its falsity would invalidate a preferred self-conception.

When persons encounter *identity bondage*, this is often associated with loss of preferred selves and persons suffer this loss. It is difficult to live with a reality of self-diminution. But, on this basis, preferences often change. Persons console themselves with their blamelessness, their honest effort, and their 'downward comparisons.' They realise new preferred *Me's* with this downward form of acceptance. But, over time, acceptance can also be associated with a

[4] Incidentally, Erikson used George Bernard Shaw as a case example of identity exploration and commitment. Shaw gave up business training at the age of 20 and left Ireland. For a period, he had no chosen career but he experimented with writing. He did this in a disciplined, time-structured way and wrote every day. During this time, he wrote five novels but it was only later that he decided to become a writer. For Erikson, Shaw experienced identity confusion and lacked identity commitment until he made that decision. However, Shaw attributed his early disciplined writing to the habits he acquired when working in an office. He believed it was important to work hard and with a structured routine. Shaw did not therefore 'lack' identity commitment before his decision to become an author except inasmuch as he was undecided on a career. It appears he was already committed to a hard-working conception of himself. See Erikson, E. H. (1968) *Identity, Youth and Crisis*, Norton, New York.

broader life and opportunities to realise valued identities. As part of this elevated self-relation, acceptance is obliged through its essential role as a means to the realisation of preferred identities.

Overall, then, *identity commitment* is a theory of selves in which preference, opportunity, obligation, constraint and entrapment are each implicated in an ongoing dynamic of self-relation. All that remains is to evaluate this theory and conclude the study.

CHAPTER NINE

JUDGING THE THEORY

Introduction

In Chapter Eight, the significance of the theory of *identity commitment* is explored and this goes some way to establishing its worth. However, in this concluding chapter, there is further evaluation of the theory.

First, the idea of 'trustworthiness requirements' in qualitative research are reviewed but discarded in favour of long established criteria for judging grounded theory research. Second, the theory of *identity commitment* is judged in terms of 'work', relevance, 'fit' and modifiability. This incorporates consideration of implications and limitations of the study as well as indications for future research. Overall, it is concluded that the theory of *identity commitment* offers a range of valuable possibilities for understanding the situations and actions of persons in the context of psychosis and for further research and theory development.

Judging grounded theory research by its product

Trustworthiness and qualitative research

In the broad field of qualitative research, there is a substantial literature devoted to the question of what constitutes 'good' research and how this can be established (such as Miles and Huberman 1994, Golden-Biddle and Locke 1999, Lincoln and Guba 1999, Seale 1999, Silverman 2000). Perhaps the most well known attempt to address this question was provided by Lincoln and Guba

(1999) who argued that qualitative researchers need to concern themselves with the 'trustworthiness' of their inquiries:

"The basic issue in relation to trustworthiness is simple: How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of? What arguments can be mounted, what criteria invoked, what questions asked, what could be persuasive on this issue?" (Pg.398)

Researchers, Lincoln and Guba (1999) emphasised, should be thorough and explicitly account for the rigour of their inquiries. They should conduct 'member checks' so that data, categories, interpretations and conclusions are tested with people to whom they apply. They should open up their inquiries to external review and provide an 'audit trail' with specific details of, and justifications for, decisions and actions taken during the process of inquiry. And they should demonstrate 'referential adequacy', that a proper range of data is accommodated in the product of a particular project. These measures help to satisfy requirements of 'credibility', 'dependability', 'confirmability', and 'transferability' by which the trustworthiness of qualitative research can be judged (Lincoln and Guba 1999).

At one level, it is difficult to disagree with measures designed to assist and demonstrate trustworthiness, rigour, credibility and the like. But there is a question of how far researchers need to go in accounting for each aspect of their inquiries. And there is also a question of what particular criteria should be employed to judge a grounded theory study.

Criteria for evaluating grounded theory research

For Glaser (2003), Lincoln and Guba went way too far with their criteria for research trustworthiness:

"Their barrage of detail on detail indicate no ability on their part to see a summarizing latent pattern under their criteria for research by which to evaluate its process or product. It is, of course, the almost hysterical pursuit of trying to solve the worrisome accuracy problem by an external, unrelenting accountability requirement imposed on honesty, skill and ability.....Their hysterical approach to the worrisome accuracy quest forgets that we are all human after all doing the best we can. QDA and GT research, both, are always as good as far as it goes and both stimulate further research to help, in part, corrections to make it better." (Pg. 147)

These criticisms were part of a more general argument in which Glaser (2003) sought to clearly differentiate grounded theory research from qualitative data analysis (QDA). Grounded theory research is concerned with conceptualisation whereas qualitative data analysis is primarily concerned with descriptive detail. In the context of a concern with descriptive detail, the question of accuracy is fundamental and explains why methodologists like Lincoln and Guba (1999) prescribed such extensive accountability requirements. By contrast, Glaser (2003) pointed out that grounded theory research is less concerned with descriptive capture than concept development. Therefore, judgements of grounded theory research should focus primarily on

the value of its theoretical products (Glaser 1978, 1998, 2003). Furthermore, Glaser (1998) identified four criteria by which this value can be judged:

"Does the theory work to explain relevant behavior in the substantive area of the research? Does it have relevance to the people in the substantive field? Does the theory fit the substantive area? Is it readily modifiable as new data emerge?" (Pg.17)

These criteria, then, are an appropriate basis for an evaluation of the theory of *identity commitment* in the context of psychosis.

Judging the emergent theory

The 'workability' of the theory of identity commitment

Glaser (1978) suggested that a theory works when it is helpful in explaining a phenomenon, predicting what will happen or interpreting what is going on in a substantive area. In the case of *identity commitment* in the context of psychosis, this theory provides a way of explaining and interpreting a range of situations in the context of psychosis. To a significant extent, this point is made in Chapter Eight by reference to the contribution the theory of *identity commitment* makes to understandings of resistance to psychiatric involvement and identification; entrapment by unwanted identities; acceptance, consolation and recovery; self-comparison in psychiatric contexts; and the dynamics of constraint and preference that are implicated in persons' ongoing relations with themselves in the context of psychosis.

Furthermore, the current theory of *identity commitment* seems to offer understandings to some quite particular issues in the context of psychosis.

These include how persons avoid suicide, how persons are adherent and non-adherent to medication, how persons come to regard themselves as mentally ill, and how 'living outside' mental illness is a possibility. Categories of *keeping true (to) self-conceptions*, *struggling through with Me's* and *engaging to identities* provide a possibility for persons- in some way involved with psychosis- to regard each of these particular aforementioned issues as various sites where persons are continuously concerned by how they live with themselves and process this concern through patterns of *identity commitment*. This links with 'relevance' as a second criterion for an evaluation of this study.

