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## The Magnificent Seven: a Narrative Analysis of Suppressed Discourses in Psychiatric Diagnoses

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Diagnoses

Clayton V. Martin

The College of William & Mary

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### **Dedication**

I thank every teacher in grade school who encouraged my writing. I thank Bob Ramseur and Richard McMichen for teaching me to connect with others. I thank Peg Steiner for being the person who most encouraged my creative ability, even when I didn't recognize it myself. I recognize Martin Rader for being a close second in this regard. I thank Corrine Nagata for being a friend when I really needed one, and I thank Rachel Bodenstein Linkwald for teaching me most of the things I needed to know about myself and dealing with others. I thank Dan and Patric for keeping me afloat in bad times, and I thank Dave, Darryl, and everyone at Davinci's for expanding my knowledge and compassion re: the human condition. I thank every woman who ever loved me. You all know who you are and there's no need to embarrass you.

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Finally, I thank each and every member of the Magnificent Seven. Everything I do from here on out is thanks to you.

**Abstract**

This study is a Narrative Analysis of the hidden strengths and positive qualities inherent to identified psychiatric diagnosis. Seven individuals were interviewed on two occasions and also corresponded with me via email and telephone. Analysis of individual narratives yielded common thematic elements and common plot points, these factors were further analyzed and contemplated in the light of their implications for the Counseling profession. An informed critique of the research design is presented, followed by implications and suggestions for future research.

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## Chapter One

As of 2015, it is presumed that approximately forty-three million Americans aged eighteen and older either have or meet criteria for a Psychiatric diagnosis. This figure accounts for roughly eighteen percent of all adults in the United States (National Institute of Mental Health, 2015). Estimated prevalence rates of mental disorders among children are even higher, as one in five Americans under the age of eighteen are currently assumed to have experienced “a seriously debilitating mental disorder” at some point in their lives (National Institute of Mental Health, 2016). The implications of these prevalence rates stretch beyond the boundaries of Psychiatry, as the effects of diagnosis ricochet throughout the legal system, health insurance policy, the financial sector, and the educational system (e.g.: Climie & Mastoras, 2015; Kress, Hoffman, & Eriksen, 2010; Stearns, 2015). From their muted origins within the confines of early American mental institutions, Psychiatric diagnoses have mushroomed to influence a multi-billion dollar network of psychopharmaceutic medications, helping professions, and a host of features across the American pop-cultural landscape (e.g.; Di Fonzo, 2007; Greenberg, 2013; Hansen, 2007; Kress et al., 2010; Surís, Holliday, & North, 2016). Drugs designed to treat Psychiatric conditions are routinely advertised on television, the motion picture industry generates fiery avatars of mental disorders to varying degrees of accuracy, and the Psychiatric stability of political minds is hotly contested in the media. Though the extravagant growth of the Psychiatric paradigm grants cause for concern, strong evidence supports the conclusion that Psychiatry and its nosological processes have greatly benefited the helping professions and the mentally ill (Craddock & Mynors-Wallis, 2014; Frances, 2014; Hansen, 2003; “Patty Duke

launches mental health site, blog,” 2005). Scholarly voices in the Counseling profession, however, frequently critique the concept of Psychiatric diagnosis and question its degree of compatibility with professional Counseling values (Eriksen & Kress, 2008; Hansen, 2007; Kress et al., 2010; Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008). To further examine the impact of Psychiatric diagnosis on the helping professions and the communities they serve, an examination of the purpose and historical development of Psychiatric diagnosis is necessary.

### **The Purpose and Development of Psychiatric Diagnoses**

Diagnosis is an integral component of the medical procedure: it identifies the nature and expression of various diseases, it aids the delivery of efficacious treatment and illuminates prognosis, it acts as a blueprint for communication between doctors, researchers, and medical educators, and informs research and planning for vital public health initiatives (Surís, Holliday, & North, 2016). Classification of diagnoses is commonly referred to as the practice of *nosology* (Surís et al., 2016), and the process of diagnosis is defined in the following fashion by the Oxford English Dictionary Online (2010):

Determination of the nature of a diseased condition; identification of a disease by careful investigation of its symptoms and history; also, the opinion (formally stated) resulting from such investigation.

Additionally, the Oxford English Dictionary Online (2010) defined the concept of “disease” in the following manner:

A condition of the body, or of some part or organ of the body, in which its functions are disturbed or deranged; a morbid physical condition; ‘a departure from the state of health, especially when caused by structural change’.

Mental disorders have been fused into the nosology of medical diseases (Guze, 1978; Joyce, 1980) by the Psychiatric profession. Currently, two main organizational texts classify Psychiatric diagnoses in medical practice: The International Classification of Diseases (ICD) published by the World Health Organization (WHO), and the Diagnostic Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (Frances, 2014). The two texts share structural similarities and are also split by organizational differences (Jablensky, 2009). Furthermore, they have been modeled after one another at various points in their respective developments (Frances, 2014; Surís et al., 2016). Though only one diagnosis is identical between the two texts, numerous disorders have highly similar definitions, and differences between disorders have possibly been overestimated due to inaccurate version-to-version comparisons (Jablensky, 2009). Other researchers, however, argue that diagnostic differences between the manuals are more substantial, despite multiple efforts to harmonize categories between the two systems' volumes (Frances, 2014).

The ICD and the DSM, however, share two salient commonalities in their nosological processes: one, both systems are “categorical:” the determination of mental illness is made by quantitative symptom clustering on a binary scale; an individual either possesses enough criteria to qualify for a mental illness or they do not (Jablensky, 2009; Pilgrim, 2007; Whooley, 2014). Two, in line with other medical disciplines, the symptoms that comprise mental disorders are uniformly seen as deficits, as marks of disease and disorder (American Psychiatric Association, 2013; Horwitz & Grob, 2011; Pilgrim, 2007). The binary scale, symptom-clustering, deficit-oriented nature of DSM and ICD mental disorders is the global standard for attaining research grants and is entrenched in clinical, legal, and administrative systems on a worldwide scale (e.g.; Cuthbert, 2014; Kress, Hoffman, & Eriksen, 2010; Moncrieff, 2010; Pilgrim, 2007). In the

United States, Psychiatric diagnoses can influence the outcomes of legal decisions, impact an individual's ability to obtain life or health insurance, alter the educational trajectory of troubled students, and impact payment for mental health services in managed care systems (e.g.: Climie & Mastoras, 2015; Kress et al., 2010).

### **History and Development of Psychiatric Diagnosis**

The development of Western Psychiatric diagnoses as they are currently understood began with German Psychologists and Neurologists of the mid-to-late nineteenth century, who were known for their meticulous focus on the description of disordered behavior and an agnostic attitude to the cause of mental strife (R. D. Miller, 1994). This paradigm began to shift, however, as the work of Sigmund Freud gained prominence first throughout Europe and later throughout the world. Trained as a neurologist, Freud created a landscape of the mind that postulated a genesis for disordered behaviors (Greenberg, 2013; R. D. Miller, 1994; Trede, 2007). Freud's psychoanalytic theory posited that mental disorders were rooted in traumatic childhood experiences and the by-product of competing forces within the human psyche (Trede, 2007). Freud understood, however, that the medical technology and techniques of his time were insufficient to adequately verify his ideas, and he viewed his conceptualization of the mind and psychoanalytic processes as tools for researching and refining psychological theory (R. D. Miller, 1994). Freud's influence in diagnosis has waxed and waned over the years, but it continues to influence a number of diagnoses, particularly the Personality Disorders (Greenberg, 2013).

Freud frequently clashed with one particular counterpart among the German school of Psychiatrists, and this adversary also continues to influence contemporary Psychiatric diagnoses: Emil Kraepelin (Trede, 2007). Unlike Freud, Kraepelin was interested in practice rather than

theory, and determined that mental disorders were a matter of biology rather than psychosocial trauma (Pilgrim, 2007; Surís et al., 2016; Trede, 2007). After studying a number of patients, Kraepelin drew three conclusions that established an enduring framework for Western Psychiatry. First, mental disorders were categorically distinct and naturally occurring categories. Second, mental disorders were inherited conditions, and each had their own predictable deteriorating course. Third, Kraepelin maintained that all mental disorders were products of brain disease, or diseases of the central nervous system (Pilgrim, 2007). While Kraepelin also understood that medical technology of the time was inadequate to verify his conclusions (Greenberg, 2013), he established an lasting paradigm for Psychiatric diagnosis that survives in both the DSM and the ICD (Pilgrim, 2007).

### **Development of Psychiatric Diagnoses in the United States**

Preceding the advent of World War Two, psychological study as a whole in the United States shared three primary goals: the amelioration of mental illness, the augmentation of personal productivity and happiness, and the identification, support, and development of strengths and talents (Seligman & Csikszentmihalyi, 2000). Helping services focused on both the identification and remediation of negative symptomology and the development of strengths and talents in order to enhance quality of life (Seligman & Csikszentmihalyi, 2000; Sheldon & King, 2001). During this time, Psychiatric diagnoses were confined to mental institutions, which housed individuals with severe mental disorders who were unable to meet the necessities of daily living (Surís et al., 2016). Each of these institutions had their own unique system of diagnosis that were largely influenced by Freud's psychoanalytic theory (Surís et al., 2016). The first attempt to establish a standardized system of Psychiatric diagnoses, the Statistical Manual for the

Use of Institutions for the Insane, was produced by the government in tandem with the Census of 1920. It was also largely ignored by American Psychiatrists (Surís et al., 2016).

The mental health paradigm in the United States began to shift after World War II, largely due to the traumatic experiences endured by American combatants and the resultant shift by military Psychologists to the immediate assessment and remediation of trauma-related psychopathology (e.g.; Climie & Mastoras, 2015; Surís et al., 2016). By the mid nineteen-fifties, nearly one-quarter of all hospital beds in America were occupied by patients with mental disorders (R. D. Miller, 1994). In response to this shift in the nation's mental health landscape, the American Psychiatric Association released the DSM I in 1952, followed by the DSM II in 1968. Both editions were heavily influenced by psychoanalysis, focused on the etiology of mental disorders, and allowed clinicians to make subjective judgements about the root causes of disordered behavior (R. D. Miller, 1994).

Both the DSM I and the DSM II suffered from a host of criticisms. As their research bases were dependent on psychodynamic practice, which relied on clinical judgment and years of extensive treatment, inter-rater reliability for both editions was very low (R. D. Miller, 1994). Additionally, during the interim between the release of DSM I and DSM II, two developments undermined the dominance of Psychoanalytic theory in the United States. One was the advent of psychotropic medications, which became increasingly popular for the treatment of mental disorders. The other was the development of neuroscientific research into mental disorders, which ushered in startling new finds including neurotransmitter systems (Surís et al., 2016). The low reliability of the DSM II made research into psychotropic medications difficult, and voices within Psychiatry criticized the fact that diagnoses were grounded in clinical opinions rather than objective, standardized factors as Kraepelin had envisioned (R. D. Miller, 1994). Critics outside

of Psychiatry accused the industry of utilizing diagnoses to wield control of socially undesirable behaviors that were not punishable within the criminal justice system, and this system was echoed by a number of voices within the profession as well (R. D. Miller, 1994). Furthermore, feminist critics began to point out the chauvinistic, discriminatory nature of psychoanalytic theory and its many biases against women vis a vis Psychiatric diagnosis (R. D. Miller, 1994). The APA responded to these critics some time later with the revolutionary DSM III.

### ***Paradigm Shift: The DSM III***

The development of the DSM III can be traced back to the "Renard School" of Psychiatry at Washington University in St. Louis during the mid-twentieth century. Two researcher/clinicians in this group, Eli Robins and Samuel Guze, found themselves increasingly disenchanted with the prevailing nosological system in American Psychiatry (Greenberg, 2013; Surís et al., 2016). Robins and Guze felt that Psychodynamic theory and clinical opinion made for unreliable research, and preferred a systematic approach similar to other forms of medicine. Believing that reliability and validity were crucial to Psychiatric diagnosis, Robins and Guze developed an atheoretical operationalization of criteria for Psychiatric diagnosis that became known as the *Medical Model* (Surís et al., 2016). Their five phase validation model for identification of Psychiatric diagnoses included the following: 1) clinical characteristics of the syndrome and patients who develop it (including core symptoms, demographics, and precipitating factors), 2) exclusionary criteria differentiating the syndrome from other known disorders, 3) family studies, 4) laboratory studies (including radiological, chemical, pathologic, and psychological screenings), and 5) follow-up studies, including stability, course of illness, and treatment response reports (Surís et al., 2016). While the Robins and Guze procedure is considered a gold standard in analyzing different sets of criteria for diagnostic categories, both

researchers understood that the requisite technology did not exist to validate the fourth phase of their process. Therefore, they designed the diagnostic process to be iterative: as technology progressed, each progressive set of diagnoses would improve upon the previous one (Surís et al., 2016).

The fruit of Robins and Guze's labor bloomed in 1980 with the DSM III. Headed by Robert Spitzer of the New York State Psychiatric Institute, the DSM III was based on an entirely new Research Diagnostic Criteria (RDC) which was heavily influenced by the work of Robins and Guze (Surís et al., 2016). The DSM III shifted away from a Psychodynamic, etiological paradigm to an atheoretical, symptom-descriptive one, and replaced the subjective framework with objective research standards that privileged reliability and validity (Surís et al., 2016). Authorship was switched from small pools of authors to task forces for each diagnosis, and authorship of the text ballooned into the thousands. Furthermore, a supplement was included for clinical conditions that had not been classified as disorders but were currently being researched by the APA (R. D. Miller, 1994).

The DSM III utilized a hierarchical, multi-axial system and exclusionary criteria in line with the Robins and Guze method, and soon became an instant best-seller with both national and global influence (Frances, 2014; Surís et al., 2016). As was the case with previous iterations of the DSM, the APA intended for the diagnoses to be compatible with the ICD mental disorders. In an ironic twist of fate, however, the reliability of the DSM III diagnoses proved so superior to their ICD counterparts that the ICD-9 was modified to fit the DSM III instead (Frances, 2014; Surís et al., 2016). While both the DSM and the ICD have undergone several revisions since this time, the influence of the Robins and Guze method of diagnostic validation remains in both nosological systems (Frances, 2014; Surís et al., 2016).



### Summary

Diagnosis is defined as the identification and classification of diseases as determined by symptomology and developmental history. Disease, in turn, is defined as a morbid, deranged, or disturbed condition of the body that stands in stark contrast to healthy biological processes and structures. Paradigms of mental health have been subsumed by these concepts, and contemporary helping professions utilize two systems for conceptualizing diagnoses that pertain to mental health: The ICD and the DSM. The two systems share similarities and are marked by differences, although researchers disagree on the degree of correlation between them. Two commonalities between the systems exist: both are categorical and binary in nature and both define diagnoses as diseases which stand in contrast to proper mental health.

Psychiatric diagnosis as it is currently understood by Western paradigms can be traced back to two nineteenth-century German researchers: Freud, who saw diagnoses as the results of developmental trauma and psychic conflict, and Kraepelin, who conceptualized diagnoses as malfunctions of the brain. In the early twentieth century, psychiatric diagnosis in America was heavily influenced by Freud and restricted to extreme cases and residential institutions. Due to the proliferation of Post-Traumatic Stress among returning combatants in World War II, however, mental health researchers redefined diagnoses as naturally occurring diseases that could be systematically researched and objectively classified. Though researchers admitted that no scientific method could validate a Medical Model of psychiatric diagnosis at every point in diagnostic history, the Medical Model subsumes most aspects of contemporary mental health research and practice.

### Statement of the Problem

As previously mentioned, the Psychiatric approach to mental health is often referred to as the *Medical Model* in scholarly literature (Hansen, 2003, 2007; Kress et al., 2010; Zalaquett et al., 2008). Concerned by the Medical Model's relative insensitivity to multiculturalism, Zalaquett et al. (2008) enumerated a number of its core features that they found most incompatible with the Counseling profession: a) presenting conditions were conceptualized as symptoms of disease, b) that it was oriented to deficits instead of strengths, c) that it contributed to a top-down attitude towards clients in professionals, d) that it places the client in a passive and disempowered position, and e) that it stressed a uniform origin of symptoms and pharmacological treatments. While acknowledging the limitations and weaknesses of the Medical Model, Craddock & Mynors-Wallis (2014) affirmed the importance of Psychiatric diagnosis to the helping professions by invoking its ecumenical utility in research and clinical practice. Surís et al. (2016) echoed these claims, and reaffirmed that the diagnostic system was designed to evolve and change over time as knowledge and technology improve.

In contrast to the medical model, the *Counseling Model* takes a more humanistic and contextual perspective towards mental health (Zalaquett et al., 2008). Zalaquett et al. (2008) listed six features that distinguish the Counseling Model from the Medical Model: a) it views symptoms as responses to environmental inputs, b) it places a premium on client strengths and resources, c) it reduces the power differential inherent to the Counseling relationship, d) it makes the client an active and engaged component of the treatment process, e) it raises awareness of environmental factors that might influence behavior, and f) its treatment focus is non-pharmacological (Zalaquett et al., 2008). This distinction has been affirmed by a number of Counseling scholars (Hansen, 2007; Kress et al., 2010). While the differences between these

models is apparent, two things remain clear: Psychiatric diagnosis has retained a prominent position in counselor education and practice (Hansen, 2007), and both models presume that the feelings and behaviors clients bring to the Counseling process are mainly problematic in nature.

### **Psychiatric Diagnosis in the Counseling Profession**

The concept of Psychiatric diagnosis grants a number of strengths and benefits to Counseling. Psychiatric diagnoses serve as a linguistic conduit between mental health researchers and clinicians; furthermore, they help to inform treatment plans and client conceptualizations (Craddock & Mynors-Wallis, 2014; Frances, 2014; Miller, 1994; Surís et al., 2016). Scholars within the Counseling profession have recognized the importance of referring clients with severe mental health issues for Psychiatric evaluation, and have afforded a place for scientific inquiry in Counseling (e.g.; Guterman, Martin, & Kopp, 2012; Hansen, 2003; Martin, Guterman, & Kopp, 2012). Counselors frequently rely upon an understanding of Psychiatric diagnoses and a willingness to use them in order to secure payment from managed care institutions (Kress et al., 2010). Psychiatric diagnoses can also provide comfort and relief to individuals in Counseling, as they conceptualize mental disorders as syndromes and medical conditions rather than character flaws or the product of poor choices (Craddock & Mynors-Wallis, 2014). The disease model of substance addiction is one of the best researched examples of Psychiatric diagnosis lending itself to client self-acceptance and organized advocacy (Freed, 2007; “Joint organizational,” 1997). The late American actor Patty Duke was inspired to become an advocate for mental health initiatives after receiving a diagnosis of Bipolar Disorder and responding positively to treatment (Duke & Turan, 1998; “Patty Duke” 2005). Lastly, a working knowledge of Psychiatric diagnoses benefits Counselors and Counselor Educators alike, as the Council for Accreditation of Counseling and Related Educational Programs (CACREP) has

integrated provisions for the understanding and treatment of psychopathology into its training standards (Council for Accreditation of Counseling and Related Educational Programs, 2015; Hansen, 2003; Kress et al., 2010)

Despite these benefits, multiple scholars within the Counseling profession continue to question the degree of compatibility between the medical model and the principles of Counseling. Scholars have questioned whether or not Psychiatric diagnoses provide a complete and fair description of individuals with mental health problems (Hansen, 2003, 2007; Pilgrim, 2007; Stearns, 2015; Whooley, 2014). Furthermore, an emerging body of research suggests that the deficit-symptom model could be enhanced by acknowledging that many symptoms of Psychiatric diagnoses carry hidden strengths and benefits.

### **Psychiatric Diagnosis and the Core Values of the Counseling Profession**

Hansen (2003) argued that the Kraepelinian philosophy of mental health problems as medical diseases is largely incompatible with the humanistic foundations of Counseling, which privileges ongoing development and self-actualization through supportive client-counselor relationships. Hansen advocates for diagnosis to be taught as a “survival skill” (2003, p. 101) to Counselors, allowing them to collaborate with other mental health professionals while maintaining a largely humanistic epistemology (Hansen, 2003). Pointing to the mounting influence of Psychiatric language across legal, administrative, and healthcare domains, Kress et al. (2010) argued that diagnoses can compromise the principles of confidentiality and informed consent, as Counselors cannot be certain how diagnoses might affect clients in extra-clinical proceedings. Other scholars have argued that strict adherence to Psychiatric diagnosis places Counselors at odds with professional mandates regarding multicultural and social justice competence. Zalaquett et al. (2008) recommended that Counselors reposition themselves in

regards to Psychiatric diagnoses, as they often harm marginalized individuals who exhibit normal and natural negative responses to oppressive social influences (Zalaquett et al., 2008). The authors also explained that behaviors conceptualized as symptoms in diagnoses often have a variety of meanings across cultures, and that two individuals from distinct cultures who share a diagnosis might benefit from radically different interventions (Zalaquett et al., 2008).

As the categorical, binary nature of diagnoses do not account for these factors, the authors suggested that Counselors conceptualize Psychiatric diagnoses through a contextual, developmental lens (Zalaquett et al., 2008). Gallo (2016) encouraged Counselors to listen carefully to clients who engage in crossdressing behavior before diagnosing them, and asserted that the relative lack of cognitive or behavioral abnormality in many crossdressing individuals suggests that their distress might be rooted in societal repression rather than psychopathology (Gallo, 2016). Eriksen and Kress (2008) discussed a number of diagnostic biases that separate males and females in contemporary society, paying special attention to how Personality Disorder diagnoses are frequently made in accordance with cognitive/behavioral stereotypes. The authors also suggested that Counselors should prevent gender biased diagnosis by incorporating Multicultural, Constructivist, and Narrative perspectives into the diagnostic process (Eriksen & Kress, 2008).

### **Rationale for a New Approach to Diagnosis in Counseling**

While a prodigious body of literature recommends supplementing diagnosis with a strengths-based paradigm (De long & Miller, 1995; Guterman & Leite, 2006; Guterman & Martin, 2016; Guterman, Martin, & Rudes, 2011; Macneil, Hasty, Conus, & Berk, 2012; Seligman & Csikszentmihalyi, 2000; Strand, 1997), a small but growing body of literature is questioning whether the negative, deficit-based descriptions of Psychiatric diagnosis might

frequently camouflage strengths and benefits that are inherent to clients' presenting conditions. Though research into these cloaked aspects of diagnostic symptoms is slight, it spans a range of disciplines from neurobiology (Carson, 2011, 2014) to creativity research (Csikszentmihalyi & Getzels, 2014; Kim & Hull, 2012; Sadre & Brock, 2008) to literature regarding educational policy and practice (Climie & Mastoras, 2015; Stearns, 2015). A wide array of Psychiatric diagnoses are included in this literature, including ADHD (Stearns, 2015), Bipolar Disorder (Murray & Johnson, 2010), Schizophrenia (Richards, 2001), Depressive Disorders (Andrews & Thomson, 2009), and Anxiety Disorders (Norem & Cantor, 1986).

The implications of this emergent body of research contrasts sharply with the one-sided conceptualizations of the Medical Model. Education researchers including Climie and Mastoras (2015), Stearns (2015), and Kim (2016) argued that applying a diagnostic, pathologizing paradigm to individuals with behaviors that generate both positive and negative effects can damage self-concept and negate the possibilities inherent to a strength-based perspective (Climie & Mastoras, 2015; Kim, 2016; Stearns, 2015). Kim (2016) argued that it is entirely possible for people to meet with great success while possessing traits that are viewed as defective by social convention (Kim, 2016), and other creativity researchers have produced similar findings (Csikszentmihalyi & Getzels, 2014). Researchers in the field of Neuroscience demonstrated that pathological traits can generate heightened aptitudes for creative output (Carson, 2011, 2014). The stigmatizing aspects of Psychiatric diagnosis have been challenged by researchers from diverse fields (Climie & Mastoras, 2015; Sadre & Brock, 2008; Stearns, 2015). Additionally, researchers have developed multiple theories that claim affective symptomology evolved to produce hidden advantages, at least in part (Andrews & Thomson, 2009; Keller & Nesse, 2005; Norem & Cantor, 1986; Watson & Andrews, 2002).

Though researchers suggest that reexamining the dichotomous nature of Psychiatric diagnosis could yield benefits, few scholars have proposed a method for investigating the issue or changing practice to reflect an improved paradigm. Among the authors who propose new interventions and perspectives on diagnosis, approaches that privilege personal development and subjective experience are commonly recommended (Climie & Mastoras, 2015; Stearns, 2015). Climie and Mastoras (2015) suggest that diagnostic assessments incorporate individuals' unique worldviews while examining both strengths and challenges. Stearns (2015) recommended that young adults who manifest complicated behaviors be allowed to explore and contemplate their consequences without pathologizing oversight, as a reserved approach that honors autonomy would allow them to “tarry with badness” throughout their development (p. 420). As scholars of disparate orientations emphasize the importance of personal development, individual subjective experience, and the identification of strengths to the counseling profession (e.g.; Guterman, 2015; Guterman & Leite, 2006; Hansen, 2005, 2012; Rudes & Guterman, 2007; Zalaquett et al., 2008), it stands to reason that an reexamination of diagnostic assumptions could yield results that inform theory and practice while adhering to the core values of Counseling.

### **Justification for the Study**

The purpose of this study is to examine the experiences, worldviews and behaviors of individuals who utilize the positive aspects of diagnostic symptomology in order to achieve personal success. Research into the dichotomous nature of diagnostic symptomology is growing; however, many inquiries that could benefit the practice and theory of professional Counseling have yet to be explored . Questions unanswered in literature include: How do such individuals manage the negative aspects of Psychiatric symptomology while capitalizing on its positive properties? What supports and environments are necessary in maximizing the positive aspects of

diagnosis? To what extent are such individuals capable of consciously harnessing these traits, and how do sociocultural influences impact their experiences of succeeding with a Psychiatric diagnosis? How do they consciously incorporate the diagnosis into their self-concepts, if they do so at all? How exactly might the hidden benefits of Psychiatric symptomology manifest themselves in a broader range of diagnoses? In summary, there is a need to investigate the personal narratives of individuals who utilize Psychiatric symptoms for personal success. Such a research endeavor could contribute to a fuller, richer, more empowering conceptualization of psychopathology that is congruent with the core values of the Counseling profession. As the Counseling profession has long understood the importance of client factors in promoting mental wellness (Asay & Lambert, 1999; Duncan & Miller, 2000; Kirschenbaum & Jourdan, 2005; Lambert & Ogles, 2014), an investigation into these questions could yield great benefits in our understanding of how people with Psychiatric diagnoses can achieve and maintain wellness and personal success.

### **Summary**

Voices within the Counseling profession have historically criticized the Medical Model of Psychiatric Diagnosis. The Counseling Model is distinguished from the Medical Model in six ways: it views symptomology as responses to environmental stressors, it places a premium on client strengths and resources, it flattens the hierarchy between helper and client, it views clients as an active agents in their own treatment, it highlights environmental factors that can affect behavior, and it focuses on non-pharmological interventions. Both models, however, view the client's presenting behaviors as rooted in some sort of dysfunction. Many researchers have lauded the benefits of Psychiatric Diagnosis and acknowledged the a place in Counseling for the Medical Model; however, other scholars remain skeptical that the two paradigms are functionally



compatible. Some scholars advocate utilizing the Medical Model for pragmatic purposes, while others suggest that it be adapted and reconfigured for Counseling in a manner that reduces potential harm to clients and honors a diversity of perspectives. Lastly, scholars are building an emergent body of literature that suggests, contrary to both the Medical and Counseling Models, that the presenting conditions that clients bring to counseling offer benefits in addition to challenges. The current study proposes to investigate the stories of individuals who harness the positive aspects of Psychiatric Diagnosis for personal success.

## **Chapter Two**

The following chapter will review disparate bands of literature that highlight problems with conceptualizing human behavior in accordance with the Medical Model. Research into the adaptive and beneficial aspects of mood disorders will be reviewed, followed by an examination of literature on the correlations between creativity and psychopathology. Research into the limiting effects of Psychiatric diagnoses will be explored, and the review will conclude with a summary of research on the Anti-Psychiatry movement and Person-Centered Care models.

### **The Adaptive Benefits of Mood Disorders**

#### **Defensive Pessimism**

Multiple researchers have investigated the potential benefits of symptomologies related to Affective Disorders. Norem and Cantor (1986) conceptualized a type of anxiety known as *Defensive Pessimism* which involves a tendency to enter performance situations with low expectations. Rather than hindering performance outcomes, however, Defensive Pessimism is theorized to help anxious individuals cope with potential failure and enhance motivation to succeed (Norem & Cantor, 1986).

Multiple studies have examined the positive effects of Defensive Pessimism. Researchers investigating Defensive Pessimism demonstrated that the trait does not have a negative impact on task performance; furthermore, attempts to interfere with this phenomenon can lead to inhibited task performance in Defensive Pessimists (Norem & Illingworth, 2004; Norem & Cantor, 1986; Spencer & Norem, 1996). Chang and Sivam (2004) studied a sample of Singaporeans subsequent to an outbreak of Severe Acute Respiratory Syndrome (SARS), and concluded that Defensive Pessimism was positively associated with the adoption of proactive disease-prevention behaviors (Chang & Sivam, 2004). Case studies of two mathematics classes in an American elementary school were conducted by Merz and Swim (2008). The researchers found links between Defensive Pessimism in students and active engagement in learning activities, the use of humor as a coping skill for anxiety, and the expression of self-congratulation after attaining success (Merz & Swim, 2008).

Other scholars, however, have produced mixed to negative results regarding Defensive Pessimism as a problem solving skill. In a study of Spanish University students, Ferradás, Freire, Núñez, Piñeiro, and Rosário (2016) determined that Defensive Pessimism was associated with both a desire for academic achievement and a lack of desire to engage in academic endeavors (Ferradás et al., 2016). Furthermore, a longitudinal study of Australian college students conducted by Martin, Marsh, and Debus (2003) examined the effects of Defensive Pessimism at the midway points of the first and second academic years. The researchers concluded that Defensive Pessimism was negatively associated with both self-regulation and persistence at both time-points (Martin et al., 2003).

### **Evolutionary Perspectives on Depressive Disorders**

Other researchers have investigated possible adaptive benefits of depressive symptoms. The *Social Navigation Hypothesis* postulates that Depression can serve as a problem-solving function in two ways: first, by generating ruminative states in depressed individuals that lead to greater clarity of underlying problems, and second, by spurring otherwise reluctant social supports to provide assistance to depressed individuals through causing impairment and distress (Watson & Andrews, 2002). A similar adaptive conceptualization of Depression known as the *Adaptive Rumination Hypothesis* incorporates the notion of depressive rumination as a problem-solving mechanism and further stipulates that depressive impairment serves to channel limited cognitive resources into dealing with immediate stressors (Andrews & Thomson, 2009). A third model of Depression called the *Symptom-Situation Congruence Hypothesis* theorizes that depressive symptoms vary in response to particular environmental triggers as a means of spurring individuals to take situation-specific remedial actions (Keller & Nesse, 2006). Though additional adaptive models of Depression exist (Hagen, 2002, 2003), all of these models assert that depressive symptoms evolved as a means of guiding individuals to take preventative measures against negative environmental stressors (e.g.: Andrews & Thomson, 2009; Hagen, 2002, 2003; Keller & Nesse, 2006; Watson & Andrews, 2002).

Investigations into adaptive models of Depression have produced positive results, but researchers have also questioned the overall feasibility of these hypotheses. Thoma, Schmidt, Juckel, Norra, and Suchan (2015) studied the problem-solving abilities of individuals with Major Depressive Disorder in an inpatient setting. The researchers concluded that participants were impaired in their ability to freely generate strategies for coping with stressful social situations, but were not impaired in their ability to recognize optimal solutions among alternatives (Thoma

et al., 2015). Bottino, Nadanovsky, Moraes, Reichenheim, and Lobato (2012) conducted survey research with women who had recently given birth, and discovered that the rate of reported Postpartum Depression (PPD) reduced as the age of participants increased. The researchers concluded that this phenomenon supported PPD as an evolutionary response in younger women to environments that generate higher rates of infant mortality (Bottino et al., 2012). Varga (2012) noted the positive aspects and empirical support for certain features of these models, but critiqued them on two major grounds: one, depressive thoughts have frequently been linked to negative affective states rather than immediate problems, and two, depressive symptoms frequently occur without any discernable triggering event (Varga, 2012)

### **Creativity and Psychopathology**

In an extensive study of impactful innovators and creatives, Kim (2016) identified twenty-seven *attitudes* exhibited by highly successful creators that contain socially objectionable aspects. For instance, the *Spontaneous* attitude is often perceived as *Impulsive*, the Playful attitude often registers as *Mischievous*, and the Energetic attitude is frequently deemed *Hyper* (Kim, 2016). Curiously, these attitudes share a remarkable resemblance to the symptoms of Attention Deficit Hyperactivity Disorder (ADHD) as designated by the DSM-5 (American Psychiatric Association, 2013). While Kim maintained that not all twenty-seven attitudes are necessary for amplified creativity, she noted that the most heralded innovators and creators- individuals like Georgia O’Keefe and Albert Einstein- did possess all twenty-seven attitudes and their concomitant disadvantages (Kim, 2016). Kim’s findings have been corroborated by research in Psychotherapy, Education, and Neuroscience, which have identified positive aspects of traits and syndromes that are typically pathologized by Psychiatric diagnosis (Carson, 2014; Laing, 1969; Stearns, 2015).

Other creativity researchers have examined the link between creativity and deviance from sociocultural norms. Csikszentmihalyi and Getzels (2014) examined a sample of 205 students at the Art Institute of Chicago, a prestigious and successful American art school. Participants were administered Cattell's 16 Personality-Factor Questionnaire, which has demonstrated high reliability in industrial, clinical, educational, and research settings (Cattell & Cattell, 1995). Results of this inquiry indicated that participants' scores were significantly outside normative ranges on factors including interpersonal warmth, introspection, superego strength (a measure of impulsivity and congruence with sociocultural mores), self-absorption, and subjective perception (Csikszentmihalyi & Getzels, 2014). Differences between genders in regards to aberrant scores were also noted: female students scored significantly higher in dominance than average collegiate females, while male students were significantly more emotionally withdrawn and prone to excessive shyness than average collegiate males (Csikszentmihalyi & Getzels, 2014). Furthermore, when the scores of high achieving male students were compared with those of low achieving male students, the scores of high achieving male students deviated further from the norm than low achieving male students on the core personality factors of interpersonal warmth, introversion, imagination, conventionality, radicalism, and self-sufficiency (Csikszentmihalyi & Getzels, 2014). Remarkably, multiple significant personality deviations detected in this study- including self-absorption, excessive shyness, excessive dominance, radicalism and departure from sociocultural mores- correlate strongly with the symptomology of disorders such as ADHD, Social Anxiety Disorder, and Oppositional Defiant Disorder as identified by the DSM-5 (American Psychiatric Association, 2013).

Research into the correlations between creativity and psychopathology is frequently conducted in the realm of neuroscience. A number of mental disorders and their concomitant

neurological features are linked to strong performance on measures of creativity. Among these disorders, Bipolar Disorder, Schizophrenia, and ADHD are the most thoroughly researched (Abraham, Windmann, Siefen, Daum, & Güntürkün, 2006; Carson, 2011, 2014; Carson, Peterson, & Higgins, 2003; De Dreu, Baas, & Boot, 2015; Minassian et al., 2011; Peterson & Carson, 2000; Sadre & Brock, 2008; Schweizer, 2006; Stearns, 2015; Zealand, Healey, & Rucklidge, 2006). Studies have demonstrated that neurological phenomena known as weak Latent Inhibition (LI) and enhanced Novelty Seeking (NS) might be influential in expanding creative abilities (e.g.; Abraham et al., 2006; Carson et al., 2003; Schweizer, 2006).