The relevance of the theory of identity commitment

Related to the idea of a theory that works is the imperative that it should be relevant. Glaser (1978) suggested that in all walks of life, there are persons 'in the know'. At a descriptive level, researchers can never know more, or as much, as persons who live through particular experiences, situations or events on an everyday basis. But, in everyday life, what persons know is largely non-theoretical:

"From the analyst's point of view what this "know" is are indicators that have yet to be conceptualized. The analyst gives the knowledgeable person categories, which grab many indicators under one idea and denotes the underlying pattern. One idea can then handle much diversity in incidents. Once ideas can be seen as conceptual elements that vary under diverse conditions, action options are provided the man in the know. Before this conceptualization, and integration, empirical incidents are seen as linked to

finite situations. Now this finite social basis of knowledge can be flexibilized to apply to other general conditions." (Glaser 1978. Pg. 13)

Grounded theory, then, should help persons 'in the know' to expand the description and meaning of events by placing them in greater scope, anticipate other kinds of consequences to those they personally encounter, extend their capacity for knowing because concepts assist the organisation of information, and transfer concepts to other situations (Glaser 1978).

The theory of *identity commitment*- emergent from this study- offers just this kind of relevance for persons somehow involved with psychosis. For one thing, it provides concepts that assist the organisation of a range of information about diverse events and actions in the context of psychosis. Non-suicide, medication adherence, acceptance of a psychiatric diagnosis, and abstinence from alcohol are examples of persons' actions that were each used to illustrate patterns of *identity commitment*. These patterns were related to matters like religious affiliation, family membership and situational location. In other words, the theory provides a broad perspective that enables persons to make sense of a range of situations and actions.

As well as breadth, the theory of *identity commitment* offers a richness of perspective. It attests to the varied ways in which persons live with themselves in the context of psychosis. Persons live in various committed self-relations as mentally ill or not-ill, as diminished or elevated, as like other persons or distinct from them, and so on. These self-relations are more or less

sustainable over time and patterns of *identity commitment* more or less change over time.

All of this is associated with a certain opening of possibilities. Awareness that persons live with themselves in various committed patterns of self-relations can inform an understanding that no single pattern is right or unavoidable. It is a question of how persons get along with themselves, a question that they continuously process. For example, in the context of psychosis, it is a moot question to wonder whether persons should 'accept' they are mentally ill. The important question relates to the version of themselves they are able to live with, a question to which persons often find different answers over time. But, persons may find it easier to find different answers when they are aware that others have already done so and this theory of *identity commitment* offers one possibility for such awareness.

In addition, this theory of *identity commitment* is a sympathetic standpoint. It is emergent from analysis of the perspectives of persons that actually experienced psychosis and reflects inquiry into how they deal with a principal concern in their lives. It is a theory of what they do and not of what they should do. One problem with the current fashion for 'recovery' in the literature of psychiatry and mental health is that it carries an implicit potential for negative valuations of persons that do not recover. This is especially the case for accounts that emphasise the personal attributes- like determination and an optimistic attitude (Tooth et al. 2003)- in recovery and pay little attention to a wider range of variables. Where recovery is defined in terms of personal

qualities, there is implicit potential for attributing non-recovery to a lack of those qualities and for a latent theory of personal defect.

By contrast, the theory of *identity commitment* is oriented to an understanding of 'wherever persons are' in relations with themselves without any assumption of 'where they should go'. Also, the concept of *identity commitment* has a certain normalising significance and this is another aspect of the breadth associated with the theory. As reviewed in Chapter Four, there is an extant literature of identity commitment. Although this literature reflects different conceptualisations of identity commitment to the ones emergent from this study, some similarities were noted in Chapter Eight. Moreover, the concepts identified in the current study, have potential 'grab' beyond the context of psychosis. Using a historical example, at the beginning of the Reformation when Martin Luther began to openly criticise the Catholic Church and papacy, the Diet of Worms (a kind of tribunal of royalty and bishops) was convened in Saxony to decide his fate and on whether to expel him to Rome. When asked to recant his heresy, his response was recorded for posterity:

"I cannot and will not recant anything, for to go against conscience is neither right nor safe. God help me. Amen. Here I stand, I cannot do otherwise." (Bainton 1995. Pg.144)

Then there is the famous passage from *Hamlet* in which Polonius advises his son, Laertes:

"This above all: to thine own self be true,

And it must follow, as the night the day,

Thou canst not then be false to any man." Act I, Scene iii

These passages are highly suggestive of *keeping true (to) self-conceptions*, a pattern of self-relation that was not discovered for the first time as part of this study of *identity commitment*. Indeed, there is a possibility that *identity commitment* is a widespread feature of human self-relations that transcends time and place. If this is the case then this attests to the 'normality' of how persons live with themselves in the context of psychosis. It supports the case of those, like Jenner et al (1993) and Jenkins (2004), who argued that psychosis (they actually said schizophrenia but this is close enough to the point here) provides a 'paradigm case' for understanding fundamental human processes. At the same time, it encourages anyone involved with psychosis to understand responses to it as essentially human rather than essentially flawed.

In summary, then, this theory of *identity commitment* appears relevant to persons in the context of psychosis. It offers the potential of a broad perspective, a rich perspective, a sympathetic perspective and a normalising perspective. However, all of this is somewhat dependent on the question of 'fit'.

The fit of the theory of identity commitment

In judging the quality of grounded theory research, 'fit' was a third criterion identified by Glaser (1978) and this meant that theoretical categories should fit with data:

"Data should not be forced or selected to fit pre-conceived or pre-existant categories or discarded in favor of keeping an extant theory intact. Our

position is that the reality produced in research is more accurate than the theory whose categories do not fit, not the reverse." (Pg.4)

One aspect of fit relates to due diligence and competence in the use of grounded theory research procedures. Open coding, comparative analysis, memoing, theoretical sampling and selective coding are procedures that provide a guarantee of fit. However, this guarantee is contingent on the proper use of these procedures and this is difficult to directly demonstrate.

In my own case, I certainly tried to apply these procedures, made extensive effort to understand them and went through many rounds of coding, mind-mapping, naming and re-naming categories and properties, memoing and so on. I did theoretically sample until I could not identify further variations on the core and sub-core categories. To the extent that this process can be demonstrated, my theoretical memos provide something of a trail of my analytic work and so a selection is provided in Appendix Six.

Furthermore, in writing Chapters Four to Eight, I tried to convey a sense of my analysis-in-action. Indeed, this was appropriate because writing the thesis was actually part of data analysis and an extended memo-writing process rather than a 'write-up' of findings. I changed the names of the major categories and selectively coded (on a number of occasions) through writing the thesis. Also, in authoring the thesis, I wanted readers to get a sense not only of concepts, indicators and illustrations but also how I went about analysing them. My hope is that my manner of writing gives readers some indication of the 'fittingness' of the theory of *identity commitment*.

Finally, I anticipate that readers of this theory will make their own judgements about whether it fits according to their own experiences associated with psychosis. They will judge whether this theory is consistent with incidents they encountered and this will also be part of their evaluations of its workability and relevance.