LI is a filtering process that neurotypical (non-disordered) brains use to perpetually weed out distracting or irrelevant phenomena from the field of consciousness. Carson (2003) stipulated that individuals with weak LI are left vulnerable to an profusion of stimuli while problem solving; however, they are sometimes able to incorporate this excessive data in a way that generates unique conclusions. The superabundance of data available to individuals with weak LI can also generate cognitive/processing difficulties, as evidenced by links between weak LI and Schizophrenia (Carson, 2011; Leumann, Feldon, Vollenweider, & Ludewig, 2002) and weak LI and ADHD (Lubow, Kaplan, & Manor, 2014). This idea of weak LI contributing to creativity is consistent with the findings of Kim (2016), who identified the ability to connect seemingly irrelevant ideas while generating unique conclusions as essential to *Outbox Thinking*, a principle component of the creative process (Kim, 2016).

Researchers also established a link between enhanced NS and heightened creativity (Carson, 2011, 2014; De Dreu, Baas, & Boot, 2015; Minassian et al., 2011; Schweizer, 2006). Carson (2014) stated that uncommon features in the brain's reward system can strengthen the human drive to seek novel, stimulating experiences; furthermore, Carson stated that enhanced

NS is linked to increased creative expression. This notion is substantiated by Kim (2016), who identified the dual “Spontaneous/Impulsive” characteristic as a vital *Sun Attitude* – a willingness to follow impulses and seize opportunities as they arise- that is necessary for creative expression. Similar to weak LI, however, enhanced Novelty Seeking presents certain risks; individuals who possess this trait may be more likely to develop Externalizing Disorders such as Bipolar Disorder and Addiction than neurotypical individuals (e.g., Carson, 2011; Donfrancesco et al., 2015; Minassian et al., 2011).

Little research has been conducted into developing helpful interventions for individuals with weak LI and increased NS; however, Carson (2014) and Carson et al. (2003) asserted that *protective factors* such as strong working memory, greater cognitive flexibility, and higher IQ might diminish some of the negative aspects of weak LI and enhanced NS (Carson, 2014; Carson et al., 2003). A limitation of these protective factors is that they cannot be amended or transformed; an individual with weak LI or enhanced NS will either possess the defending traits or not. Therefore, the notion of protective factors is also of limited use to Counselors and the clients they serve. Perhaps more troubling, however, is the one-sided and stigmatizing manner in which Psychiatric diagnosis sometimes conceptualizes the human experience.

### **Diagnosis, Stigma, and Suppression of Strengths**

Stearns (2015) questioned the utility of conceptualizing ADHD solely from a standpoint of deficits due to the extensive overlap between ADHD symptomology and the potential for heightened creativity. Stearns argued that such categorization generates stigma that young people commonly internalize, which leads to poor self-concept and an inability to feel responsible for self-regulation. This admonishment against the *self-fulfilling* properties of Psychiatric diagnosis is affirmed throughout the literature (Honkasilta, Vehmas, & Vehkakoski, 2015; Probst, 2006;

Sadre & Brock, 2008). Stearns recounted two incidents from her teaching experience as illustrations for the importance of constructing *problem behavior* in a non-stigmatizing manner. In one instance, a student diagnosed with ADHD convinced her classmates that a character from one assigned reading was really a character from another assigned reading in disguise; in another example, a student gave a presentation which attempted to prove John F. Kennedy masterminded the attacks on Nagasaki and Hiroshima. Stearns protested the school administration's decision to punish these students for exhibiting distracting, inappropriate behavior without acknowledging the creativity inherent to their (admittedly erroneous) arguments. Additionally, Stearns argued that the tendency to condemn nonconformist thought in contemporary education is harmful to young people, and leads them to become jaded with the educational system and mistrustful of authority. Stearns' position was corroborated by Kim & Hull (2012), who identified *anticreative environments* in education as predictors of early dropout in highly creative, idiosyncratic students (Kim & Hull, 2012).

### **Anti-Psychiatry**

The *Anti-Psychiatry* movement of the 1960's coalesced around the idea that the Medical Model of Psychiatric Diagnosis caused more problems than it solved (Pilgrim, 2007). It was comprised of ex-patients, writers, social activists, and critical professionals from myriad disciplines (Murray, 2014). The purpose of this movement was to demand more humane treatment for mentally ill individuals and to question the measure and influence of institutional power within Psychiatry (Murray, 2014). Proponents of Anti-Psychiatry within the profession called for practitioners to look beyond symptoms and deficits by focusing on the beliefs, values, and multidimensional experiences of mentally ill individuals (O'Brien, Woods, & Palmer, 2001). Though many voices in mainstream Psychiatry resisted and counter-attacked the Anti-Psychiatry



movement, its line of thought contributed to subsequent alterations to Psychiatric diagnosis including the removal of homosexuality from the DSM III (Pilgrim, 2007). Primary contributors to Anti-Psychiatric doctrine included Thomas Szaz, R.D. Laing, Michel Foucault, and Kate Millet (Bracken & Thomas, 2010; Clarke, 1999; Iliopoulos, 2012; Murray, 2014; Nasser, 1995; Pilgrim, 2007)

The psychiatrist Thomas Szaz contended that human consciousness cannot be disordered in a biological sense and that distinctions of illness and wellness are largely constructed by professional disciplines (Nasser, 1995). Szaz viewed the central problem of Psychiatric Diagnosis as the misapplication of institutional power, and claimed that the primary beneficiaries of the Medical Model were the professional organizations that created and maintained it rather than the individuals who were subjected to diagnostic classification (Nasser, 1995; Szaz, 2007). Szaz sharply criticized the fact that mental illness largely defied methods of scientific validation, and stated that the inability of the Medical Model to empirically validate its claims disqualified it as a form of legitimate science (Bracken & Thomas, 2010). Szaz did not dispute that individuals could be mentally distressed or behave in incomprehensible and dysfunctional manners; however, he considered these issues to be problems of living rather than symptoms of medical conditions. More specifically, Szaz viewed psychiatric symptomology as a form of language that was designed to mobilize help (Nasser, 1995). To illustrate his view of mental illness, Szaz likened the Medical Model to a futile attempt to repair a person's television set when the problem lied in the poor quality of broadcast television programs (Bracken & Thomas, 2010). Szaz compared the mentally ill individual's desultory access to community and professional supports to the omnipresence of bad television, and claimed that a different type of

discourse would be necessary to treat mental illness than the one proposed by the Medical Model (Bracken & Thomas, 2010).

Szasz's contemporary, the Scottish psychiatrist R.D. Laing, produced a body of work that inspired and informed the Anti-Psychiatry movement despite the fact that Laing was ambivalent towards the movement and never described himself as part of it (Clarke, 1999; Nasser, 1995). Whereas Szasz saw mental illness as a problem of oppressive institutional power, Laing believed that mental illness was the product of a complex and multifaceted web of influences on the individual's sense of self (Clarke, 1999). Laing maintained that these influences included institutional power but were also comprised of myriad social expectations on both the macro and micro levels (Nasser, 1995; Pilgrim, 2007). For instance, Laing maintained that dysfunctional and unsupportive family structures played a large role in the development of mental illness, and that family structures were likewise warped by oppressive societal constructions (Nasser, 1995). Laing paid special interest to the conceptualization of schizophrenia, and maintained that its antisocial manifestations were successful attempts to refuse the subjugation of harmful social influences rather than markers of biological disorder (Nasser, 1995). Laing posited that before disordered behavior can be treated, it is necessary to understand the context in which it occurs (Nasser, 1995; Pilgrim, 2007). To illustrate Laing's attitude towards the contextual interplay between subjective experience and social mandates, Clarke (1999) recounted an anecdote Laing would frequently utilize to explain his viewpoints:

For instance, he would tell the story of his daughter who was committed to a psychiatric hospital when found kneeling in the rain on the steps of a cathedral. Apart from the disreputable fact of her forced detention, it was all the more inexplicable, said Laing, that

had she been kneeling inside the cathedral, she might well have been treated differently (p. 315).

The Post-Structural Philosopher Michel Foucault contributed to the Anti-Psychiatry movement in a generally similar fashion to the previously mentioned individuals; however, his contribution was also unique on a fundamental level (Bracken & Thomas, 2010). Like Laing and Szasz, Foucault acknowledged that sociocultural influences played a critical role in shaping institutional discourses about mental illness (Bracken & Thomas, 2010; Nasser, 1995). For instance, Foucault (1971) argued that prior to the European Enlightenment, many behaviors that are currently associated with mental illness were accepted as alternate ways of being and knowing (Foucault, 1971). After the rise of the epistemology of reason, however, these behaviors were deemed to be incongruent with Enlightenment values and were classified as manifestations of aberrant being (Foucault, 1971). Unlike figures such as Szasz, however, Foucault attempted to critique sociocultural influences on mental illness rather than to repudiate them (Bracken & Thomas, 2010). Foucault viewed the Medical Model as a betrayal of the spirit of inquiry and challenge that fueled the Enlightenment (Foucault, 1971). Foucault sought to understand and explain the historical development of the Medical Model in order to empower people who were subject to its dicta and suppositions (Foucault, 1971). He did not view Psychiatry or psychotherapy as inherently evil or oppressive; rather, he sought to explain that these institutions reflected social constructions and were amenable to reinterpretation (Foucault, 1971).

The feminist sociologist Kate Millet contributed to the anti-psychiatry movement by writing about her experiences under Psychiatric care (Murray, 2014). Through recounting her experience with a diagnosis of Bipolar Disorder and her subsequent difficulties in Psychiatric treatment, Millet claimed that she grew to see her condition as an integral an indispensable

component of her personality (Millet, 1990; Murray, 2014). After enduring involuntary commitment at the request of family members, Millet frequently stated that authoritarian constructions of mental normativity such as family hierarchies and enforced confinement interfered with individual self-expression and creative development (Millet, 1990; Murray, 2014). During a speech in 1990, Millet (n.d.) expressed her opinion that involuntary commitments had little place in contemporary practices of mental health:

Just as your physical liberty is taken from you and you are imprisoned without having broken the law or committed a crime, you are henceforth subject to any form of treatment, to forced drugging, to the torments of electroshock and restraint, that is, the brutality of being tied down at your wrists and ankles in leather cuffs that perform the function of shackles (pp. 1-7 at 3).

Millet frequently stated that her Psychiatric treatments dulled her thinking and weakened her sensibilities as a writer (Murray, 2014). She frequently corresponded with female readers who shared similar experiences with Psychiatric treatment, and her efforts influenced Second-Wave Feminism in addition to the Anti-Psychiatry movement (Murray, 2014). Millet's work helped bolster Anti-Psychiatry's advocacy for humane mental health treatment, and her involuntary commitment was followed by comprehensive, legally-mandated changes to institutional Psychiatric care (Murray, 2014).

Despite these changes and the enduring efforts of scholars and activists, many aspects of the Medical Model that were targeted by Anti-Psychiatry endure in modern mental health care (Pilgrim, 2007). In fact, many contemporary psychiatrists view Anti-Psychiatry as a failed revolution that could not follow-through on its many mandates or prove its various claims (Nasser, 1995). Other voices in Psychiatry, however, state that the legacy of Anti-Psychiatry

helpfully endures in the proliferation of mental health advocacy groups and an ongoing shift in focus from institutional treatment to community based-care (Nasser, 1995). Regardless of these conflicting views, themes and propositions woven throughout the fabric of Anti-Psychiatry stand ready to inform a reconceptualization of Psychiatric symptomology. The warnings against complacency towards harmful sociocultural influences on mental health forwarded by Foucault (1971), Laing (1969), and Szaz (2007) are congruent with the admonishments of contemporary scholars such as Climie and Mastoras (2015) and Stearns (2015); the call from Foucault (1971) to view Psychiatric Diagnosis as a flexible, constructed reality that can be adapted and changed is reflected in the work of Hansen (2003), Guterman and Rudes (2008) and Rudes and Guterman (2007); and Millet's choice to take prideful ownership of behaviors stigmatized by the Medical Model is recalled through the work of Clayton (2013), Davidson and Roe (2007), and (Davidson, 2016).

To fortify the last proposition, an examination Ashley Clayton's (2013) writing will conclude this section of the literature review. After being subjected to sexual abuse during childhood, the author often experienced difficulty with regulating her emotions and communicating her emotional needs to loved ones (Clayton, 2013). Ms. Clayton stated that she attempted suicide twice during adolescence and was mandated to ineffective and impersonal treatment both times. Ms. Clayton explained that a subsequent hospitalization left her with little hope for recovery, but her experiences with the new hospital's staff slowly altered her perspective. Clayton detailed a turning point in her treatment that occurred during an art therapy exercise, stating "we had to write things we knew to be true about ourselves on pieces of paper that we placed in the bag. I wrote these words on the outside: *Outspoken. Stubborn. Creative.*

*Difficult. Rude. Slut. Feisty. Opinionated. Bitch.*” (Clayton, 2013, p. 624). Clayton continued her story by recounting the reaction of a hard-nosed Psychiatric nurse who observed the endeavor:

Jessica, who had long, chestnut colored hair like mine, read these words on the outside of my paper bag. Then, she looked at her colleague and chuckled. “Do you know who this reminds me of? Me!” she said.

Jessica and I had often butted heads, but that day, her lighthearted aside surprised, delighted, and puzzled me. In the language of Psychiatry, Jessica would be described as “high functioning” and “well-adjusted”- unlike me. Yet she recognized herself in the words I had written on my bag! (Clayton, 2013, p. 624).

Clayton stated that her relationship with Nurse Jessica improved dramatically from that point onwards, and that the trust she subsequently placed in the hospital’s staff helped to improve and reconstruct her self-concept: “I began to see aspects of myself in Jessica and the other staff...I worked incredibly hard on my recovery in this hospital” (Clayton, 2013, p. 624). Clayton discharged from the hospital several months later, and at the time of her writing, she served as a researcher in Community Psychiatry at Yale University’s Program for Recovery and Community Health (Clayton, 2013).

### **Person-Centered Care in Mental Health**

If the Anti-Psychiatry movement’s legacy is intact, it is perhaps best represented in the Person-Centered Care movement in Psychiatry and related mental health disciplines. Like Anti-Psychiatry, the Person-Centered Care movement urges mental health practitioners to look beyond symptomology and deficits (e.g.; Davidson et al., 2007; Davidson & Roe, 2007; O’Brien et al., 2001). Both movements are characterized by a call to understand mentally individuals in context, and focus on the strengths, values, beliefs and hopes of mentally ill people in addition to their

problems and challenges (e.g.; Davidson & Roe, 2007; O'Brien et al., 2001). Adherents from both movements have advocated for a reduced power differential between clients and practitioners and warned against the potential harm in identifying clients with diagnostic labels (e.g.; Davidson & Roe, 2007; O'Brien et al., 2001). Finally, adherents to both the Anti-Psychiatry and Person-Centered Care movements have recognized the dangers of misapplied institutional power, particularly in the case of inpatient and involuntary care (e.g.; Borg, Karlsson, Tondora, & Davidson, 2009; Laing, 1969; Murray, 2014; Szaz, 2007). The Person-Centered Care movement is distinct from Anti-Psychiatry, however, in that it places special emphasis on galvanizing community and social supports for mentally ill individuals and setting a distinction between recovery *from* and recovery *in* mental illness (Borg et al., 2009; Davidson & Roe, 2007).

In a review of literature on the long-term prognosis of individuals with severe mental illness, Davidson and Roe (2007) determined that 25% to 65% of each sample surveyed experienced the attenuation of symptomology to a degree that allowed the resumption of everyday personal, interpersonal, and vocational functions. The authors also discovered that approximately 25% of each sample demonstrated a “classic Kraepelinian deterioration over time” (Davidson & Roe, p. 462), with the remaining 35% to 75% of each sample experiencing partial amelioration of symptomology (Davidson & Roe, 2007). The authors conceptualized the 25% of each sample that experienced full recovery as being in recovery *from* mental illness (Davidson & Roe, 2007). The authors suggested that such individuals might benefit from treatment in much the same way that individuals profit from the treatment of physical ailments (Davidson & Roe, 2007). The authors also concluded that individuals who recovered from mental illness would respond well to routine assessments and psychoeducation about treatment

options and their various side effects (Davidson & Roe, 2007). Despite this seemingly positive appraisal of recovery from mental illness, the authors voiced their concern that major to total amelioration of symptomology would not protect individuals from the social impact and stigmatizing effects of mental illness (Davidson & Roe, 2007). Regardless, the authors stated that recovery from mental illness generally involves the removal of obstacles to an individual's aspirations and goals (Davidson & Roe, 2007).

The remainder of each sample that did not experience progressive deterioration was conceptualized as experiencing recovery *in* mental illness (Davidson & Roe, 2007). The authors contrasted this condition to recovery from mental illness by stating that it was more resistant to treatment, and that individuals who experience recovery in mental illness would initially struggle with limited gains "in much the same way that repeated doses of Tylenol do little in the face of an infection" (Davidson & Roe, 2007, p. 463). The authors did not recommend a fatalistic acceptance of limited gains, however; rather, they advocated continued engagement and treatment coupled with a focus on enjoying and experiencing life within the parameters of enduring symptomology (Davidson & Roe, 2007). The admonishment to maximize quality of life within the confines of mental illness was stated as follows:

To be "in recovery" from addiction and/or mental illness refers to the process of living one's life, pursuing one's personal hopes and aspirations, with dignity and autonomy, in the face of the on-going presence of an illness and/or vulnerability to relapse (Davidson & Roe, 2007, p. 464).

The authors reiterated that recovery in mental illness benefits from the pursuit of normative life activities including the attainment of education, vocational duties, romantic and sexual relationships, the development of spirituality, and involvement in community affairs that



transcend the boundaries of diagnosis and treatment (Davidson & Roe, 2007). The authors also likened such endeavors to the efforts of paraplegic individuals to learn new methods of mobility while continuing to engage in restorative treatment: “While not preferable, it is nonetheless possible to have a life without the use of one’s legs (Davidson & Roe, 2007, p. 465).