The modifiability of the theory of identity commitment

A final criterion for judging the study is modifiability. Whilst Glaser (1978, 1992, 1998) was always confident about the value of grounded theory, he was also cautious about the claims that should be made for it. Grounded theory research, he emphasised, does not generate 'findings' and does not provide concepts that are proven or tested. Instead, the products of grounded theory should be regarded as a set of integrated hypotheses:

"The research product constitutes a theoretical formulation or integrated set of conceptual hypotheses about the substantive area under study. <u>That is all, the yield is just hypotheses!</u> Testing or verificational work on or with the theory is left to others interested in these types of research endeavor. Their approach is usually one of replication or verification of some crucial hypotheses with a form of quantitative method such as a survey or a controlled experiment." (Glaser 1992. Pg. 16)

The idea of grounded theory as grounded hypotheses provides a response to those- like Hammersley (1992) and Dey (1999)- who claimed there is confusion about whether grounded theory research is designed to generate theory or both generate and verify it. This criticism is reasonable on the basis of

a reading of the initial methodological text by Glaser and Strauss (1967) but not on readings of Glaser's subsequent work to which Hammersley (1992) made no, and Dey (1999) almost no, reference. Classical grounded theory methodology is oriented to the generation of theory that can be useful and relevant but remains to be verified and modified. This is a clear point in Glaser's extensive writing.

Taking this point, the current theory of *identity commitment* is limited in its generalisability. Indeed, it is not a research study with 'generalisable findings'. However, as already suggested in previous sections, this does not mean that the theory of *identity commitment* has no significance beyond the persons and autobiographers who provided data. Instead, its significance will depend on whether its concepts have what Glaser (2001) called "enduring grab". This refers to the possibility that concepts have an ongoing appeal as a way of viewing things and persons will employ them accordingly.

So, no claim is made for the generalisability of the theory of *identity commitment* but there is potential that its concepts will have 'grab' in the many contexts in which persons experience psychosis. But this still leaves questions about how the theory can be modified. In general methodological terms, Glaser (1978) suggested that grounded theories can be qualified through further grounded theory research. More recently, he re-formulated 'formal' theory to refer to a theory of the general implications of a substantive core category (Glaser 2007). This formal theory is generated from data collection and analysis

in the same substantive area (as the original core category) and other substantive areas.

In respect of the substantive area of psychosis, the current theory of *identity commitment* could be qualified through study in different settings and populations. As part of the current study, theoretical sampling was employed and published autobiographies were especially useful in seeking out variation beyond limits imposed by a reliance on participants from North Dublin who are service users in community mental health care. On this basis, theoretical saturation was achieved to the extent that I could identify no new variation in the core and sub-core categories. At the same time, there were inevitable limits on theoretical sampling. For example, the theory of *identity commitment* is predicated on persons' main concern with self-viability which, in turn, is predicated upon a concept of self-relation. This raises a question about psychosis in cultural contexts where Western notions of selfhood do not predominate. At the very least, *identity commitment* might be less relevant in such contexts and this is an example of how further research could generate further understandings of the concept.

On the subject of formal theory, there are questions about the general implications of *identity commitment* as they relate to particular substantive areas that overlap with those of the current study like suicide, 'non-psychotic' mental health problems, and institutional psychiatric settings. There is scope to pursue these questions through further research and the use of extant literature. Also, given that there is already a wider extant literature of identity

commitment, there is scope for systematic analysis of this literature to extend the ambit of an integrated theory.

Finally, there is potential for verificational research. For example, it is possible to envisage the development of a measurement tool for ‘upward acceptance’ in relation to psychiatric identities. After validation, this construct could be tested as a predictor of positive psychosocial outcomes.

In summary, the theory of *identity commitment* offers a basis for an understanding of a range of situations and actions in the context of psychosis and constitutes a sympathetic stance towards persons who experience psychosis. Finally, identity commitment offers a range of interesting prospects for further research and theoretical development.

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APPENDIX ONE

RECRUITMENT LEAFLET

DUBLIN CITY UNIVERSITY
School of Nursing

RECRUITMENT ADVERTISEMENT FOR A RESEARCH PROJECT

Title of study: **Enduring and psychosis: an exploratory study**

Researcher: **Mark Philbin**
Lecturer in Nursing
School of Nursing
Dublin City University
Collins Avenue
Dublin 9

Tel 01 7008543
mark.philbin@dcu.ie

Introduction

This leaflet is designed to give you some information about a research project that I am undertaking so that you can decide if you might want to participate. My name is Mark and I work in the School of Nursing, Dublin City University. This research project is part of my PhD studies and two senior researchers are acting as my supervisors.

Participation is entirely voluntary in this project and so it is up to you to think about whether you would like to take part.

Who will participate in the research?

I am looking to recruit people who are diagnosed with a mental illness, have spent some time in a psychiatric ward in the past and experienced 'psychosis'. Psychosis is a term used by mental healthcare professionals to refer to experiences that involve sensations, thoughts and ideas that seem very strange and that are often very distressing. One example of such an experience involves what professionals often call 'auditory hallucinations' where people may hear voices saying negative things about them and yet the source of those voices is not anyone that is physically present.

So, if you have experienced psychosis, been in a psychiatric ward at some time and are diagnosed with a mental illness then I am interested in recruiting you to this project.

What is the research about?

When people experience psychosis and are diagnosed with mental illness, they often have a very tough time. Spending time in a psychiatric ward, side effects of medication and the responses of other people to mental illness can all add to the problems people experience. Yet people generally manage to somehow survive all of this and keep going even though it can be tempting to give up. In this research, my aim is to find out how people (who have experienced psychosis) manage to endure the moments or periods when life is difficult or even awful. I am also interested in the ways that people look back on such difficult times and what that means for their current everyday lives.

What will participation involve?

If you decide to participate in the study, you will be interviewed at least once for about one hour. I will ask you to discuss moments or times when things were tough, it was difficult to keep going and yet somehow you managed to survive.

I might also ask you to take part in a subsequent interview because I am interested in how people keep going over time. Therefore, it will be useful to interview some participants at different points in time.

The interviews will be conducted in a location that is as convenient as possible for you. This could be a local healthcare facility like a health centre or day centre. Or it could be anywhere else that best suits you.

All the interviews will be audio-taped.

Why might you want to get involved?

You might find it interesting to talk and think about how you have kept going when things are tough for you. Perhaps you have not thought very much about this and might surprise yourself by the scale of your achievements in surviving all that you have. Also, this is an opportunity to meet with someone who is interested in your story and this is also something that might be interesting for you.

The other thing about this study is that its findings should be useful. If we can learn more about how people ‘keep going’, this knowledge may help anyone that wants to assist people in their most difficult moments.

Are there any risks?

For some people, it can be distressing to talk or think about events that were, or are, troubling. To this extent, participation in the study carries a risk. However,

the interviews will be conducted in a sensitive way and follow-up will be available if things do get upsetting.

What about confidentiality?

Anything that you say in the interviews will be treated as confidential. Only my two supervisors and myself will have direct access to the audio-tapes. Relevant paperwork will be kept in a locked cabinet and computer files will be password protected. In reports of the research, biographical details will be changed to protect confidentiality. However, in research of this nature, it is possible that certain details serve to identify individuals and so complete guarantees of confidentiality cannot be provided. Also, assurances of confidentiality are subject to legal limitations.

What if you are interested?

If you are interested in participating in the study, please contact me on 01 7008543 or **mark.philbin@dcu.ie**. Or, if you were given this leaflet by a mental healthcare professional, you can let him or her know if you are interested. If you might want to participate in the study, I will then contact you and we can talk more about whether you want to be involved. You can then decide.

At any point in the project, you are free to change your mind and withdraw. This is absolutely fine. There is no pressure to participate in this project. Only come forward if you think that it sounds interesting to you.

Thank you for reading this information and for considering this project.

APPENDIX TWO

INITIAL INTERVIEW GUIDE

Interview Guide: Enduring and psychosis

1. **Please tell me about yourself:**
    - What is important in your life;
    - The kind of person you are;
    - Likes and dislikes;
    - People in your life;
    - Interests and how you spend your time;
    - Number of times in hospital;
    - Time since last hospital;
    - Diagnosis;
    - Names for problems/illness.

2. **Please tell me what it has been like living with psychosis.**

3. **Please tell me about one of the difficult times or moments, to do with living with psychosis, that comes immediately to mind:**
    - What happened?
    - When?
    - What was going on in your life at the time?
    - What role did others play? How did they respond?
    - What makes this time important in your memories?

4. **Looking back on this difficult time, how did you manage to keep going (or hang on or stay alive)?**
    - What did you do that kept you going?
    - What worked well? What did not work?
    - How did others help? Not help?
    - What else was significant?
    - How did keeping going make a difference?

5. **Again looking back to that difficult time, what happened afterwards?**
    - Did things improve?
    - If so, what brought about this improvement?
    - How did you contribute to this improvement?
    - If things did not improve, how do you manage to keep going over time?
    - What helps/hinders you?

6. **It can be tough to get through really difficult life situations. Seeing that you have survived, what does that mean to you?**
    - How does it influence the way you view yourself?
    - The way you live your life?
    - The way you view your future?

- The way that you now deal with difficult situations? Examples?

7. **What do you currently find difficult in your life? What things do you encounter that are difficult to get through?**
    - What keeps you going?
    - What role do others play?
    - What helps? Hinders?
    - Description of a bad day.

8. **What are the good things in your life at present?**
    - Please describe a recent good moment in detail?
    - What happened?
    - What made it good?
    - Who was involved?
    - What did you do?
    - How do the good moments contribute to how you see life?
    - To how you see yourself?

9. **Is there something else you think I should know so that I can better understand the things we have just talked about?**

10. **Is there anything else you would like to ask me?**

APPENDIX THREE

AMENDED INTERVIEW GUIDE

Interview Guide: Living through psychosis

1. **Please tell me about yourself:**
    - What is important in your life;
    - The kind of person you are;
    - Likes and dislikes;
    - People in your life;
    - Interests and how you spend your time;
    - Number of times in hospital;
    - Time since last hospital;
    - Diagnosis;
    - Names for problems/illness.

2. **As you know I'm researching experiences to do with living through psychosis. Please tell me your story of living through psychosis, all the events and experiences that have been important to you personally. To begin with, I will just listen and I won't interrupt. Take as long as you like and I'll only ask you some questions when you've said everything that you wanted to say.**

   I'll take a few notes to remind me of what you said and so that I can follow up on them if I need to.

3. **Problem-self issues:**
    - How problem was named and what happened;
    - Definition of problem over time and influences on that;
    - Implications of problem definition.

4. **Location-self issues:**
    - Hospitalisations and view of hospital;
    - Housing situations and evaluations of accommodation.

5. **Believability of extraordinary experiences:**
    - What bizarre experiences?
    - Detail.
    - Believing them? When? What effects? What made them believable/unbelievable? Changes over time?

6. **Enduring:**
    - Difficult times/moments in the past and present;
    - Managing to keep going;
    - View of self as a survivor.

7. **Treatment:**
    - Views of treatment and medication;

- Better/worse treatment.

8. **What are the good things in your life at present?**
    - Please describe a recent good moment in detail?
    - What happened?
    - What made it good?
    - Who was involved?
    - What did you do?
    - How do the good moments contribute to how you see life?
    - To how you see yourself?

9. **What else is there that you think I should know so that I can better understand the things we have just talked about?**

10. **Is there anything else you would like to ask me?**

APPENDIX FOUR

INFORMED CONSENT FORM

DUBLIN CITY UNIVERSITY

School of Nursing

INFORMED CONSENT FORM

Research title: **Enduring and psychosis: An exploratory study**

Researcher: **Mark Philbin**
Lecturer in Nursing
School of Nursing
Dublin City University
Collins Avenue
Dublin 9

Tel 01 7008543
mark.philbin@dcu.ie

Supervisors: **Dr. Pamela Gallagher**
Prof. Chris Stevenson

i. Purpose of the research

The purpose of the research project is to explore how people endure the difficulties that are associated with psychosis and a diagnosis of mental illness. This should help to inform nurses and other mental healthcare professionals in helping people to keep going during adversity.

ii. Involvement in the research

Please complete the following- circle Yes or No for each question:

Have you read or had read to you the Plain Language Statement *Yes/No*

Do you understand the information provided? *Yes/No*

Have you had an opportunity to ask questions and discuss this study? *Yes/No*

Have you received satisfactory answers to all your questions? *Yes/No*

Are you aware that you may be asked for more than one interview? *Yes/No*

Are you aware that your interview will be audio-taped? *Yes/No*

iii. Voluntary involvement

Please be aware that your involvement is entirely voluntary and that you can withdraw from the study at any point. You will not be negatively affected in any way if you do not want to be involved in the study or decide to withdraw from it.

iv. Confidentiality

Anything that you say in the interviews will be treated as confidential. Only the researcher, and his supervisors, will have direct access to the audio-tapes. Relevant paperwork will be kept in a locked cabinet and computer files will be password protected. In reports of the research, biographical details will be changed to protect confidentiality. However, in research of this nature, it is possible that certain details serve to identify individuals and so complete guarantees of confidentiality cannot be provided. Also, assurances of confidentiality are subject to legal limitations.

If any follow-up is needed because the interviews were too distressing, this means that the relevant professional would have to know that you participated in the research. But a decision about such follow-up would only be taken with your involvement.