Other scholars identified fundamental differences between Person-Centered Care models and deficit-focused paradigms such as the Medical Model. Borg et al. (2009) identified salient characteristics of ineffective mental health treatment that included a focus on diagnoses instead of a holistic view of individuals, an emphasis on symptoms and deficits instead of strengths and abilities, and the utilization of restrictive environments instead of diverse community settings (Borg et al., 2009). Conversely, the authors reviewed a series of Person-Centered human service programs for individuals with developmental disabilities, and identified five common components between them: a) clients were the primary drivers of treatment planning, b) romantic partners and other social supports were actively involved with the treatment process, c) treatment plans focused on strengths and abilities rather than symptom reduction, d) concerted efforts to arrange access to integrated community environments instead of settings restricted to disabled individuals, and e) an acknowledgement that ambiguity, setbacks, and disputes are naturally expected in the pursuit of self-determination (Borg et al., 2009). Borg et al. (2009) also reviewed qualitative studies of individuals who progress through degrees of recovery from mental illness, and identified four commonalities that inform Person-Centered Care: a) recovery involves individuals taking the initiative in managing symptoms and pursuing life goals, and recovery-oriented care requires practitioners to support clients in these endeavors, b) recovery is less about symptom relief and more about adapting to current circumstances and overcoming barriers related to both the illness and social stigma, c) recovery is a systematic and social

undertaking which incorporates individual perspectives, environmental perspectives, and the interplay between them, and d) recovery depends on both the development of strengths and abilities and the resolution and reduction of problems (Borg et al., 2009).

The process by which social supports are integrated into the treatment process is another foundational feature of Person-Centered Care (Borg et al., 2009). Person-Centered planning requires the regular and continuous gathering of clients and their primary support systems for the purpose of “reconstructing” (Borg et al., 2009, p. 87) clients’ histories, identifying strengths, values, positive changes, and hopes for the future, and developing plans for actualizing these hopes (Borg et al., 2009). These gatherings are generally led by a “facilitative advocate” (Borg et al., 2009) who catalyzes the development of these plans while safeguarding them from doubts and demands imposed by clients’ social and therapeutic supports (Borg et al., 2009). During the process of constructing personal histories, strengths and values, and treatment plans, the facilitators utilize interview questions designed to elicit all-inclusive perspectives of their clients that transcend issues of mental illness. Typical interview questions include:

What is the person’s history? What is your dream for the person? What is your nightmare? What are the person’s strengths, gifts and abilities? What does the person need in order to overcome the limitations of his or her illness? What would the person’s ideal day look like, and what must be done to make it happen? (Borg et al., 2009, p. 87)

While conceptual and Qualitative investigations of the principles of Person-Centered Care are fairly common (Beckett et al., 2013; Borg et al., 2009; Flanagan, Miller, & Davidson, 2009; Mezzich et al., 2010; Watson, Bonham, Willging, & Hough, 2011), Quantitative investigations of the strength and efficacy of Person-Centered care are underrepresented in the current literature. As of September 2017, a comprehensive search revealed one randomized

control trial and one published protocol for a study currently in development. The randomized control trial implemented Person-Centered planning as an enhancement of illness management for a sample of 300 Latino and African American individuals with Psychotic Disorders. The facilitative component of care planning was associated with an increase of participants' sense of responsiveness of the treatment and the degree to which the treatment incorporated essential life goals and contextual matters (Borg et al., 2009; Tondora et al., 2010). Furthermore, the care planning process was associated with an increase in participants' sense of control over their treatment and lives (Borg et al., 2009; Tondora et al., 2010).

While scholars of Person-Centered Care does not directly investigate the duality of Psychiatric symptomology, many of its guiding principles and philosophies are congruent with strengths-based conceptualizations of diagnosis as described by Climie and Mastoras (2005) and Stearns (2005). The Person-Centered paradigm focuses on the development of strengths in addition to the remediation of symptoms, develops hopes and possibilities instead of concentrating on deficits and limitations, and takes a holistic view of mentally ill individuals that involves advocacy and support (Borg et al., 2009; Mezzich et al., 2010). Furthermore, the Person-Centered model includes the integration of community resources and personal support figures into the treatment process, and these factors uniquely inform the subject of the current study.

### **Summary**

Multiple researchers have investigate the hidden, adaptive benefits of Mood Disorders. Two frequently researched concepts are Defensive Pessimism and evolutionary models of Depression. Empirical investigations of these concepts have yielded mixed results. Studies of the correlation and overlap of creativity and psychopathology, however, have proven more

significant. Strong correlations between creative ability and psychopathology have been discovered in psychotherapeutic, educational, and neuroscientific literature. Anti-Psychiatry questioned the foundational assumptions of Psychiatric diagnosis while challenging mental health practitioners to adopt humane, respectful, and holistic positions towards mentally-ill individuals. Lastly, the Person-Centered Care movement built upon the essentials of Anti-Psychiatry while advocating for integrated community support and the incorporation of personal supports in the treatment process.

### **Chapter Three**

The purpose of this chapter is to explain the design and methodology of the current study. Informed assumptions of the study will be reviewed, and a Qualitative approach will be proposed that includes the theoretical perspectives of Social Constructionism and Narrative Analysis.

#### **Guiding Assumptions of the Current Study**

Excepting studies of the adaptive benefits of Mood Disorders, literature on the positive aspects of Psychiatric symptomology are purely conceptual, editorial, or theoretical in nature (Clayton, 2013; Climie & Mastoras, 2015; Stearns, 2015b; Winter-Messiers et al., 2007). Despite this limitation, numerous themes and principles found in closely related literature were used to bolster rationale and shape the research questions of the proposed study. These themes and principles include:

- the assumption that symptoms associated with Psychiatric diagnosis are not merely indications of disease, and have positive or beneficial aspects (Keller & Nesse, 2005; Kim, 2016; Norem & Cantor, 1986; Stearns, 2015)

- the demonstrated correlation between creative ability and traits traditionally associated with psychopathology (Carson, 2011; Csikszentmihalyi & Getzels, 2014; De Dreu et al., 2015; Kim & Hull, 2012)
- the assumption that conceptualizing mentally-ill individuals in a holistic, empowering manner will lead to better therapeutic outcomes than deficit-oriented approaches alone (Borg et al., 2009; Davidson et al., 2007; Laing, 1969; Mezzich et al., 2010)
- the assumption that supporting mentally ill individuals who have not fully recovered in enjoying and experiencing life as fully as possible will lead to positive therapeutic outcomes, greater client satisfaction, and quality of life for clients (Borg et al., 2009; Davidson & Roe, 2007).
- the assumption that discourses on mental illness and wellness are, in large part, socially constructed and capable of being revised and reconstructed to empower marginalized individuals (Bracken & Thomas, 2010; Gergen, 2015; Laing, 1969; White, 2008).
- the assumption that discourses of mental illness are specifically shaped by professional institutions and other power structures that benefit from the resulting developments (Bracken & Thomas, 2010; Foucault, 1971; Szaz, 2007).
- the assumption that therapeutic interventions that integrate mentally ill individuals into broad community structures rather than limiting them to narrow, restrictive ones will produce greater therapeutic outcomes and better quality of life for clients (Paul Beckett et al., 2013; Borg et al., 2009; Davidson & Roe, 2007).

- the assumption that incorporating personal support figures into mental health recovery efforts will lead to greater therapeutic outcomes and better quality of life for clients (Borg et al., 2009; Davidson, 2016; Davidson et al., 2007)

### **Theory**

Two theoretical perspectives were utilized to investigate the current research problem. The first perspective is Social Constructionism, which conceptualizes human understandings of reality as co-created through language and social relationships rather than recognitions of an objective, independent mode of existence (Guterman, 1994; Rudes & Guterman, 2007). The second proposed theoretical perspective is Narrative Analysis, which examines human experiences, ideas, hopes and feelings through the study of personal narratives (Riessman, 1993, 2008).

#### **Social Constructionism**

A Postmodern school of thought that branches across multiple disciplines, Social Constructionism posits that human perceptions of reality are largely subjective, relationally-defined, and constructed through the communal use of language systems (Gergen, 2015; Guterman & Leite, 2006; Rudes & Guterman, 2007). Social Constructionism is further characterized by features that include the notion of multiple realities existing simultaneously, a decentralized and fluid concept of individual identity, and a recognition of sociocultural influences on the development of individual identity (Freedman, 1996; Gergen, 2015; Rudes & Guterman, 2007; White, 2008). Guterman (1994) pondered a Social Constructionist perspective on the “reality” of Psychiatric diagnosis:

When the concept of reality is referred to in Psychiatric discourse, this is rarely the reality of a thing per se, i.e., its basic properties, if such do exist, or even what is simply

observable, though this is the ostensible subject. Rather, the "reality" referred to concerns . . . the meaning and value attributed to the phenomenon in question. This is a far cry from the simplistic but widespread assumption that there is an objective reality, somewhere "out there," and that sane people are more aware of it than crazy ones. On reflection it becomes obvious that anything is real only to the extent that it conforms to a definition of reality--and those definitions are legion (p. 229).

A Social Constructionist framework is appropriate for this research, as many critiques of the Medical Model have examined both the sociocultural factors that shape diagnosis and the negative effects that mental health consumers experience as a result (e.g.: Ali, 2004; Eriksen & Kress, 2008; Honkasilta et al., 2015; Stearns, 2015). Furthermore, the matter of personal identity and how it is shaped by external factors is germane to both the research problem and a Social Constructionist epistemology. An additional tenet of Social Constructionism unique to the field of mental health will inform this research; specifically, the idea that human beings are inherently capable of redefining their relationship to problematic narratives of identity (de Shazer, 1994; White, 2008).

### **Narrative Analysis**

Clandinin (2013) characterized Narrative approaches to Qualitative research in the following manner:

The focus of narrative inquiry is not only valorizing individuals' experience but it is also an exploration of the social, cultural, familial, linguistic, and institutional narratives within which individual experiences were, and are, constituted, shaped, expressed, or enacted (p. 17).

Narrative approaches to Qualitative research examine human experiences as they are illustrated in lived and told stories of individuals (Creswell & Poth, 2018). Narrative Analysis is grounded in a philosophy of social justice that challenges dominant social perspectives and practices (Fraser, 2004), and is frequently utilized to examine multiple perspectives of social phenomena that elicit a “plurality of truths” (Fraser, 2004, p. 181). Researchers utilize Narrative Analysis to identify and strengthen suppressed perspectives on social phenomena that challenge dominant knowledge and practices (Fraser, 2004). In these aspects, Narrative Analysis shares fundamental ground with paradigms including Critical Theory, Queer Theory, and Feminist approaches to Qualitative research (Fraser, 2004). In other aspects, however, Narrative Analysis is distinct and unique among approaches to Qualitative research.

For instance, Narrative Analysis is characterized by a friendly and informal data collection process which permits discussions that might seem irrelevant or extraneous in other Qualitative methodologies (Fraser, 2004). The Narrative data collection process is highly reflexive, and incorporates dialogue and exchanges of ideas between researcher and participant (Fraser, 2004). Narrative interviews deprioritize the use of structured interview questions in favor of an approach that privileges participant perspectives and narration (Fraser, 2004). The Narrative style allows participants to control the flow of conversation and refrains from prematurely judging the content or direction of discussion (Fraser, 2004).

Though methods exist for conducting Narrative Analysis –which is alternately referred to as Narrative Inquiry (Clandinin, 2013)- the proposed study will be informed by processes and guidelines set forth by Fraser (2004) and Riessman (1993, 2008). To best preserve the aims of Narrative Analysis while containing the possibility of paradoxical harms brought on by researcher positionality, Fraser (2004) created a seven-phase research protocol for



conceptualizing and executing Narrative research. Fraser's protocol informed the process and structure of the study, and specific techniques and methods of data analysis were informed by Riessman (1993, 2008).

In phase one of Fraser's protocol, researchers listen attentively to participant stories while both parties attend to each other's emotional responses to the interview process. During this phase, researchers attend to participant emotions through an awareness of body language and the affective content of discussion (Fraser, 2004). Researchers may keep a journal to reflect on their emotional responses to interviews, listen to interviews as if they are "radio shows" (Fraser, 2004, p.186) to create new ways of conceptualizing narratives, and take note of points of agreement and disagreement between researcher and participant (Fraser, 2004). Later actions of the first phase include considering how interviews start, unfold and finish as a means of conceptualizing narratives (Fraser, 2004).

In the second phase of Fraser's protocol involves the transcription of interview material. Researchers decide whether to "clean up" (Fraser, 2004, p. 187) the transcriptions by removing extra-verbal expressions including pauses, stammers, and backchannels; for the purpose of the proposed research, these expressions will be included in transcriptions in alignment with methods endorsed by Riessman (2008). To ensure that participants remain in control of their own narratives, they are given an opportunity to review the final transcript prior to analysis; however, they are under no obligation to do so (Fraser, 2004).

The third phase of Fraser's protocol involves interpreting individual transcripts. During this process, researchers examine themes that arise in the dialogue, or when narrators emphasize a salient point (Fraser, 2004). Researchers take note as to whether stories appear to be well-rehearsed or spoken with difficulty, and take note of moments when participant body

language and the emotional content of their stories are in conflict (Fraser, 2004). The interview text is disaggregated into narrative components; these segments can be analyzed through chronological, thematic, syntactic, or plot-driven development (Fraser, 2004; Riessman, 2008). In order to provide conceptual clarity, disaggregated data are marked by numbered sentences, clustered into narrative units, and given names (Fraser, 2004). Additionally, the evolution or consistency of the narrator's syntax is examined by analyzing the stories in "stanza" form; this process is similar to methods of analyzing works of literature (Fraser 2004; Riessman, 2008).

In the fourth phase of Fraser's protocol, the disaggregated narratives are probed across interpersonal, intrapersonal, cultural and structural dimensions (Fraser, 2004). *Intrapersonal* dimensions generally involve narrators' mind-body experiences, *interpersonal* dimensions typically involve engagement between narrators and others, *cultural* dimensions are roughly defined as the narrators' experiences with overarching sociocultural conventions; lastly, *structural* dimensions share traits with the previous domains but focus on narrator experience with policies, laws, and rules that enforce sociocultural norms. Whereas the cultural dimension might involve references to pop culture, "old wives tales," and media conventions, the structural dimension places focus on institutions that enforce the guiding ethos of society and culture (Fraser, 2004).

The fifth phase of Fraser's protocol involves linking "the personal with the political" (Fraser, 2004, p. 193). After narratives have been codified and analyzed across the four dimensions, Narrative researchers consider how dominant cultural discourses can be utilized as a framework for interpreting and contextualizing participant narratives (Fraser, 2004; Riessman, 2003). Particular focus is afforded to references made to established linguistic conventions such as "recovery," "coming out," and "falling in love." (Fraser, 2004, p. 193).

In the sixth phase of Fraser's protocol, researchers peruse transcripts for commonalities and differences among participant narratives (Fraser, 2004). This process can involve comparing and contrasting the style, subject and tenor of individual participant narratives (Fraser, 2004). If powerful, rich, and broad comparisons and contrasts are identified, storylines and themes can be collected across participants for intensive analysis (Fraser, 2004). Researchers also explain their criteria for how such narrative components are aggregated, and tie these narrative clusters to the dominant social discourses identified in phase five (Fraser, 2004). Researchers may also choose to emphasize narrative interpretations that are "inconsistent, counter-intuitive, surprising or anomalous." (Fraser, 2004, p. 195).

In the seventh and final phase of Fraser's protocol, Narrative researchers edit and evaluate the scholarly quality of their findings while reflexively positioning themselves to the final product (Fraser, 2004). While admitting that multiple truths can be culled from participant data, researchers hone and question their findings to ensure they are ready for formal presentation (Fraser, 2004). These questions include, but are not limited to: Are the analyses congruent with the research questions? If not, is it logical to alter the questions in order to properly reflect participant narratives? Are the interpretations repetitive? Has the researcher considered personal biases that might undermine the credibility of their claims? Do the analyses sustain a respectful position towards participants, and if not, how does the researcher justify their position? Are the interpreted narratives fair, and do they understate or romanticize participant narratives? (Fraser, 2004).

Narrative Analysis rests on many philosophical principals that make it appropriate for the proposed study. Specifically, its focus on subjective and intersubjective constructions of reality, the collaborative and responsible collection of data, potential power differentials that affect

observation and analysis, and an emancipatory process that grants a voice to marginalized people are highly congruent with the guiding assumptions of the proposed research (Riessman, 1993). Additionally, Narrative Analysis allows for intercomparisons between participants, as it encompasses techniques for analyzing samples as a whole, subgroups within samples, and individual comparisons (Riessman, 1993). As a homogenizing analysis of data could potentially and ironically marginalize participants, these aspects of Narrative Analysis added accountability and credibility to the research endeavor. Finally, the tenets of Narrative Analysis are highly congruent with the philosophy and ethos of Social Constructionism.

### **Trustworthiness and Credibility**

The principles of trustworthiness and credibility and their enforcement in Qualitative research are contested in Narrative approaches, as some scholars consider them to be irrelevant or perpendicular to the social justice foundations of Narrative Analysis (Loh, 2013). In fact, some proponents of Narrative approaches are more concerned with researcher trustworthiness (e.g.; refraining from exploiting or marginalizing participants) than participant trustworthiness (Fraser, 2004; Fraser & MacDougall, 2017). However, other researchers afford a place for trustworthiness and credibility in Narrative Analysis that privileges academic rigor while remaining faithful to doctrines of social justice (Fraser, 2004; Fraser & MacDougall, 2017; Loh, 2013). Though scholars of Narrative Analysis argue that determining what “really happened” to participants is of less importance than how they organize and present their personal storylines, methods and styles of promoting credibility can be promoted while researchers honor and respect participant voices (Fraser, 2004; Loh, 2013). The proposed study utilized the following methods of safeguarding trustworthiness that are both promoted in relevant literature and respectful of participant experience:

- **Reflexive Positioning:** As the process of data collection and interpretation is conceptualized as a co-constructive between researcher and participants in Narrative Analysis (Fraser, 2004), I positioned myself to participants in accordance with my clinical experience. As a counselor, I have worked with individuals who are diagnosed with each condition presented in the literature; furthermore, I have worked as a clinical mental health counselor in a broad variety of settings. As I have extensive experience in working with diagnosed individuals in multiple contexts, I stood ready to address any concerns or problems with the narratives during the data collection process. The members of the Magnificent Seven, however, proved to be more than knowledgeable about the nature and treatment of their various disorders, and I did not identify any immediate concerns regarding trustworthiness.
- **Member Checks:** Member Checks are an appropriate method for attaining trustworthiness in narrative approaches (Loh, 2013). Participants were given an opportunity to review data both after it was aggregated and before it was published in its final form, and their reactions to the analyses were included as data with participant consent.
- **Peer Briefing:** Peer Briefing is a suitable means of pursuing trustworthiness in Narrative Analysis (Loh, 2013). As it is necessary to pursue trustworthiness and credibility of research in a manner that is congruent with the philosophical aims of Narrative Analysis (Fraser, 2004; Fraser & MacDougall, 2017; Loh, 2013), I sought out the assistance of two professional volunteers who are well versed in both clinical mental health and social justice advocacy for marginalized communities.

- **Triangulation of Data:** Triangulation of data is a suitable method of ensuring credibility in Narrative Analysis (Loh, 2013). As Narrative Analysis privileges an ongoing dialogue between participant and researcher (Fraser, 2004; Fraser & MacDougall, 2017), the proposed elicited data from participants at multiple points in time. Data was obtained through semi-structured interviews, follow-up electronic and written correspondence, and written reflections of the research process authored by the me. As Narrative practitioners recommend that researchers engage in events and efforts that are meaningful to participants (Fraser, 2004; Fraser & MacDougall, 2017), I as a participant-observer and recorded a personal narrative of the supportive events to be utilized in data analysis. Themes, salient points, and pivotal events and experiences were tracked across this ongoing spectrum of data collection.

### **The Compatibility of Social Constructionism and Narrative Analysis**

Narrative Analysis and Social Constructionism share a rich and progressive scholastic heritage. Both perspectives are informed by Jerome Bruner (1993), who argued that social identities, language, and meaning-making processes are developed through intersubjective and collaborative processes between individuals and communities (Bruner, 1990; Gergen, 2015; Riessman, 1993). Both perspectives acknowledge that individual realities and meaning are influenced by sociocultural mores and power structures inherent to relationships and organizations (Gergen, 2015; Riessman, 1993). Both perspectives maintain that responsible research depends on collaborative construction between scholars and participants that is mindful of such mores and power differentials (Gergen, 2015; Riessman, 1993). In the narrativization of data collected in the current study, a focus was placed on potential power differentials between

the researcher and participants; furthermore, the participants and I worked collaboratively to identify social discourses and institutions that were meaningful and/or impactful to participants.

### **Target Population and Participant Selection**

The proposed study utilized purposive sampling. Sample size requirements are highly flexible as Narrative Analysis allows for a wide range of sample sizes. Recommendations for recruitment include sample sizes as small as two to three (Creswell & Poth, 2018); however, other Narrative Analyses are also conducted on a scale congruent with Ethnography with samples as large as 35 (Ginsburg, 1989). The proposed study incorporated approximately 7 participants (hereafter known as the Magnificent Seven). The majority of Qualitative research achieves saturation in the range of 5 to 9 participants (Creswell & Poth, 2018). Participants were recruited through the online listserv CESNET and social media accounts including Facebook and LinkedIn. Criteria for participant inclusion included the following:

- Participants were 24 years of age or older. Though many Psychiatric disorders manifest well before this age, specific disorders identified in the literature review- including Bipolar Disorder and Schizophrenia- typically manifest in young adulthood. The cutoff age ensured that potential participants who identify with these disorders were not automatically excluded from the study
- All participants received a diagnosis congruent with the conditions examined in the literature review; in other words, participants were required to have a diagnosis of ADHD, Bipolar Disorder, Schizophrenia, Depression, Anxiety, a Personality Disorder Diagnosis, or have been placed on the Autism Spectrum.
- Participants spent at least one year without requiring or engaging in inpatient care, and demonstrated current compliance with basic activities of daily living. These

activities included basic grooming and hygiene, the ability to meet basic nutritional and sleep requirements, the ability to maintain meaningful and supportive interpersonal relationships, and the ability to engage in essential community engagement (going to the library, volunteering or part time work, and pursuing entertainment or education with or without supportive figures, etc.)

- All participants were currently satisfied with their lives, though a desire for improvement was permissible.
- All participants consider the symptomology related to their diagnosis to be essential to their personal success, or an integral part of their identity.

### **Data Collection and Analysis**

The researcher obtained permission to gather data through the William and Mary School of Education's Institutional Review Board. Participants engaged in semi-structured interviews that occurred either over the phone or through a televisual program such as SKYPE. All interviews were audio recorded and transcribed. The text was then uploaded to the NVivo Qualitative software platform, which has been noted for its flexibility in processing multiple levels of analysis and its ability to work with expanding and evolving analyses while remaining linked to original data structures in Narrative Analysis (Rich & Patashnick, 2002). Participants' data were also collected through electronic and written correspondence; additionally, I gave a written account of events or reflections that were pertinent to the data collections process.

### **Conclusion**

The current research did not seek to upend and supplant the concept of Psychiatric diagnosis; however, it was highly informed by generations of critique regarding the relationship between Psychiatric diagnosis and the Counseling profession. After reviewing the evidence, I



was inclined to recount the words of Lafrance & McKenzie-Mohr (2013) who stated that “despite its lure, a biomedical construction of ‘mental illness’ all too frequently fails to protect individuals from delegitimation and stigma” (p. 119). On the other hand, when I considered the significant benefits that antidepressants provide to the severely depressed (Johnson & Kirsch, 2008), the pride with which advocates from within the Autism community wholeheartedly embrace their identity (Cascio, 2012; Greenberg, 2013) and the life changing effects that medications such as Risperdal can produce for severely mentally ill individuals (Harrison & Goa, 2004), I could not fully support the conclusion that any paradigm “that requires solutions that focus on radical social change” will inevitably improve on the Medical Model (Lafrance & McKenzie-Mohr, 2013, p. 136). Hallucinations, delusions, and depressive episodes are not likely to be scared away by hiring initiatives, person-first clinical language, or improved population depiction in popular media.

Rather, this research endeavor sought to illuminate an entryway to a middle path between the Medical and Counseling Models. By examining the experiences of people who harnessed Psychiatric symptomology for success, this research project sought to reveal a hidden angle of the age-old story of diagnosis: a perspective that privileges client viewpoints, personal skills and resources, and empowering aspects of traits that have been strictly pathologized for generations. In light of the previously mentioned self-fulfilling properties of Psychiatric diagnosis, I recall Paul Watzlawick’s (2001) opinion on the subject: “A self-fulfilling prophecy is an assumption or prediction that, purely as a result of being made, causes the expected or predicted event to occur and thus confirms its own ‘accuracy’.” (p. 95). If this statement is true, then perhaps investigation of how Psychiatric symptomology can be both blessing and curse could change the way it is experienced by millions of people in the future.

## **Chapter Four**

After receiving approval from the William & Mary School of Education's Institutional Review board, I set out to recruit a sample. Calls for participation were posted on the CESNET listserv for Counselor Educators; two individuals with whom I had no prior relationship, Amanda and Patricia, were recruited through these posts. I also placed requests for participation through social media. Though I posted on both Facebook and LinkedIn, the remaining five participants were personal acquaintances and friends recruited through my Facebook page. For the sake of preserving participant anonymity, specific details about my relationships with these five participants will not be provided. One was an old friend from college, three were friends and former colleagues from my days as a theater artist in the city of Atlanta, and one was a former college professor. After receiving signed informed consent documents from all participants, I began enacting the phases of Fraser's (2004) protocol.

### **Phases One through Three**

To satisfy requirements for the first phase of Fraser's protocol, I kept a journal of reflections on each of my interviews. I engaged each participant in one semi-structured interview, all of these encounters ranged in time from approximately 45 minutes to approximately 80 minutes. Participants were given the choice to conduct the interview over Skype, Signal, or the telephone; four participants were interviewed over Skype, three were interviewed over the telephone. After initial interviews were concluded, I listened to the audio recordings and wrote my reactions down in a journal.

To satisfy requirements for Phase Two of Fraser's protocol, the decision was made to transcribe all audio recordings verbatim. Backchannels, stammers, and shifts in speech were all recorded in print by transcriptionists at Rev.com. I originally intended to classify participant

narratives accordingly by marking times in the stories where participant speech was either labored or delivered in a natural, flowing manner. Due to the richness and expansiveness of participant data, however, only one such classification was included in chapter four as the dimensions of theme and plot became increasingly important and manifold. To maintain structural clarity, however, I indicated whether each excerpt of the participant narratives were spoken aloud or written over email. As for my own contributions to the interviews, encouragers such as “go on,” “mmm-hmm,” and “okay” were edited out of the transcription process while my dialogue that shaped a turn in participant narratives or emphasized important themes was included in the final draft.

I completed Phase Three of Fraser’s protocol by disaggregating participant narratives on NVivo 12.0 software. Cases were created for each of the seven participants; from these cases 78 separate codes were generated. During this process, I attempted to arrange the nodes along thematic, plot-driven, and chronological structures. Common themes and plot points readily arose from the data; however, a chronological order proved far more difficult to identify. Though the participants had shared many experiences, feelings, thoughts and developments in their narratives, these factors were largely arrayed at varying time points in each participant narrative. For this reason, the decision was made to organize the data along thematic and plot-driven lines rather than matching up participant accounts in chronological order. After applying this organizational structure to the data, nodes were condensed to five factors that represented crucial plotlines, two factors that identified crucial themes in participant narratives, and two factors that represented barriers to and influences on participant development.

### **Phases Four Through Seven**

After the disaggregated data was assembled into codes, I reviewed the notes in my journal. Following this, participant narratives were examined along the multiple dimensions described in Fraser's Fourth Phase. After the results of this process were reviewed, I drew up a list of follow-up questions for every member of the Magnificent Seven. These follow-ups were sent to the Magnificent Seven over email. Participants were again given a choice; this time to respond to the questions through a second interview, their own pre-made audio recording, or through email. Two participants responded via email, two made their own audio recordings and emailed them to me, two responded over a telephone follow-up, and one responded over Skype. After listening to or reading the follow-up responses, I again processed my reactions through journal entries. To illustrate the impact of my reflexive position, I have included excerpts from my journal entries at various points in Chapter Four. These excerpts are marked with the phrase "Researcher's Note" at various points in Chapter Four. Responses to the follow-up questions were also coded along the dimensions enumerated in the Fourth Phase.

After the follow-up responses had been coded and analyzed across dimensions, I began writing up the research results. Upon the completion of Chapter Four, the finished material was sent out for peer review and member checks. All member check responses focused on making changes to preserve the anonymity of members of the participants' support systems, no objections were raised to the coding or analysis. One peer reviewer suggested a "thickening" of the initial descriptions of the Magnificent Seven and addressed the lack of expository language for the purpose of fully situating client narratives, another complimented the thorough application of Fraser's protocol and expressed her opinion that the document was ready for

defense. All feedback from peer review and member checks were incorporated into the current draft of the research.

### **Description of the Participants**

“Amanda” is a 26 year old woman living with Generalized Anxiety Disorder. Originally from a small town in New England, she is currently pursuing a doctoral degree in Counselor Education from a public university in the Midwest. Amanda possesses a strong Christian faith, is devoted to all members of her immediate family, and has rich and varied experience in a number of physical and artistic endeavors like group leadership, acting, writing, cheerleading, and dancing. Amanda also identifies as a recovering binge eater and has sought professional mental health assistance for both disorders.

*Researcher’s Note: The minute Amanda’s face popped up on my Mac’s Skype App, I felt both relaxed and excited to begin- her friendliness and enthusiasm for the project were written all over her face. Amanda’s blue eyes sparkled as she spoke, and her hands swished and swayed across the screen as she used them to emphasize points and convey her emotional reactions to the interview. Amanda is one of those people- how do I say this? If I sought counseling for a problem but wasn’t sure about how it would turn out, and I walked into the room and saw Amanda sitting there, I would instantly think, “Yeah, this is gonna be okay. This is someone I can talk to.*

“Patricia” is a 52 year old woman living with Schizoaffective Disorder. She lives in the state of her birth which is located in the northern mid-Atlantic region of the eastern US. Patricia is currently pursuing a masters’ degree in clinical mental health counseling- complete with a 3.8 GPA- and is preparing for her practicum. A fiercely strong-willed woman, Patricia has a long and storied educational and employment record that was not restrained by her disorder. Prior to

enrolling in her masters' program, Patricia earned an Associate's degree in Criminal Justice and a Bachelor's degree in Human Services. Patricia also worked long-term as a customer service agent, and successfully ran a housecleaning operation for a number of years prior to returning to school for her Master's degree.

*Researcher's Note: If you are lucky in life, you will get the chance to befriend a vibrant, down-to-earth, worldly-wise woman whose voice is caked over with decades of cigarette smoke and powerful wisdom. If you're really lucky, this woman will like you well enough to advise you, and might kick off a truly inspirational talking-to by taking a long drag off her cigarette and saying, "Sweetheart, let me tell you something you should never forget..." What I mean by all of this is that Patricia is that person.*

"George" is a 61 year old male living with Bipolar II Disorder on the West Coast of America. He is married and in a child-free union. George has extensive experience as a teacher in both primary and secondary education; however, he is currently a Jazz pianist and a piano instructor. A true renaissance man, George has steadily honed his prodigious talents for musicianship, writing, drawing, and scholarship over a period of decades. George previously worked as a professor of theater history at the University level and taught a number of subjects in various institutions of primary education in the state of California.

*Researcher's Note: Experience has taught me that there are two types of Nutty Professors- A) the eccentric and most likely lecherous asshole who nevertheless possesses good showmanship. You know the type, this professor is constantly producing and achieving but somehow manages to burn bridges way faster than he/she can build them, and B) The genius with a heart of gold whose quirky sense of humor, slight absentmindedness, and genuine love of*

*teaching (and his/her students) makes them someone every university kid wants to learn from. I've gotten to know both types pretty well, and George is one of the latter.*

“Kitten” is a 45 year old woman living with Generalized Anxiety Disorder and working as an actor in Los Angeles. Kitten is married and in a child-free union. Native to the dusty plains of south Georgia, Kitten moved to the city of Atlanta as a young adult and made a home for herself in the local theater community. She has also worked as an actor in the city of Chicago, and has practically made a second career as a supportive assistant for bands, solo musicians, performance artists- any artistic professional she befriends who could benefit from her help. For years, she could be found helping to sell artists’ merchandise at the legendary Dragon\*Con in downtown Atlanta.

*Researcher’s Note: I was quite enamored of Kitten when we first met, but I think that’s par for the course. Just to meet her is to crush on her. She was always dressed in dramatic, dark colors, she had piercing hazel eyes that could light up a coal mine, and her infectious giggle could bring a smile to anyone’s face. She looked like the sort of girl who could put a knife to your neck when angered, but in reality she’s one of the sweetest people I ever met. I still wouldn’t want to make her angry, but she’s a cherub. Not only that, she’s a voracious reader, performer, and helped write the first edition of my favorite role playing game of all time.*

“Astrid” is a 35 year old Autistic woman living in New York City. She is a professional stage manager for theatrical productions and has been working in this capacity since her student years as a Theater Major over a decade ago. Astrid is highly involved in a number of advocacy efforts for Autistic individuals and has authored educational material for parents of young autistic girls. Originally from the Midwest, Astrid has also lived in the deep south, is an alumna of a

famously large southern public university, and has been a resident of New York for over ten years. She is the author of an incredibly intelligent blog and a cat lover.

*Researcher's Note: I've known Astrid for a long time, and the phrase that always comes to mind when I think of her is "still waters run deep." Astrid has a serene, quiet friendliness about her, and like Amanda, she's one of those people who make you feel like you can open up fairly quickly. Don't let her pleasant aura completely fool you, however. When she gets mad, as she sometimes does when detecting unfairness, ugliness, and willful ignorance in adversarial types, she could easily show up with charts, graphs, logs, and portfolios to obliterate your premises before you even understood you were in an argument. Astrid is one of the top three most brilliant people I think I've ever met.*

"Faith" is a 35 year old woman living with Attention Deficit Hyperactivity Disorder in a major metropolitan area in the American south. She works as the Community Outreach Coordinator in a Community Health Center and is also a freelance grant writer. Faith is currently engaged to her long term partner, Samara, and has a bright-eyed five year old daughter from a previous relationship. She also has experience as an actor and has worked professionally in both Los Angeles and Atlanta.

*Researcher's Note: Faith was another one who everyone crushed on at one point or another. Her sunny, loving personality rubs off on everyone she meets, and I can't think of a single person who knows her who would tell you otherwise. Seriously, she has that Michael-Landon-on-Little-House-on-the-Prairie-Hi-There-Stranger-Can-I-Help-You-Build-a-House thing down pat. We did one play together almost two decades ago, and even though I haven't seen her since, we keep up regularly on social media because- well, she's just the sort of person you want to be around.*



“Harley” is a 41 year old man living with Post Traumatic Stress Disorder in the San Francisco Bay area. A broad, tall, square-jawed man with an indefatigable smile, Harley is a professional actor and playwright who has performed in Atlanta, San Francisco, Oakland, and New York. A nomad by nature, Harley followed his military family from place to place in his youth and never lost his sense of wanderlust. On an international level he has worked in Russia, Scotland, and Indonesia. Harley is also a puppeteer, a graphic artist, and a Bay Area native. He recently returned to the San Francisco Bay area after living in the city of Atlanta for seventeen years.