For five years after the completion of the study, data will be kept in a secure place and then destroyed.

v. Signature:

I have read and understood the information in this form. My questions and concerns have been answered by the researchers, and I have a copy of this consent form. Therefore, I consent to take part in this research project

Participants Signature: _____

Name in Block Capitals: _____

Date: _____

APPENDIX FIVE

DISTRESS PROTOCOL

DUBLIN CITY UNIVERSITY
School of Nursing

PROTOCOL: LIMITING AND RESPONDING TO INTERVIEWEE DISTRESS

Research title: **Enduring and psychosis: A grounded theory study**

Researcher: **Mark Philbin**
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Supervisors: **Dr. Pamela Gallagher**
Prof. Chris Stevenson

Introduction

There is a possibility that participation in this study may be distressing for persons who are interviewed about past experiences that were difficult or even traumatic. However, measures will be taken to limit the potential for interviewee distress and to respond appropriately should such distress be occasioned. These measures relate to recruitment to the study, the conduct of interviews, and follow-up after interviews.

Recruitment to the study

- Where possible participants are identified in collaboration with mental healthcare professionals, the potential for distress must be considered. More specifically, relevant mental healthcare professionals need to be confident that any persons, nominated as potential participants, are able to talk about significant experiences in their lives without undue distress.

- Where recruitment to the study is channelled through the Irish Advocacy Network and its related groups, it will be requested that the publicity leaflet be made available to persons with experience of 'telling their story' and who can remain within a reasonable zone of comfort whilst doing so.
- All potential participants must be made aware of the potential for distress associated with the interviews. This will be included in written information about the study and discussed prior to written consent.
- All potential participants must be informed of their right to withdraw from the research at any stage of their involvement in the interviews, to identify feelings of distress to the interviewer, to expect a sensitive and respectful response from the interviewer, and to receive follow-up following an interview.
- In preparing for interviews, the interviewer should agree on a time and venue that is comfortable and convenient for interviewees.

The conduct of interviews

- At the start of an interview, some time should be spent in 'problem-free talk' that helps interviewees to feel comfortable in the situation and to build some rapport with the interviewer. The interviewer should check the subjective comfort of interviewees and seek their agreement on readiness to proceed.
- The interviewer needs to be alert to the emotional states of interviewees throughout the interviews and explicitly acknowledge observations of apparent distress. This can then inform a discussion of whether an interview should be continued, temporarily discontinued with a break, or discontinued altogether.
- The interviewer needs to listen attentively and make every effort to understand the perspectives of interviewees. This generally promotes interviewee comfort and sense of affirmation that reduces the potential for distress.

- The interviewer should exercise discretion in influencing the relative balance between material that is negatively emotive and that which relates to the strengths, positive qualities, skills, and achievements of interviewees. As the interview progresses towards a conclusion, the latter issues should predominate.
- Before the interviews end, the interviewer should ask about the experience of the interview and 'how it was' for the interviewee. Where it is established that the interview was somehow upsetting, this needs to be discussed. One specific focus for discussion should be 'what happens next': whether there is a need for further follow-up and the form this will take.

Follow-up after interviews

- If interviewees are unduly distressed through the interviews, the interviewer will agree with them on the appropriate actions to be taken. The interviewer will not act without such agreement unless there is an extreme situation where the interviewee's safety is in doubt and no such agreement can be reached.
- Interviewees will be informed of the availability and office contact details of the interviewer should any issues arise from the interviews.
- For interviewees who are clients of a community mental healthcare service, one option will be to refer them to their 'key worker' or Consultant Psychiatrist (whichever the interviewee defines as most relevant) for help with any ongoing distress.
- For interviewees who are not currently clients of a community mental healthcare service, a free counselling service is available through the 'Centre for Psychological Health and Well Being' in the Healthy Living Centre, Dublin City University. An alternative option will be to make a referral to the relevant mental healthcare service in collaboration with the interviewee's General Practitioner.

- Referral to any professional will mean that an interviewee's participation in the research is made known to that professional. To this extent, this will involve a breach of confidentiality and this implication will be discussed with potential participants when initial consent is sought.

The interviewer will not attempt to provide ongoing therapeutic assistance to interviewees who are unduly distressed by the interviews but has an obligation to ensure that such assistance is provided to whatever extent proves necessary. This does not imply that the interviewer will 'walk away' if faced with significant distress. Instead, the interviewer will attempt to respond sensitively and helpfully to issues that arise in the moment. It is in this context that referral for further professional help will be considered and discussed.

APPENDIX SIX

ASSORTED MEMOS

Memo 3: Self-comparing

18th April, 2007

This refers to a process of making various kinds of self-comparisons. These comparisons can be used to establish a creditable self, to evaluate changes of self over time, and to account for the effects of mental illness.

One property of self-comparing involves comparing self with others. Joe (interview 1) portrays himself as both unlike and like others. He is unlike others in two main ways. *First, he compares positively with others in relation to his personal qualities.* Compared to others (generally identified as other people with mental health problems, his friends and his family), he considers himself more thoughtful and deep; more insightful and knowing of himself; more sensitive; more talented, gifted and creative; more academic and learned. *Second, he compares negatively with others in relation to his destiny*. He has an illness that is 'for life' whereas many others have problems that are temporary, his illness is attributable to the bad luck of defective genes whereas there are others personally responsible for their problems, and he has been severely wronged by others for no good reason.

Joe is like others in that he has a breaking point, limits. Everyone can have a psychiatric breakdown or a limit to what they can endure.

Through comparing self with others, Joe establishes, or seeks to establish, a creditable self. He has positive qualities, he has been unlucky and he shares limits with all other human beings. He cannot be blamed for any of this but he finds it difficult to reconcile his positive qualities with his suffering

and the wrongs that have been done to him. He goes some way toward this reconciliation by associating his sensitivity, depth and creativity with mental illness. On this basis, he prefers a diagnosis of 'manic-depression' that he associates with these kinds of qualities. In his own words, it is a thinking man's illness and so he thinks it more apt for him than his official diagnosis of schizophrenia. But he expresses a more dominant sense that his past should not have happened, that the wrongs should not have happened to such a good man. Indeed, he suggests that his past was unfair because he was such a good man. For example, the CMH was the wrong place for him because he was not a wrongdoer like the other patients and therefore this was in injustice. Throughout the interview, he implicitly posed the question 'how could this possibly happen to a man like me?' (see memo 5)

Another property of self comparing involves past/present comparisons. Whilst Joe makes some reference to being older and wiser, he generally presents a past self that is superior to a present self. His past self had more talent, was more popular with other people and had positive aspirations. This past self relates to time before first experiences of psychiatric breakdown and hospitalisation, "before the explosion" as he puts it.

Similarly, he makes real self/sick self comparisons. The real self is happy, mixes with people and gets on with life. The sick self feels desperate, suicidal, useless and, most especially, conscious of all the things that have happened. This sick self is dominant over the real self but the extent of this

domination varies. And the real self marshals some resistance to the sick self and this is largely how Joe accounts for his ongoing survival.

Memo 6: (Dis)Believing the extraordinary

22nd April, 2007

In the context of psychosis, people experience disturbing and/or extraordinary realities. Josiah (interview 3) saw ghosts, heard voices, saw a UFO and was spoken to by God. Michael (interview 4) heard voices that accused him of crimes and told him that they were the police.

These kinds of realities present people with a problem of determining what are 'really real' and what are apparently real but actually unreal. In addressing this question of what to believe, there are at least three possible positions that are identified in the data to date:

1. *Extraordinary realities are not real;*
2. *The truth status of such realities is doubtful- they might be real, they might not be;*
3. *Extraordinary realities are definitely real even if unbelievable to others.*

In working out a position on a particular extraordinary reality, there are a number of relevant variables and these are as follows.

Retrospective doubting/disbelieving

People seem more likely to believe in the extraordinary 'at the time' and somewhat less likely to believe it afterwards. Doubt and disbelief grows in retrospect although not in all instances. This doubt and disbelief appear to be associated with attributing experience to illness.

Illness attributing

Both Michael and Josiah suggest that they 'have schizophrenia' and link this to certain perceptions and interpretations that they identify as false. By attributing certain experiences to illness, they invalidate at least some of their perceptions/interpretations.

This raises questions of how people come to doubt or disconfirm their own experiences by attributing them to illness. How, and in what ways, do mental healthcare professionals influence this process of experiential disconfirmation? What role does treatment with medication play? How does illness attributing work for people- what are the gains involved? These questions may be worth pursuing if I continue to develop the category of (dis)believing the extraordinary.

Sensory evidencing

Although illness attributing can help people to invalidate extraordinary realities in retrospect, this is less possible 'at the time'. This is at least partly because people are faced with the evidence of their own senses. It is difficult to set aside what one actually sees and hears. Extraordinary realities can be absorbing, vivid and intrusive. This can mean that it is difficult to attain the kind of detachment required for an evaluation of whether perceptions are real. Furthermore, sensory evidencing can mean that illness attributing does not account for all extraordinary experiences. Josiah simply knows that he saw a UFO because he saw it and this is sufficient for him to sustain his conviction.

Believing in positive extraordinary realities

Extraordinary realities can be positive and this may be significant to their believability. Josiah composed a beautiful song in harmony with a chorus of voices, heard the soothing voice of God and of angels. He is less inclined to dismiss these kinds of perceptions as illness than some other voices he heard. Indeed, he is animated in his account of these perceptions. Perhaps persons may have less of an incentive to invalidate positive, compared to negative, extraordinary experiences and this may be especially the case if such experiences are significant for how persons view themselves and how they explain their experiences. Josiah considers himself blessed for having these experiences and such an attribution seems to link to his religious beliefs. Similarly, I once did a life history study with a man who described his first psychotic breakdown in considerable detail. He attributed most of his experiences to illness but, like Josiah, did not define an experience of God in these terms. After his discharge from a psychiatric hospital, he reflected upon what had happened to him, concluding that his breakdown was at least partially spiritual in nature and that God had come to his aid at a critical moment. This account was associated with a subsequent return to a life of Christian belief, identity and observance.

So, there appears to be a relationship between views of self and the truth-value accorded to extraordinary perceptions. A view of self as blessed by God may provide good reason to define certain extraordinary experiences as

real. In addition, religion provides a legitimating framework for such definitions.

So, to return to the beginning, persons may define extraordinary perceptions as definitely unreal, maybe real/maybe unreal, and definitely real. There is considerable complexity in these determinations and I should inquire further into them.

Memo 10: Diagnosis-self fitting

3rd May, 2007

Professionals often name psychiatric diagnoses in their conversations with persons diagnosed with psychotic illness. The diagnosed process that name and its symbolic implications through *diagnosis-self fitting*. This is a process of working out the congruence between a diagnosis, or varying diagnoses, and self.

One aspect of this diagnosis-self fitting relates to qualities of the self. Here, persons deal with the question of fit between the diagnosis and the kind of person they perceive themselves to be. For Joe (interview 1), manic-depression is 'a thinking man's illness' and so it makes more sense to him, as a self-depicted deep and thoughtful man, that this should be his rightful diagnosis rather than schizophrenia. The manic-depressive diagnosis provides a more meaningful, though not satisfactory, link between who he is and what he suffers.

Another aspect of diagnosis-self fitting concerns what one has experienced. Bernie (interview 2) expresses a preference for the word 'psychosis' as a name for what she experienced during her breakdowns. She describes these breakdowns as times when she 'completely lost it' and views psychosis as a term that does justice to experiences of losing it altogether. Jamison (1996. Pgs.181-182) suggests that manic-depression, as a term, does justice to what she suffers in a way that bi-polar affective disorder does not.

Indeed, she finds this latter term offensive because of what she sees as its sanitised and non-evocative connotations.

What all of this suggests is that there may be different degrees of diagnosis-self congruence. At one extreme, there may be a complete diagnosis-self incongruence. I once decided to 'educate' a client about her illness and informed her of her diagnosis of schizophrenia. For her, this diagnosis represented future permanent hospitalisation and the inevitability of irredeemable madness. She was therefore very upset and this event precipitated something of a crisis that led to a significant increase in her medication. In a sense, the meaning of the illness was overwhelming to her self.

At the other extreme, there may be diagnosis-self integration. Here, there is a unifying of diagnosis and self. I need to ground this concept if it is to have any future in the study.

In between the two extremes, there is more or less of a diagnosis-self fit and this may vary according to circumstances that require investigating.

Memo 34: Self wrestling and enduring

14/09/07

In getting through, people talk about various kinds of struggle between self and self. This is variously expressed in terms of pushing self, dragging self, getting a grip on self and fighting against a sick self. The common pattern in these kinds of expressions is the notion of two selves in interaction.

One of these selves is depicted negatively- either it is a recalcitrant self that is tired, immobile or inert or it is a destructive self that is dangerous and potentially overwhelming.

The recalcitrant self relates to a motional self that pushes it or drags it. This pushing or dragging can involve self chastising and is associated with the perceived benefits of rolling stoning- see memo 25. Over time, the recalcitrant-motional self dialectic may dissolve as activity becomes normal and persons just do things.

The destructive self relates to the danger of being overwhelmed such as by a desire to commit suicide. Joe (interview 1) 'gets a grip on himself' when he is suicidal so there is a struggle between a destructive and restraining self. As well as rolling stoning, altruistic enduring and trusting others are relevant here as others are invoked in the effort to restrain what is potentially overwhelming.

Perhaps a good way of expressing these kinds of self-self dialectics is in terms of self wrestling.

Memo 43: Just like a normal illness

23/9/07

In processes of self-problem integration, questions of moral culpability and moral worth are relevant.