*Researcher’s Note: Maybe you’ve heard this story, maybe not- it’s about Andre the Giant. He grew up just outside of Paris some fifty-sixty years ago, and being Andre the Giant, it didn’t take long for him to grow too big to ride the provincial bus to school. So, a kindly old man from his neighborhood who drove to work on a cycle that matched the bus offered to take Andre to school and pick him up each day. That kindly old man was legendary Irish playwright Samuel Becket.*

*What does that have to do with Harley? He’s like both of those guys squished together. He’s big, (though not towering like Andre), he’s contemplative, he’s perpetually existential, and he’s one of the most creative souls you’ll ever meet. He also has a killer dark sense of humor.*

### **Introduction of Themes and Plotlines**

The organization of chapter four is congruent with the research findings as they pertain to Fraser’s protocol (2004). The first section presents the Prologue, in which the participants describe cherished childhood and family memories that are defining of their identity and character. As I will explain, the importance of these stories lies in how they reflect and presage themes and plotlines that comprise the bulk of the research findings. The next five sections-

Emerging Awareness of Difference, Early Struggles with the Problem, Epiphanies of Identity, Duality of the Problem, and Development of Empathy- contain plotlines (i.e., developmental stages) that are germane to each of the Magnificent Seven's personal narratives. In other words, these five stages illustrate salient events, changes and periods of growth that were expressed across narratives when participants described the developmental journeys that enabled them to embrace their diagnoses as personal strengths. The next two sections- Activities of Difference and Persons of Difference- present common factors among behaviors and support figures, respectively, that were described across cases throughout the seven participant narratives. The eighth section of the fourth chapter- Linking the Personal and the Political- presents refined results from the fifth stage of Fraser's protocol, in which participant narratives are examined in the light of social and cultural institutions- i.e., discourses- that influence or shape the terrain of the analyzed plotlines and themes. Finally, the chapter is closed out with a two-part Epilogue, in which participants answer questions that investigate the most important aspects of their personal narratives.

The rationale for organizing Chapter Four in the aforementioned manner requires explanation of contextual factors that influenced the process of data analysis. While the "plotline" sections do address developmental processes that were illustrated across multiple participant narratives, it is important to note that not all participants underwent the same developmental stage at identical- or even similar- points in their personal chronologies. For instance, Amanda experienced an Epiphany of Identity in her adolescence, Faith and Kitten experienced their Epiphanies in young adulthood, and George experienced one in his early thirties. For this reason, plotlines were not arranged in strict chronological order from case to case.

However, it is likewise important to explain that though participant plotlines unfolded at disparate points in the participants' ages, the effects of these plotlines were remarkably similar from case to case. For instance, the idea that Epiphanies of Identity empowered participants to view their diagnoses as points of strength- i.e., they enabled participants to understand the Duality of the Problem- is a core stipulation of the fourth chapter. As most readers may assume, the majority of participants experienced an Epiphany of Identity before they comprehended the Duality of the Problem. In George's case, however, the Epiphany of Identity came after his experience of the Duality of the Problem, which occurred ten years earlier when his "manic confidence" propelled him to play piano with jazz musicians considerably more capable than himself. Despite this chronological anomaly, it is important to emphasize that it was only after George experienced his Epiphany that he was able to reflect on that time of his life and realize a) how his musical development had benefitted from the experience and b) how the experience was a direct result of his psychiatric diagnosis.

Finally, I will offer a word of explanation regarding two subsections of the "Linking the Personal with the Political" segment. These two subsections- Harley and Me, A Deadtime Story and Patricia vs. Institutional Power- are anomalous in that they strictly examine the experience of a singular participant. The rationale behind presenting these subsections was inspired by three factors. Firstly, a primary purpose of Fraser's protocol involves the liberation of oppressed voices that are typically obscured by dominant sociocultural discourses. While the level of oppression and marginalization inherent to Patricia's narrative is quite unique, it intensely and comprehensively reveals how individuals with Psychiatric Diagnoses can be adversely affected by multiple forms of institutional power. Therefore, I made the decision to present key portions of Patricia's history of wrestling with authority in a singular and standalone section. Secondly,

my interview with Harley directly spoke to the second research question (e.g., What supports and environments are necessary in maximizing the positive aspects of Psychiatric diagnosis?). Over the course of the interview, certain “in vivo” developments illustrated the type of support that Harley found useful in embracing the positives of his diagnosis. Furthermore, Harley went on to contrast this type of support with the type of behavior he had encountered in professional helpers that had discouraged him from continuing the Counseling process. Given the high degree of relevance this interview brought to the second research question, I decided to present key moments from the interview in order to better inform the reader. Finally, I partly chose to utilize Narrative Analysis due to its flexibility- as previously mentioned, it has been utilized with samples as small as three and as thirty-five. After considering this fact, I chose to present two segments of individual transcripts due to their degree of application to the goals of both Narrative Analysis and the current study.

### **Prologue: In the Beginning**

“I tried to eat with my dog out of his bowl and he bit me.” - George

During the series of interviews, I presented each participant with the following request:

Clay: “I’m hoping you can tell me about a memory of your early life that your parents, older relatives, or early caregivers cherish about you...the kind of thing that happens when we’re babies and toddlers that we don’t remember at all. The kind of memory that gets retold again and again at big family gatherings or when you bring a person that you’re dating home to meet the family for the first time. If you don’t have a story like that to tell, do you know a story about your parents from before you were born that is meaningful to you?”

The purpose of this question was to elicit stories that shaped the participants’ earliest notions of personal identity. As other Narrative researchers have argued, our earliest ideas of self

and identity can be inherited or influenced by narratives constructed within our family of origin and in our earliest support networks. (Parry & Doan, 1994; White, 2008). I was curious to know if these inherited narratives identity had somehow shaped the relationship between my participants and their respective psychiatric conditions.

Astrid (Written): “This is somewhat double-edged, in retrospect, because what that story is that I was silent until I was three years old but then I started talking in complete sentences. That people thought I might be deaf, or I might be autistic (whoops, I was), but it turned out I was just really smart. The less adorable part of the story is that why that happened is that an SLP [speech language pathologist] apparently told my parents I could be convinced to speak if they simply stopped giving me what I wanted in response to any other communication until I did.”

The last part of this memory was indeed an unfortunate predictor of themes and plot points to come in Astrid’s development. The theme of participant knowledge clashing with institutional knowledge is recurrent through most of the Magnificent Sevens’ narratives. However, Astrid was also able to recall a much more palatable memory that spoke to several essential characteristics of her narrative.

Astrid (Written): “There aren’t really any other stories about incidents involving me that I don’t remember at all; I kind of have a ridiculously detailed memory from the time I was about three, so there’s not much of note that I don’t remember, but probably the other most...characteristic and oft-told story is about me and the cat who decided she was mine when I was about six. I had begged and begged for a cat for virtually as long as I can remember, actually. My father loathes cats and my mother’s allergic to them, so it was out of the question. Then one day in the spring,

about a week before my 6th birthday, I woke up (before anyone else, which I usually did) and went into the kitchen and there was this gray cat just sitting at the back door like she belonged there. And I just knew she was supposed to be my cat! My mother asked our vet's advice on how to get her to go away; he said to just not feed her and she'd move along, but she didn't. After about a week my mother broke down and snuck out in the middle of the night to take her food, and then she really was mine."

In the preceding story, Astrid somehow knew she was supposed to have a cat. Her parents disagreed, and as they had all the decision-making power about such matters, the issue seemed settled. Reality had other plans, however, and in the fullness of time Astrid became a cat owner. The idea that Astrid was waiting on the world to catch up with what she already knew to be true is a frequent theme in her narrative. Throughout her childhood, Astrid clashed with an educational system that constantly told her that she was wrong, noncompliant, or lesser-than her neurotypical peers. Astrid knew good and well that there was nothing wrong with her, however, and all she could do was wait out the storm until she had greater control over her own narrative.

Astrid: "One of the overwhelming feelings of my childhood and adolescence was that I hated that other people controlled my life and undermined my autonomy. And I was pretty determined that one day, things weren't going to be like that. And academics were what I was good at, and the avenue I could see to making that true—to winning scholarships, to getting as far away as I could get for college, to being able to live the way I wanted. I wasn't keen to screw up what I felt like was kind of the only chance I had to wind up in control of my own life."

Kitten's early memory was likewise prescient, as it reflected the sense of calm and acceptance she brought to situations where she was, sometimes literally, in over her head. In the following passage, she describes an incident at the community pool that occurred in her remote childhood.

Kitten: "Um, I feel like, uh, the story that I have from that is when I was toddler, uh, and I guess we were out at the community pool in, uh, in Americus, and I had one of those little like, floaty child seats that's sort of like a, a life preserver ring with a little seat in it and babies can sit in it and sort of like, kick their feet in the water and float around. Uh, and somehow apparently I flipped myself over, and my parents looked over at some point and just saw like, my little legs hanging onto the seat and my head was completely under water. And they freaked out and come swimming over and flipped me up, back up right and they have no idea how long I was upside down. Um, and they were expecting me to be like screaming and red-faced and upset, and my only response to it was, "My hair got wet." Um, and my parents thought that this was adorable. Um, I have no idea why, (Laughs). Um, the, uh, as an adult I look back on it and I kind of appreciate it, because I'm like, well even as a kid I guess I didn't panic much. Um, so there's that."

Kitten's nonchalant response to a frightening and stressful situation presaged many dramatic events in her adolescent development. Her parents had a very unorthodox approach to family bonding, and she was exposed to events and actions that most teenagers would find absolutely terrifying.

Kitten: “Um, oh goodness. We ... we did a lot of work with local Atlanta bands, and this was something that we started doing because my ... my mom worked for the warehouse for Warner Elektra Atlantic. Uh, and so they would occasionally get like tickets to shows and things like that for some of the like small brands on the label, um, and my parents had gone to a, uh, timeshare meeting and were given a free video camera for it. (Laughs) And so they became friends with this one band and started taping their shows, and then from that would start, you know, made friends with people in other bands, uh, and started taping their shows. So at like 14, 15 years old, I was bouncing around with my parents to all these little dive bars in Atlanta, uh, and doing tech and working merch for bands. You know, it had its, uh ... it had its consequences, um, and you know, and little local Atlanta bands have extreme tendencies towards alcoholism. Uh, and ... and from that, there were so many occasions of drunken musician girlfriend spats that even though like ... it was not my business, it was not my place, and I was 14 for fuck's sake. I had no business intervening, but oh, you know, girlfriend would be upset because drunken musician boyfriend would start macking on some other girl there and, you know, and ... and it was always me. It was always me that would just like jump right into it and have to be like the consoling shoulder to cry on and ... and the voice of reason to stop the fighting between the couples you know, and ... and all of that.”

Despite her experience with what many might describe as an impossibly abusive upbringing, Kitten somehow stayed calm and grounded during these times, even when she was expected to demonstrate emotional fortitude beyond her years. In the following passage, Kitten relates the story of how she gave an exceedingly precocious answer to a question well above her developmental pay grade.



Kitten: “Um, yeah. I was ... 10 or 11 years old, and we had, uh, this one girl living with us who was, God, I think 18 or 19. Um, and she had gone out to a party with some people and gotten really drunk, and then was realizing the next day that she thinks while she was passed out drunk that somebody raped her. And she was talking to me because she was trying to figure out like, what she should do about it, and should she tell anybody, and should she tell my parents, um, because my parents were very much like parents to her, and she didn't want them to be ashamed of her. Um, and she didn't want them to be scared for her or anything else. Um, so yeah, that was a lot to take in at that age. Uh, and my advice to her was, you know, she, she kind of had to follow her heart. But if I were her I would tell my parents because if anything really horrible did come of it, my parents were gonna be the only ones who were there to help her out. Um, and it was best that they know so that they could be prepared in advance. Um, yeah.”

This story reflects the overall tenor of Kitten's narrative, as she frequently tries to do all she can in situations that seem completely out of her control. Patricia, however, had the opposite problem growing up- it was her way or the high way, every time.

Patricia: “When I was little- I don't know, it's a funny story and it's the only one I remember. When I was little me and my brother were arguing in the garage, he was trying to keep the door closed, and I was trying to keep it open. He was over on the one side, and I was all the way over on the other, and I yanked it up and up he went. He was stuck up there, and I went running in the house going, I stuck Anthony on the ceiling, I stuck Anthony on the ceiling!... that was the

earliest memory I have, and they still talk about that. But I think that it was my way or no way kind of thing, that I had going on when I was little.”

The preceding story is a testament to Patricia’s iron will, which served her many times over as she struggled with the challenges of Schizoaffective Disorder. In the following passage, Patricia explains how she reacted to a hard-nosed nurse practitioner who was unwilling to take her complaints seriously.

Patricia: “What happened was, my doctor retired, and they were trying to get me new doctor, but the Family Guidance Center, I don't think was ready, or Dr. Montesan did not have the time to do it. She was supposed to be there three days a week, she cut it to one. So they called me and said, you no longer have a doctor, we're going to put you with a nurse practitioner. So I was in, I don't want to call it an episode, but I kind of get these things where I start staring at the wall and day dreaming. That was starting to happen and I was starting to get a little weepy and agitated. And I thought, oh, time to call, let's get my meds adjusted, I don't have time for an episode. I've got too much to read, you know? So I called her and I told her. What I made the mistake of doing, is instead of telling her about staring at the wall, Dr. Groves always knew that if I said I'm agitated and I'm snapping at people, that something was up, so that's what I told her. And she said that agitation and anger are not symptoms of a mental illness and that I should seek counseling for that. So I said thank you very much, have a nice day, I called the insurance company and I got a new doctor and a new therapist and we meet on Monday and Tuesday.”

Individuals with severe mental illnesses are at a particular disadvantage in their dealings with the mental health system due to the stigma attached to their conditions and the power differential inherent to the doctor/patient relationship (Flanagan et al., 2009). Patricia, however, understood exactly what her needs were and was not deterred by the dismissive attitude of the nurse practitioner. Rather than passively accepting her situation, Patricia continued to pursue her best interests until she found the help she needed.

While Kitten floated on early in her narrative and Patricia literally drove people up a wall, George's early life memory was marked by a sense of moral pondering and delightfully eccentric behavior. George identified three memories that met criteria for the prologue question.

George (Written): "I have a couple of those. One of the first toys I remember is a big stuffed tiger that I went everywhere with. One Sunday morning I asked my parents and Granny, "Can Tiger come to church?" They laughed and said no. Then, according to them I said, "Well Tiger, I guess you'll just have to go the debbil."

"My Aunt Holline said that my first word was "Tequila" which I said because the song prompted it!"

"I tried to eat with my dog out of his bowl and he bit me."

George's stories about his tiger's inevitable damnation and his dog's impatience are both amusing and predictive. George's narrative is frequently punctuated by bursts of humorous reflection, and his tendency to use laughter as a coping skill will be exemplified many times over in this study. Underneath this humor, however, lies a deep contemplation of the moral factors that

influenced George's thinking about his condition. Even in his childhood, George felt a moral weight behind the feelings that influenced his behavior. In the following passage, George recounts his mother's reaction to a mea culpa he professed following his first depressive episode.

George: "But my mother took me to my doctor as soon as we got back from Texas because (laughs) I had, done all these things that stood out as peculiar, like making all sorts of confessions, thinking maybe it was something I was holding inside that caused the strange feeling I was having. I told my parents that I masturbated and I told them that I didn't believe in God anymore, and stuff like that-that I had never told anyone."

To this day, many of George's scholarly and political interests are marked by a deep contemplation of the moral factors that influence mythology and politics.

A narrative of moral decision-making and political justice likewise influenced *Faith*. When I asked her the prologue question, her memory immediately flew to a popular documentary from the 1990s.

Faith: "When I was in first grade, that's when Ken Burns documentary of the Civil War was on PBS. And um apparently like the concept of slavery, like I could not understand it. So my parents kept trying to explain to me like, "Well, you know, these people would own other people." And I was like, I don't, that, this does not compute. Like I don't, you can't own people. You, people are people."

Faith's continual concern for others and her deep sense of justice will be revisited many times in her narrative. In the following passage, she makes a request of me based on her reading of the Informed Consent document.

Faith: "Um, oh well so I read in like the paperwork that you sent to me that there's like a \$20 something or other- like, pick an organization and donate it. And I'm saying that now so that it's on the record."

*Researcher's Note: You can see why everyone likes Faith.*

Faith had another prologue story:

Faith: "Um, so my mom and dad met on a blind date and um they went out for Italian food. And my mom though she was putting Parmesan cheese on her pasta, but she was putting sugar on it or, it was either sugar or salt. Whatever it was, it was gross. She poured it on and took a bite and though oh my God, I put sugar slash nine pounds of salt on my spaghetti. Well, I'm going to have to eat it because I can't be embarrassed. So my dad just let her eat the entire plate of food. And then he was like, "I can't believe, I've just never seen anybody eat that much salt on spaghetti or whatever." And my mom was like, "I just didn't want to be embarrassed."

This story is also reflective of many moments in Faith's ongoing narrative. Throughout her story, she continuously suppressed or subverted her own wants and needs based on ideas of

what was expected of her, or what would please others. This notion is, perhaps, most apparent in the story of how she wrestled with her sexuality.

Faith: “After I graduated from college I moved to LA for a couple of years, and then came back to North Georgia when the writers’ strike hit, because I was out there acting, and- that killed all jobs in every industry. (laughs) Um, so I came back, and I was like I got into a horrible car accident, and so I was stuck in Georgia for a little while. Um, and that's when I met Blake, um, and we got married. And it was a very not-good marriage. Um, I had a daughter, her name is Emory. She's five now. Um, I left him, um, and three and half years ago... and I started doing some soul searching. And, um, I'm now in the process of coming out to friends and family. I'm dating a woman who is just the most amazing person ever. Um, I guess so that's sort of where I stand now. My relationship with my parents is very good, they're excited ... My girlfriend's name is Trish. My parents are excited to meet her. Um, yeah, so that's sort of my background, I guess.”

Though Faith’s story has a happy ending, her narrative is likewise sprinkled with plot points in which she acted against her better interest for the sake of avoiding embarrassment.

### **Summary**

Previous narrative researchers have posited that early life narratives can, when enforced by family and support figures, have lasting influence over an individual’s identity- even when the individual has no memory of the narrative in question (White, 2008). Influenced by this assertion, I asked each of the Magnificent Seven to speak of an early life narrative that was popular with their family and/or early support system- even if they themselves had no memory of it. Each member of the Magnificent Seven was able to identify an early life narrative that was predictive, at least in part, of their overall life narrative as it pertains to the current study. Some

memories spoke to autonomy and willpower, some spoke of the participants facing barriers and articles to self-actualization, and some spoke to the powerful influence of the immediate family over the individual. Regardless of the memory, all members of the Magnificent Seven were able to identify early life narratives that presaged skills and characteristics used to take personal ownership of their diagnosis.

### **Emerging Awareness of Difference**

“Want some Pepto Bismol?” – George’s Grandad

Each member of the Magnificent Seven shared stories about their early development. In all of these stories, the participants described an innate sense of somehow being different from their peers in a way they couldn’t fully understand. For most participants, this feeling was disturbing, for others, it stoked an insatiable curiosity about the human condition. At some point in their narratives, six of the Seven reached out to their support systems for help or understanding regarding this experience of difference. In each instance, these efforts were rebuffed, punished, or left unanswered in a manner that stymied the participants’ willingness to continue seeking help with their differences. In one instance- Kitten’s, to be precise- life was lived through a lens of 20/20 chaos that did not permit her to reach out for help. Amanda was the first of the Seven to be interviewed; likewise, she was the first to share a story of Emergent Awareness.

Amanda: “So, I guess when I think back to like when I was very little, I’ve always been really sensitive. I can’t really remember thinking about my weight in a way that was positive. So I think I just started to catch on at some point that something was wrong. So, I remember third, fourth,

fifth grade starting to feel weird about it. Um, and when I was very young I um, kind of was a wallflower. I didn't want people to see me, I didn't want people to notice me or to um, kind of talk to me. I was like, "Ah, don't, don't look at me." I think when it initially started um, I didn't know what it was so I thought that I was crazy or that something was wrong with me."

Amanda's Emerging Awareness of Difference was heavily shaped by her family of origin; which is something she had in common with all of the participants. What made Amanda's story unique, however, is that she shared one difference in particular with each member of her family:

Amanda: My family um, everybody in my family growing up was overweight. So my dad was overweight, my mom was overweight, both me and my brother were overweight...from the time, the first time I went on a diet was probably when I was 12...Um, so I had been dieting on and off with my mom and, and with, you know, other peo-, my aunt, and had, had been involved in Weight Watchers. Um, and my parents, and my mother in particular, really started to worry about me, um, and the amount of weight that I was gaining and yada, yada. So um, she really tried everything she could, um to kind of get me to stop or knock it off. Um, and I think one of the ways she tried to do that was by like ol-, you know, like kind of really managing what I'm eating. So, "Should you be eating that? You should put that down." It was, I know, I don't think she ever meant it to be this way but it, it was very like shame-inducing, like food became a shameful thing.

*Researcher's Note: That doesn't seem very fair, but I'd better not say anything about it.*



Amanda further explained her youthful understanding of being “really sensitive” in her follow-up interview:

Amanda: “So, I think for me there was an element ‘cause I’ve always been called sensitive or dramatic or things like that. And I’ll even call myself dramatic sometimes because I am dramatic sometimes. But, I think for me what when I started to see that as a bad thing, like I would try not to cry. I didn’t want to show my emotions and I would try to be like “Stop, stop”, I didn’t want to be that way. And I would try to get myself to stop. Like just stop crying, stop. I didn’t want people to know, or people to say it. So I would try to hold in my emotions and just hold onto it real tight. So, like me and my Mom are connecting right now. We have always been close but when I was a kid it was really my Mom that was like “Stop being dramatic like you are being. Stop crying, why are you crying?” And she’s said that to me. She’s said “I just don’t understand why you’re crying right now. Stop crying.” So I think for me, when I got those messages of like stop being sensitive, stop crying, stop essentially making a big deal about this. I tried really hard to not make a big deal. And I still find myself doing that today.”

Like most of the Magnificent Seven, Amanda learned to internalize her feelings of difference in a fashion that would generate developmental difficulties later in life.

Echoing the themes identified in his prologue, George explained his Emerging Awareness of Difference while relating the story of his first depressive episode as a preteen boy.

George: “How it felt was just that something was wrong. It almost seemed like the world had changed somehow, like the rest of the world wasn't the same. There was a different kind of slant to the light it seemed. Nothing anyone wanted to do sounded very interesting to me.”

Similar to Amanda, young George began to sense a growing disconnect between his inner world and his outward reality. Similar to Amanda's mother, George's family found themselves perplexed and irritated by the situation.

George: “I became upset about the breaking up [of The Beatles] to the point where I was obsessed with the inadequacies of their solo projects. But then when I heard Plastic Ono Band, it was kind of like a revelation to me because Lennon was screaming the same sort of things that I wanted to scream. Uh, and that record got associated with my first depression. My dad, who still doesn't get it...said that maybe the record was responsible for what was wrong with me, (laughs).”

Feeling the tension rising within him, George began to flail out blindly for help and understanding, leaving his family bewildered and frightened. He recalled a moment between himself and his grandfather following a family member's funeral that reflected this dynamic and his ability to cope with difficulty through laughter:

George: “But, uh, I remember one night, (laughs) laying there on the hotel couch and just like, I, I don't know what's wrong, but I, I have this sense of urgency that I needed to do something about it, that, that something was wrong and I, uh, with me and I didn't know what it was. And it was really confusing. And I, I (laughs) remember calling, uh, for help from my aunt, my grandfather who, who stumbled- ... stumbled in, and, uh, I ta- ... He says, "What's wrong? Do

you feel sick?" And I went, "Maybe. I, I, I guess." He says, "Want some Pepto-Bismol?" (laughs)  
That made me laugh, and I remember like I was like, "Oh, okay. There's, that was good."

Like Amanda, however, George internalized the blame for his sense of difference and began to view himself as an immoral being. This development did nothing to allay his parents' confusion:

George: "I made all sorts of confessions, thinking maybe it was something I was holding inside that was, uh, you know, like I was ... I told my parents that I masturbated and I told them that I didn't believe in God anymore, and stuff like that- thinking that that would relieve me. So, my parents were freaked out by this."

Soon enough, the situation reached a boiling point, and George's parents sought professional help.

George: "My dad hit me once. Uh, it was the last time he ever hit me. Uh, and, uh, my mom took me to the doctor and the doctor said, "Have you been experimenting with drugs?" And I was like, "No."

Clay: (laughs)

George: "I haven't had any, and I want some, (laughs)."

Clay: (laughs)

George: “You know, I was like, I'm still, you know, just a kid. We don't have ... I haven't had any drugs. And, um, he laughed and, uh, thought I was okay.”

*Researcher's Note: I'm gonna include every time I laughed during this interview in the final product, and I bet you anything my committee is gonna ask me why. How is it important to the dialogue? The answer is simple: shared laughter was a seminal feature of this interview, and George's use of humor as an organizing framework for his narrative can't be ignored. When you read the written transcript, it might look like I was laughing at him- nothing could be further from the truth. George's glee in recanting the trials and tribulations of his narrative was infectious, and it frequently bubbled up to the surface in boyish bursts. I caught those giggles in waves, and neither of us minded a whit.*

*But not everything we discussed was very funny.*

Like Amanda, George soon realized that the outside world held no answers for him, and he, too, began to internalize the negative feelings that resulted from his inability to understand himself.

George: “Gradually I decided that whatever was wrong, it was with me. And then I stopped talking about it.”

While Amanda and George dealt with inner turmoil, young Kitten was buffeted by chaos from all sides. Following an unfortunate outcome generated by a kindergarten project gone awry,

Kitten experienced a period of Emerging Awareness that featured a similarly brief and unhelpful encounter with professional helpers:

Kitten: "I got kicked out of kindergarten because we had to do this thing where we were, uh, like the little counselor in training comes to our kindergarten class, and we were all told to like draw pictures of stuff we're afraid of and other kids are like drawing pictures of monsters in the dark and she's being all perky and be like, "Oh well monsters aren't real and things that are there in the dark are still there in the light so there's nothing to be afraid of." And I drew a picture of somebody shoving a kid into the trunk of a car because I was afraid of kidnappers and child molesters because I had been told about them. And so my parents got called into the school and there was a whole like .. Because like my description of like how these things worked like traumatized my kindergarten class. And so my parents got called in, and they're like, "She doesn't need to know about stuff like this," and my mom in her ever practical way is like, "What, we should wait until she's an adult to tell her about child molesters?" A little behind the ball at that point."

*Researcher's Note: God Damn. Well, you knew the job was dangerous when you took it,*

*Fred.*

Kitten seemed to agree with her parents in retrospect, and she explained that she was always aware that their unorthodox parenting style made her understanding of life distinct from those of most children. Part of that parenting style was a tendency to open the family home to "strays," a term Kitten used to describe local youths who befriended Kitten's mother and father.

The strays had socially unacceptable interests and desires alongside and poor relations with their own parents. As a preteen, Kitten would often speak to and interact with these adolescents, and found herself dealing with youths who abused drugs and alcohol:

Kitten: “These kids were basically just well-meaning geeks and nerds with like ... they'd be into D&D and they'd be into science fiction, and their families would decide that they meant that they were into devil worship and would kick them out of the house. Um, and so they'd wind up at our place, or, you know, they really were ... like, they did have issues with drugs and alcohol and everything else, and you know, so my mom would take them under wing.”

Though Kitten understood that most children her age would be discouraged from socializing with the “strays,” a more nebulous and unexplained Emerging Awareness bubbled just beneath the surface:

Kitten: I knew from a very practical standpoint that the realities that I was given as a child were very different than the realities that all other kids my age were given. And ... and I had that as like a practical knowledge, but even beyond that, even talking to like college students and the teens in our household and everything like that, I still always felt like there was something more with me that wasn't quite right.

For some reason, the strays found the preteen Kitten to be a strong and helpful social support, and their interactions granted her with an enduring sense of identity as a mother hen figure.

Kitten: “And ... and these teenagers would talk to me as like, you know, first, second, third grader about the crap in their lives, about their problems. And they were legitimately coming to me for advice, and that's kind of fucked up. (Laughs)”

Kitten’s identity soon coalesced around the notion of serving as a den mother to the strays, and it would be years before she gained a helpful understanding of what was going on inside her.

Patricia’s Schizoaffective Disorder made her Emerging Awareness of Difference a good deal more dramatic and pronounced than those of other the participants. The reaction she got from her family and wider environmental figures, however, was remarkably familiar:

Patricia: “I remember at the, at an early age, say 7, 8- Hearing music in the walls and telling my mother that I heard music in the walls, and people assuming I was dreaming. When I was even younger than that, now I don't remember this, I only know this from my mother, um, I had an imaginary friend. And my, I wanted my mother to feed this person, and I was sure this person existed. So they took me to the doctor, and the doctor said that I had made it up, that I was just a lonely kid and I made it up. So that there, so I was different then. But, um, I didn't realize that I had a real problem until, um, I was 32.”

Soon enough, however, young Patricia began to experience more serious symptoms:

Patricia: “I had other things happen where, there was a time in high school I thought I was psychic. Um, I went for years undiagnosed. I'd go through fits of crying, and then I'd be, I

thought I could do any ... You know, the, the, the manic depressive thing that goes along with schizoaffective disorder. But I really wasn't as, um, I didn't start really breaking with reality until I was 32. I was able to get to school, I was able to get to work. You know, I just was depressed, to me, um, I knew I was depressed... And I didn't know anything about mental illness either. and I had so many people say to me, um, when I was in high school, I was depressed. There's no doubt in my mind. And people would say, "What 15-year-old girl isn't depressed?" And that kind of like, 'cause when you're a kid, they don't really think of mental illness. They think that it's just life. So I got that a lot. What 15-year-old kid isn't depressed, you know?"

Even after Patricia had a full-blown break with reality at age 32, it took a lot of time to convince members of her support network that her problems were real and substantial.

Patricia: "I was telling people what happened, they didn't believe me. You were sick. You don't know what you were hearing. When, to this day, I know the difference between ... I was completely out of my head. There's no doubt in my mind. I thought the CIA was coming and they were gonna kill me and ... You know, but I can look back now and say, you know, what was real and what wasn't...I remember clear as day. Now, it was a whole year before anybody believed me. I spent a lot of time after that episode proving what I was saying."

Of all the other members of the Seven, it is likely Astrid who experienced early harm on a scale most comparable to Patricia's. Astrid's narrative held many accounts of difference that manifested at an early age, and such differences were largely born in silence due to a lack of



options. In the following passage, she recounted the first time she realized she was different from her peers:

Astrid: “Um, this was in preschool, and I remember like trying to like interject myself into the situation, and it was just like I was not there. And I remember just like sitting back for a minute and ... again, like thinking in words that I didn't have at the time, like, they can do something that I can't do, and I don't know what that is. Like, there's something that, there's something that they're getting and I'm just not. And I can't, I couldn't even tell you like what that was.”

As in the previous cases, Astrid tried to communicate this difference and its concomitant concerns to her immediate support figures. As in the previous cases, these gestures proved futile for Astrid and her support figures alike.

Astrid: “Um, I know I tried various times probably starting in like late elementary school and middle school especially to tell my parents like, um, I know I'm a social outcast, nobody else likes me, um, I'm not sure if I ever used the words, something wrong, there's something wrong with me, but, but I know I got told over and over again, like, no, that's not true, you're just like everybody else. Um, and, you know, in many years of retrospect, um, I, yeah, I feel like, I remember, there was this one moment especially where I said something to my dad, and I don't even remember what, and he actually said, that's ridiculous, you're completely normal, and just being gobsmacked that, like, that's a thing he could think.”

Not all of the Emerging Awareness periods occurred in the participants' childhoods. Two members of the Seven, Harley and Patricia, experienced the Awareness as adults. As previously mentioned, Patricia developed an Emerging Awareness at the age of 32, shortly after her first full psychotic break. Harley experienced his Emerging Awareness at 38 following a theatrical performance that will be discussed later in this chapter.

Faith's account of an Emerging Awareness of Difference is unique in that she considers it to be positive and a personal point of pride. Faith was an adult when she received a diagnosis of Attention Deficit Hyperactivity Disorder; however, she did report that her Emerging Awareness of Difference began in childhood and made for a positive identity development.

Faith: "Um, a- a lot of the time that was really, it was just, um, being able to feel for people, um, a lot harder than the people around me did. Like I- I know that it's important anyway to not, to not bully, but I- I couldn't even, like I couldn't deal with it if I knew somebody was being bullied, even if I wasn't like witnessing it. Um, and when people would, uh, like ... Okay, when I was in high school once some guy slapped me on the butt, and I turned and I slapped him in the face so hard that my bracelet flew off. Like I just, I could not abide by any kind of injustice that I saw. And that seemed to be very different from everybody else. And it still is. That's like, I joke around that my favorite thing to do is to call 9-1-1, because (laughs) like if something is going wrong, I want to help. I want, I want the person to not be in that situation, which seemed to be very different."

Faith's intense devotion to justice and her strong will would prove quite useful years later as she navigated the waters of diagnosis and making sense of mental disorders.

*Researcher's Note: I felt sad at times during this interview because of a contradiction that became apparent upon reflection. Faith could be very bold and so assertive in standing by her commitment to justice, but at times, she seemed to deny herself that very dedication- she had a way of sweeping her needs and feelings under the rug to conform with expectations.*

### **Summary**

Each member of the Magnificent Seven reported the experience of an Emerging Awareness of Difference early on in their personal narratives. The common thread in these experiences was the participants developing an innate sense that something inside them was wrong, radically different from others, or profoundly disconnected from the outside world. Five of the Seven reached out for some sort of help or assistance from support figures during this time, but all five were unable to connect with meaningful help or were quickly dismissed. Two members of the group were adults when they experienced an emerging awareness of difference, four had the experience in childhood, and one participant had the experience in childhood but considered it to be a positive development.

### **Early Struggles With the Problem**

"It's a real page turner!" - George

In the aftermath of the Emerging Awareness of Difference, each member of the Seven had to navigate the complexities and challenges of their differences through trial and error. Some of them received some type of intervention or support, and not all of these efforts proved helpful or even tolerable. Regardless of circumstance, however, each of the Seven developed their own manner of traversing the terrain of external reality. None of these strategies were fully effective, however, and none of the Seven would feel fully empowered to deal with their inner differences

for quite some time. Some of the Seven had watershed moments in their adolescence, others would not gain greater clarity regarding their inner differences until young adulthood (or beyond). The plot points that ushered in a sense of clarity will be explored later in this study, but for the most part, the Magnificent Seven first learned to cope with their feelings of difference by internalizing the emotions they generated. Faith, for example, was not fully supported through her primary education and learned to channel the resultant anger inward. In the following passage, Faith describes her experience with early education and her several near-misses with proper support.

Faith: “Um, when I was in first grade, I had this teacher, Miss Wheeler. \*Faith’s phone goes off\* And she was so mean. (laughs) Um, but it's, I mean, part of it is because I was in her class with my best friend. And so she and I would bounce off the walls and be disruptive and all that kind of stuff. Um, there's actually a note in my medical records from when (laughs) I was like six years old, and the pediatrician says, "ADD" like underlined a bunch of times. Um, but my mom didn't want to have me medicated, which makes sense. I mean, when you're seven or six or whatever, that's- that's a lot to think you're gonna give, you know, amphetamines to a six year old. So, they didn't, they didn't do that. Um, so I was tested for the gifted program, um, and they actually wanted me to skip a grade. Um, but my parents were very against that, because they wanted to you know, make sure I had time to be a kid and enjoy being a kid and all that.”

*Researcher’s Note: There it is again. That feeling I got when I interviewed Amanda. That feeling that I’m not so pleased with the parents.*

Faith went on to describe her pre-diagnosis adolescence and early adulthood as a tumultuous time of confusion and inner turmoil. She knew she was different than others and that difference angered and confused her. She learned to cope with these feelings by turning them inward:

Faith: “A lot of times I felt like I was very lazy, and it's not, I mean, it- it's not that I was lazy, it's that I was overwhelmed, and I couldn't figure out how to manage projects, how to manage myself. Um, and I- I would get very frustrated to see other people doing the same path that I was doing, like, for example, you know doing background work. Or, you know, looking for tech jobs or whatever while I was acting. Um, and I, it was, it was very frustrating to see people who could just, you know, get up and go do a project. I- I, for whatever reason, it was like somebody put weights on me that I just couldn't, like do a data entry thing or something like that. Like I just couldn't get it together enough. And so I- I was angry at myself a lot, um, for feeling inadequate and comparing myself to others.”

Astrid's early struggles were very similar to Faith's, particularly regarding the inability of the educational system to provide necessary support.