Bernard (Interview 10) defines bipolar affective disorder as 'just like a normal illness' in that it is morally neutral, it is a given for which individuals cannot be held to moral account. He is not precisely sure about why he has the illness except to say that it is God-given, possibly hereditary and possibly related to imbalanced brain chemistry. However, he is clear that he is not responsible for his illness and therefore has no reason to feel inferior to others because of it.

Yet, this is not to suggest that Bernard absolves himself of moral responsibility in relation to his illness. He is not responsible for his illness but he is responsible for how he lives with it. He 'does his best' to push himself when he is 'not well'. He goes to self-help groups, attends Mass more regularly, keeps active and so on. And he takes a certain pride in the level of efforts he makes and in the extent to which he enacts a moral obligation to try. The valorisation of this moral obligation appears to be supported by Recovery Inc. where it is emphasised and so Bernard relates to brethren who support his definitions of self worth.

So Bernard is able to frame his understandings of his illness in a way that supports a presentation of self as worthy- it is not his fault and he does his best. Therefore, he stands up in comparison to others.

Hence, in Bernard's case, an illness definition of his problems integrates with a process of comparison to others as 'not inferior' and an account of self worth. This is in contrast to accounts of mental illness categories as necessarily demoralising.

Furthermore, this distinction between the moral neutrality of illness and the obligation to try to live well with it is reflected in his accounts of psychiatrists. They deal with the illness- in diagnosing it and treating it. He accepts their authority and expertise in these matters but only 'up to a point'. That point concerns living with the illness for which he is responsible. Again this process illustrates complexity in matters that are often crudely portrayed. Bernard's account is able to incorporate both professional authority and user agency, things that are often viewed as antagonistic.

Memo 71: Brethren and committed self

15/03/08

There can be a link between committing to an identity and finding brethren.

The notion of ‘others like me’ helps towards clarity about me. Identifying others as brethren amounts to a strong affinity with them. Such affinity is conducive to friendships and someone to talk to. In turn, this serves to cement affinity and identification of me-ness with them-ness. Also, there may be opportunity for altruistic me-ing as one becomes respected as a senior member of the brethren. This provides an opportunity for self elevation- because there is esteem from others associated with helping them and with their recognition of one’s accumulated wisdom. Furthermore, a community of brethren supports explicit and public identity commitment (see Bassman and the conditions for his public disclosure of psychiatric survival and associated identity as a survivor).

At the same time, relating to brethren can also provide an opportunity for Distinctive Me-ing and ‘building self up’ through downward comparisons (see Joe).

Memo 109: Wrestling with commitment

13/04/08

'Commitment' refers to consistency in a line of action, interpretation, and/or identity. In addition, a commitment is 'built up' over time in a series of events and actions (see Becker 1960).

Persons commonly have a range of commitments. They may be committed to their families, to their friends, to their religion, to their community, to their work, and to their pastimes. And they may be committed to certain conceptions of themselves as fit, sick, self-reliant, tough, altruistic, and so on. Such commitments can be immensely significant for how persons deal with the suffering associated with psychosis.

For example, commitment to family obliges persons to act altruistically towards their relatives. This kind of obligation is often significant in the context of potential suicide. Persons, living through and after psychosis, commonly contemplate suicide but usually do not actually commit suicide. A common reason that persons give for their own non-suicide is the negative impact their death would have on their relatives. They 'live on', at least in part, because they 'have to' for the sake of their families.

However, 'living on' is not easy in these circumstances. When I interviewed Joe, for example, he described waking every day in the early hours of the morning. When he awakes, he feels a sense of desperation and an urge to commit suicide. Often, this urge is almost overwhelming. In response, he reminds himself of the hurt that his suicide would do to his parents. To use his

own words, he also “gets a grip” on himself. He berates himself for his ‘weakness’, tells himself to ‘toughen up’, and ‘makes himself’ get active. Getting out of bed, having a shower and shave, making coffee, smoking a cigarette, and watching television mark the beginning of his daily activities. Through these initial activities, Joe finds that suicidal impulses have ‘less of a hold’ upon him. He maintains activity throughout the day- especially through walking- and this also involves ‘pushing himself’. But this is helpful because, so long as he is moving, desperation and suicidality are kept at bay. Repeatedly, he used the expression ‘a rolling stone gathers no moss’ to account for his everyday way of living.

In this situation, there is a sense in which Joe wrestles with his own suffering. And his efforts seem explicable by reference to his commitments. He stated himself that he cannot commit suicide because of his love for his family. Also, he believes that he is essentially strong (a ‘tough bastard’ as he put it) and that he should be strong, that his strength is a proper focus for how he judges himself and how he relates to himself. These commitments provide motivation, strength and purpose as he wrestles to avoid his own self-destruction. In this sense, ‘wrestling with commitment’ refers to the idea of wrestling with suffering because of some commitment.

This kind of pattern is evident in the accounts of other participants in the study. In relation to potential suicide, several interviewees described occasions when ‘living on’ was explicable by reference to their love for their families. Another commonly mentioned commitment, in this context, was religious.

Several participants associated their non-suicide with their practice as Christians and the inconsistency between suicide and their religious beliefs. More generally, participants commonly described tough times where they 'had to keep going.' Terry, for example, wanted to go back to work after several years of 'lying on his couch' in a state of lethargy that he explained by reference to the effects of neuroleptic medication and a general loss of interest in life. He procured a part-time job and found this exhausting. He 'dragged himself' to work, 'fought' through each day, and yet did not give up. This was associated with a commitment to his marriage- he wanted a better relationship with his wife and believed that maintaining a job would give him something to talk about in their conversations. It would make him more interesting to her. Terry also wanted 'somewhere to go' or, to put this another way, he was committed to the idea of 'going somewhere', of having direction and purpose.

So commitments can go some way to explaining endurance in a range of circumstances. And persons might ultimately 'win' in their wrestle with suffering. They might 'come out on top'. To return to the example of Terry, going to work got progressively easier and, over the past five years, he has undertaken retraining courses and a variety of paid employment. At the time of our interview, his week was full between participation in a personal development course, computer skills training, and various kinds of contract work in a sheltered employment/training centre. He has established a pattern of activity that no longer requires undue effort to the extent that he simply goes

about his business without giving it any particular thought. Now, ‘it is just what he does’. He seems to have won his battle with lethargy and demoralisation.

But wrestling with suffering does not necessarily end in victory even when persons are energised and fortified with commitment. For one thing, persons may not be able to sustain the effort. To return to the example of Joe, he is not confident that he will be able to keep going forever. He laments the quality of his life that he views as a constant struggle and he is not altogether sure that it is a life worth living. In addition, suffering can have a cumulative quality- one thing can pile upon another. This can mean that committed enduring becomes progressively more difficult, even untenable.

Bernie is a 50 year old woman who I interviewed and whose biography illustrates an accumulation of suffering over time. As a child, she was sexually abused by her father but lived for over three decades without remembering this reality. However, from early puberty, she thought there was ‘something wrong’ with herself, she felt persistently guilty, and found life hard. Nonetheless, as she emerged into adulthood, she was able to ‘get by’. She worked, kept herself very busy, had an active social life, and kept up her religious faith. Life was a struggle but she endured. The strain of life increased when she married and had children. She found it very hard to live with the responsibilities of others being dependent upon her. Bernie was intensely committed to the welfare of her children but it was wearing to meet their needs. Yet still she endured. Subsequently, her father died and, shortly afterwards and following a conversation with an ex-neighbour, memories of the abuse pervaded Bernie’s

consciousness. At this stage, Bernie was 45 years old and, in her own words, she ‘completely lost it’. She experienced a manic psychosis and was admitted to a psychiatric ward for the first time.

In this case, suffering accumulated to a point where it could not be ‘wrestled’. Bernie was overwhelmed in spite of her commitments.

Hence, there are situations in which suffering surpasses a capacity for committed wrestling. In some circumstances, persons may have difficulty in recognising that some things cannot be outfought and some commitments are impossible to maintain. For example, in her published memoirs of living with schizophrenia, Elyn Saks describes her longstanding and strongly held commitment to a view of herself as strong, as a ‘fighter’, as self-reliant (Saks 2007). She explains the considerable successes in her life by reference to this identity: she has an outstanding record of educational achievements, she is a professor of law in a prestigious university, and she has received several notable awards in recognition of her attainments. These achievements, she believes, are attributable to her hard work, determination, and resolution.

But this ‘identity commitment’ (see Strauss 1969) meant that Elyn rejected the idea of herself as mentally ill. Psychosis was a persistent feature of her life, a source of considerable torment, and something that regularly disabled her capacity for study, work, and relationships. From her perspective, psychosis was something she should fight against and defeat through her strength of will. A diagnosis of schizophrenia, admission to psychiatric hospital, and taking neuroleptic medication were all viewed by Elyn as an invalidation of her

personal strength and as signs of weakness. On this basis, she rejected them and often avoided treatment unless she was ‘forced to submit’: when her resistance was overwhelmed by the extent of her suffering or when she was forcibly treated in the most literal sense when hospitalised (for example, by being tied in restraints and injected with medication). However, once enforcement was removed, Elyn was again reluctant to take medication and often reduced or terminated it of her own accord. This represented a re-assertion of her personal identity oriented to self-reliance. But in time, her psychosis re-emerged and the same cycle of events recurred.

So persons, by virtue of certain kinds of commitments, can be willing to wrestle when they cannot win or, more accurately, when they cannot win if they continue to wrestle in the same way. Elyn Saks eventually learned this lesson and wrestled in a different style. She learned to ‘give way’ to mental illness and to accept the limitations that this imposed. Her acceptance of her own vulnerability has enabled her to more effectively manage it. She now willingly takes medication and this contains her psychosis, allowing her to pursue her life goals with her customary determined vigour. Through giving way rather than ‘fighting against’ or submitting, Elyn is ‘coming out on top’.

One aspect of Elyn’s story is worth further mention here. She experienced compulsory psychiatric hospitalisation and treatment and, in this respect, she shared the fate of many persons that experience psychosis. A commonly used term for such compulsion is ‘involuntary commitment’. This is a form of commitment that persons often ‘wrestle against’ but they are forced to

submit to a particular line of action like taking neuroleptic medication or conforming to an institutional regime. Yet such submission may be temporary in the sense that persons re-enact their prior commitments once enforcement is removed. However, such enforcement might prompt a shift in a person's stance and movement in the direction of a new commitment.

Finally, there is the possibility of competing or antagonistic commitments. Josiah is a 29 year old man that I interviewed and who experienced extraordinary things like seeing ghosts, hearing the voice of God, observing a UFO, conducting a choir of angels, torment by malevolent spirits, and the like. To an extent, he attributes these experiences to mental illness and he is committed to the idea of himself as mentally ill. At the same time, he is also religious and open to the idea of supernatural explanations for events. On the basis of these dual commitments, he is unsure of the status of some of his experiences: whether they are real in the sense that they really happened or whether their reality can be discounted as illness. He wrestles with the implications of these commitments and often changes his stance on the reality of his experiences.

All of this provides a brief summary of a pattern that is central to living through and after psychosis. This core category of 'wrestling with commitment' accounts for variations in four sub-core categories:

- Taking a position;
- Enforced submission;
- Giving way;

- Coming out on top.

Becker, H. S. (1960) Notes on the concept of commitment. *The American Journal of Sociology,* **66**(1), 32-40.

Saks, E. R. (2007) *The Centre Cannot Hold: A memoir of my schizophrenia*, Virago, London.

Strauss, A. (1969) *Mirrors and Masks: The search for identity,* Sociology Press, Mill Valley.

Memo 120: Unsustainable commitments

18th June 2008

'Unsustainability' is a good term for addressing the limits of commitment. A commitment becomes unsustainable because of its pragmatic limitations. It may be too hard to sustain because of the level of suffering or effort involved. It may not 'fit' with a lived reality to the extent that it provides insufficient direction about how to understand or deal with a particular reality. It may generate negative consequences which may undermine the commitment as they become apparent. It might be confronted with something that negates it. And it might be irreconcilable with other commitments.

The unsustainability of a commitment may become gradually or suddenly apparent. When the realisation of unsustainability is associated with a lesser Me, this can provoke a crisis of self where 'I' negatively judges a present 'Me' in comparison to the lost 'Me'. But this is often offset by 'Preferred Me-ing' within pragmatic limitations. For example, 'Sick Me' may be comparatively inferior to a 'Special Me' associated with psychosis. But 'Sick Me' can offer opportunities for self-legitimation and indeed a foundation for reconciling different 'Me's'. Also, by reference to 'Sick Me', 'Special Me' can be undermined or discounted as unreal, misleading or dangerous.

Nonetheless, unsustainability is not necessarily a 'once and for all' issue. A commitment might be unsustainable at a given time but re-lived at a subsequent point.

Memo 126: Interpretive resources and accounting for psychosis

9th July 2008

When Lori Schiller heard Voices, she concealed this information for a long time and tried to work out the meanings of her experiences.

A student at school was treated for mental illness and Lori wondered if she was mentally ill like her peer. She was repelled by this possibility because of the way other students shunned the affected student.

Lori also wondered about whether she was possessed- this possibility was made vivid by a Stephen King film, *Carrie*, that was in the cinema and which reminded her of herself.

Furthermore, she read *The Bell Jar* and was disturbed by the similarities between Esther Greenwood and herself.

What all of this illustrates is the way persons use the interpretive resources at their disposal and make comparisons. In this case, another high school student, a film and a book were each an opportunity for meaningful comparisons, an opportunity for 'I' to realise 'Me's' as 'like that' or 'not like that.' These comparisons were integral to Lori's attempts to make sense of her experiences.