Astrid: “Um, and, and I went to in a, in a lot of ways like a really good school, like, um, you know, we were in a really enviable school district, and it's easy to recognize in a lot of ways that I was incredibly lucky to be in the school system that I was, uh, and it was also, um, a terrible environment for me. From beginning to end. My school was not bad at recognizing gifted kids, so that was actually recognized to an extent starting when I was about eight, um, but they were

one of the schools that would either recognize giftedness or disability and not really both. Um, and there, there of course is the, the really common prejudice about gifted kids, that they're so smart they should be able to do anything. Um, so, like a lot, a lot of basic kid things, like especially in P.E., were impossible for me, but, but the prejudice was...um, and of course because at the time, like, I had no language to describe or even to identify like what those things were that seemed so easy for other people, um, that I just couldn't get my head around. Um, a lot of that stuff I just got blamed for instead of it being recognized that that was, you know, issues I was actually having trouble with because I was so smart.”

Much like Faith, Astrid learned that having no way to actualize her needs or make sense of her experience meant turning her frustrations inward:

Astrid (Written): “I wish I could say I had terribly effective coping mechanisms for negative feelings, but I didn't. I spent a lot of time just internalizing distress, which come to find later is something a lot of autistic girls report from childhood; that we often weren't having stereotypical explosive meltdowns until later because we're socialized to internalize blame and distress instead of lashing out.”

Like Faith and Astrid, Amanda experienced distress as a private, internal phenomenon.

Amanda: “So, I think for me there was an element 'cause I've always been called sensitive or dramatic or things like that. And I'll even call myself dramatic sometimes because I am dramatic sometimes. But, I think for me what when I started to see that as a bad thing, like I would try not

to cry. I didn't want to show my emotions and I would try to be like "Stop, stop", I didn't want to be that way. And I would try to get myself to stop. Like just stop crying, stop. I didn't want people to know, or people to say it. So I would try to hold in my emotions and just hold onto it real tight.”

Similar to Astrid, Amanda managed to maintain public composure in spite of her continuous struggles with anxiety and binge eating. This restraint, however, did not come without a price:

Amanda: “I had a good strong group of friends, um really starting freshman year of high school. Um, I had good grades, I was in, I was like the president of the drama club and I was in orchestra and I was in cheerleading and I, I really kind of, if you look at it on paper, have like, it was like primo privileged working well within the system life...she [Amanda’s mother] became a teacher, um, went to school to be a teacher when I was in middle school and had graduated with her Masters by the time I got to high school, the end of high school. Um, but then starting probably sophomore year of high school... so what I would do is, I would come home at 2:30, she'd be home at 3:30, and I would eat everything I could between 2:30 and 3:30 and I would clean everything up. It was just like classic binge eating behavior.”

Unlike either Faith or Astrid, however, Amanda could not conceal the evidence of her binge eating behavior . When her mother decided to intervene, however, Amanda internalized her feelings and complied with her people-pleasing instincts:

Amanda: “So sophomore, junior year um, of high school, my mom uh, she found this program in Burlington and it was called the Chrysalis Program and you get like a therapist, a nutritionist and there was a third person you get. But for, it was for kids who are really overweight. Um, and she found the program and like she told me much later that she really tried to figure out a way to tell me in a way that I would accept it. I just remember her going, "Hey, you want to do this?" And I just, at the time, really wanted to make her happy, I wanted to like I just didn't want them to be disappointed in me and so I was like, "Yeah, sure I'll, I'll do it." Um, so I got a nutritionist and a therapist.”

*Researcher's Note: Amanda gave a fantastic interview, but I often got a sour feeling in my stomach whenever she discussed her mom. If everyone in the house was heavy, why did Amanda catch so much heat? Why wasn't she ever given a choice about, well, anything? This is was sticky wicket to navigate, however, because I knew they are close and any attempt I made to go against that particular grain would defeat the purpose of a Narrative Analysis (I'm nervous now because I know she's gonna read this during member checks). Still, my mind kept jumping to other stories as she spoke, where participants had watershed moments in which their counselors helped them identify abusive behaviors in figures who comprised their support networks. Should I initiate a dialogue about this sort of thing?*

*Absolutely not. Thankfully, I came to my senses very quickly on that one. I'm not Amanda's therapist, I'm her research partner, and any personal reactions I have regarding her story are small potatoes in comparison to the larger goal- liberating her own voice. I did my best to keep those feelings out of the process, and as you'll see later, it turned out to be the right call.*



George's educational environment was even less prepared to support him than most of the Seven's educational systems; this factor might account, at least in part, for why he did not receive proper education and care for his disorder until his early thirties. Predictably enough, however, George's story of early struggles was continuously peppered with his trademark sense of humor.

George: "I remember this incident. At the end of eighth grade (laughs) when I was really restless in class and I couldn't focus on anything. And, uh, (laughs) I decided that I would get up and read the giant dictionary the teacher had at the back of the room. So, I went over there and I was just reading the dictionary. I got to the end of the page and I turned the page and I read to the end. Finally our teacher, Ms. Hodgkins, I still remember her, uh, said, "Uh, have you looked up your words?" I said, "Yes." (laughs)

Clay: (laughs)

George: "She said, "What are you doing?" I said, "This, uh, this book is fascinating," (laughs).

Clay: (laughs)

George: "And but she said, uh, "Well, , you need to return to your seat." So, I started to pick up the book, you know. And it was big, and I picked it up and she was ... And the class was laughing by this point, so I was encouraged. And uh, she said, uh, "Put the book down." And I said, "I can't. Uh, it's a real page turner," (laughs).

Clay: (laughs)

George: “And I started making all these jokes, and then it got a little bit tenser and she told me to go to the principal's office. And I was like, "That sounds fun," (laughs).

Clay: “Yeah!” (laughs)

George: “I've never been to the principal's office!” (laughs)

Clay: (laughs)

George: “And I was so disappointed the bell rang before I got in to see him, that I acted up again the next day so that I could (laughs) go to the principal's office...” (laughs).

Clay: (laughs)

George: “And then it became an obsession with me to get to go to the principal's office. I did something to be sent there every day until I thought they would call my parents. So, when I look back on that, I was due for a depression after that, and that's when it happened.”

*Researcher's Note: In case you're wondering, I just ran a text query on (laughs) in George's first interview to see how often one of us laughed. 141.*

Harley's case is unique in that he is a trauma survivor, and his disorder did not manifest itself in childhood. He had long been the “gentle giant” type, but shortly after enduring his trauma, he began to feel aggressive and angry.

Harley: “Uh, I was dissociative. Uh, I was hyper vigilant. Uh, I almost got into several fist fights just walking the streets of Oakland, with people that would approach me in ways that I deemed inappropriate. Uh, yeah uh, night terrors. Um, my, my, my sleep got super disrupted.”

Thus, Harley’s early struggles with the problem were experienced through both internal and external phenomena. He would not fully come to terms with his inner turmoil until his Epiphany of Identity.

### **Summary**

After experiencing the Emerging Awareness of Difference, members of the Magnificent Seven were largely left to navigate the waters of these differences on their own. Each participant carried on and negotiated with external reality as best they could, but all seven of them internalized the frustration and resentment that grew as a result of their inability to find meaningful support. Each member of the Seven continued to experience symptomology that reflected their future diagnoses, and for most of them, coping with these symptoms was exceedingly or frustratingly difficult.

### **Epiphanies of Identity**

“If everything is just going to fall apart, if everything is just going to die, I have to have something that is for me.” – Kitten

““You know what? It doesn't matter. It doesn't matter if people see me. It just doesn't.” - Amanda

Though most of the Magnificent Seven internalized their differences as character defects early on in life, all of them found a way to reframe their experience of being different at some point in their development. This largely happened through Epiphanies of Identity, which refers to moments, events, or interactions that instantly changed the participants’ self-concept or directly led to more positive and empowering personal development. Six of the Seven identified an Epiphany of Identity during their interviews, however, these epiphanies occurred at different

points in each participant's life. Three of the Seven experienced the Epiphany during a positive event, the other two experienced the Epiphany during negative or challenging plot points.

Regardless of how the Epiphany was experienced, however, all six members were able to reframe their identity in a more positive light following the occurrence of this phenomenon.

Amanda's Epiphany of Identity, for example, occurred as she was walking to homeroom during middle school, and it diminished some of the power that anxiety held over her self-concept.

Amanda: "Um, so I was very much a wallflower. And then um, and, and up until probably seventh grade, and it's really weird 'cause I vividly remember um, this memory of um, I was walking down the hall or so-, I, and I can remember what I was wearing and I was like, "You know what? It doesn't matter. It doesn't matter if people see me. It just doesn't." Um, which was the weird thought for me to have because I am, uh you know, I was a self-conscious person...I continue to be a people pleaser and whatnot, but I just remember being like, "It doesn't matter. It just doesn't matter." So I started to kind of come out of my shell."

Amanda had more to say about this plot point in her follow-up interview, and her addendum will be included later in this study.

Faith also experienced an Epiphany of Identity, however; it came later in her chronological narrative than Amanda's. As she progressed into young adulthood and became more comfortable in accepting her sexuality, she engaged in a long-term relationship with another woman. Her identity development soon ran into an obstacle, however, when darker aspects of her partner's personality began to manifest themselves:

Faith: “I guess the healthy realization came when, so the relationship that I was in, ended. Which is fine, like it was super sad at the moment, but it's ... Oh, I'm so sorry...I just elbowed my cat in the face. *Researcher's Note: I could not bring myself to take that line out.* Um, so it's really sad like when it ended but she, uh, um, I guess showed her true colors, she got physically violent. Um, and uh, just very scary, like to the point where it ended up I was on the streets in Philadelphia like praying I could find a fucking Lyft at 3:30 in the morning on like a Saturday night. And I was just like, "Please God, please, please, please, like I need a Lyft. I need, please." And no Lyft came. Um, so like she just absolutely scared the holy hell out of me.”

*Researcher's Note: This excerpt is highly representative of Faith's narrative. I had no idea she had moved to Philadelphia to join her partner prior to this moment, in fact, I had no idea she had lived in Philadelphia at all. Of all the Magnificent Seven, Faith arranged her narrative in the manner most antithetical to chronological order. Thoughts, feelings, and life themes swam up to the surface in colorful bursts, however, her narrative was neither less cohesive nor more difficult to follow than those of her fellow participants. I purposely included the moment about her hitting her cat in the face, as it reflects her kinetic style of communication in word and body.*

This plot point served as a watershed moment for Faith as it stands in stark contrast to the earlier shape of her narrative. For a long time, Faith's narrative was governed by the rules laid out in the prologue: she was reluctant to assert herself or pursue the satisfaction of her needs due to the desire to avoid embarrassment. At this moment in time, however, Faith put her needs at the front and center of her narrative, even if doing so meant searching for a Lyft on the dirty streets of Philadelphia in the wee hours of the morning.

Faith: “So, when I left that relationship, I had no regrets about leaving it. So that took one stress off.”

Kitten’s Epiphany of Identity also occurred in her young adulthood during a moment of fierce conflict. Unlike Faith, however, this conflict was not with a romantic partner (at least not fully). Rather, Kitten’s conflict put her up against organizational medicine. Unfortunately for Kitten, however, her clashes with the medical institution weren’t her only pressing concerns:

Kitten: “I really at that point, I think I kind of hated myself, uh, because I was going through these strings of like crappy jobs and crappy relationships with emotionally abusive alcoholics and ... and then I had a year in which in a six month period I lost my mother to kidney cancer, I lost a cat I had had for 18 years and I lost my uterus. Using ... losing the uterus by the way, best thing that ever happened to me. But h- having all of those things pile up like that, something in me just sort of snapped in a good way. Um, and I realized that, you know, as cheesy as it sounds, that life's too short to be unhappy and ... you know, and the thing in my life that had always made me happy, the thing in my life that had always made me feel fulfilled was my theater work and my acting work. And I had plucked my life from Atlanta and moved to Chicago so that I could do more theater work because it was a richer theater town at the time, and I had taken a job at a horrible, horrible call center that was literally killing me and doing nothing. And so finally after that string of losses in that short period of time, I ... I realized, I'm like, you know, I am ... there was absolutely zero part of my life that I was living for me, and in hindsight it had actually been that way for a very long time. I have always done work for other bands and artists, and things like that and I put my own creative aspirations on hold over and over and over again.

And...and I finally just reached that point where I was like, you know what, if...if everything is just going to fall apart, if everything is just going to die, I have to have something that is for me.”

*Researcher’s Note: Through most of Kitten’s interview, I was keenly aware of the emotional reactions her narrative provoked in me. It was tragic, it was beautiful, it was poetic, and it was brutal. I was on the verge of tears stirred up by a mishmash of these factors for nearly the whole damned interview. As she spoke the following words, however, I had to hold back from raising my fist in the air. Maybe I should have.*

Kitten: “And I left my horribly, horribly soul crushing job. I got out of the extremely shitty, emotionally abusive relationship with the alcoholic, and decided, I was like, you know, I’m going to get back to doing theater work, and even if it means that I wind up, you know, living in a cardboard box underneath an overpass, at least I’ll have time to go to rehearsals and to shows. Um, and ... and that was sort of it. Um, so yeah, so the ... the medical community itself never really helped me beyond giving me names for what was in my head.”

George’s Epiphany of Identity proved to be the most pithily stated and the most ironic of all. He experienced an Epiphany not as an act of rebellion or self-assertion; rather, his Epiphany was ushered in by the introduction of his clinical diagnosis:

George: “It was that mental restlessness that I had felt all my life, that when I, when I was diagnosed, I thought "Okay. That makes sense and explains a lot."

*Researcher's Note: As soon as George made this statement, my thoughts flew to Patty Duke. Strangely enough, diagnosis isn't the antagonist of this whole meta-narrative. The way society and the helping professionals conceptualizes diagnosis is the problem.*

### **Summary**

After traversing through early and difficult struggles with their problems, six of the Magnificent Seven experienced an Epiphany of Identity. This epiphany refers to a moment of event that allowed the participant to reframe their self-concept as it pertained to their sense of being different. These epiphanies occurred at different points in each participant's lifespan, and arose from both positive and negative situations. Four of the Seven experienced the Epiphany from a positive set of circumstances, and two of the Seven experienced the Epiphany during negative life developments. Following the Epiphany of Identity, the members of the Magnificent Seven acted with more autonomy and a more positive self-concept.

### **Duality of the Problem**

"Um, clown raid, it's a clown raid!" - George

After a time- be it after receiving a diagnosis, expanding healthy social supports, or going through other processes of self-discovery- all of the Magnificent Seven began to experience their conditions as a positive aspect of their personality. Some members of the Seven were inspired to own their disorders in a single moment; for others, it was a slower and more gradual process. For Amanda, the process that led her to grasp the duality of her problem was fairly rapid.

Amanda: "I remember somebody just, or maybe I was watching a video. I don't remember. But I remember having this moment where something or somebody brought it to my attention that like, "Who said being sensitive was bad?" Like, "Who, who put that out there into the universe?" And I, I remember having this moment of like, "Oh my god, like what if it's not, what if it's not



bad?" And having a follow-up thought of, "I'm going to be sensitive either way." Like no matter what goes on, like I can't, I can't change my brain chemistry. I can't change the fact that when I'm happy I'm so happy and when I am sad I am super sad. When I'm anxious, it's awful. I, a- an- and like so what are you going to do about it? Like if you can't change it, like what do you, why are you trying to somehow make it go away if it's not? Um, and that was a turnkey moment and acceptance from that point turned into sort of a celebration of it. Um, so once I accepted it, once I was like, "All right, it's going to happen." Like somet- any, anytime I have an emotion level over a four or five, and that could be anger, that could be happiness, like I'm crying. When I'm really mad, when I'm really happy, when I'm really sad I just, crying is where I go. Uh, and who, who said that that was bad? Um, so it really from that point forward became an acceptance. And then fo- after that it really became a celebration. It's my livelihood. Um, why not use it? It's my profession, I'm supposed to feel feelings. I'm supposed to be able to identify other people's feelings. Um, and I think as long as, 'cause I think with anxiety sometimes your sort of feeling meter can be off 'cause you're feeling something that's not there, so I think as long as you're monitoring yourself and you're being honest with yourself about where your emotions are coming from, it's a great thing to have in my career. It's necessary."

By embracing the Duality of the Problem, Amanda realized that the same traits that fed her diagnosis could also be utilized to make her a better counselor. Following this understanding, she recommitted herself to the Counseling profession and eventually went on to pursue a PhD in Counselor Education and Supervision.

George also came to understand that his pathological traits had served him in his numerous vocations, and clearly came to see their influence in his musicianship. George's case

is unique, however, in that he identified instances when the duality of his problem manifested before his Epiphany of Identity, whereas for the other five members a working understanding of the Duality of the Problem only came after the Epiphany of Identity. George's Epiphany allowed him to look back on his pre-diagnosis hypomanic episodes and realize their positive contributions to his identity development. For instance, George took time to share how riding the wave of mania brought extra dimensions to his early teaching abilities (along with one unfortunate administrative leave), and again, both of us came down with a case of the giggles.

George: "Because I was a teacher, and both in city schools and then at a private K-12 school, I developed this ability to just be there for the students somehow. And that got me through my having to function while I was depressed. But the bad thing that I did was, I probably told you this story before, but...Uh, on April 1st I let the, uh, junior high drama class dress up as scary clowns, and then we attacked the rest of the school."

*Researcher's Note: Why, no, he hadn't told me that...*

Clay: (laughs)

George: "Now, later, after diagnosis, I realized, "Oh, that was a manic episode." That was the first time I ever like recognized all the symptoms because I thought that this was the greatest idea--"

Clay: (laughs)

George: "... anyone (laughs) had ever had, (laughs). And we had a tremendous amount of fun doing it but I was really in trouble." (laughs).

Clay: (laughs) "I'm sure. Oh wow. That's, that's so cinematic. I can just see that playing out in my head."

George: "Yeah. Yep. We were carrying all sorts of strange thing with us, sorts of props. I told them they could cannibalize any, any props or costumes in our storage room to make their clown outfits. And they, I told them, "You can be scary and you can be, you know, any animal, do anything," (laughs).

Clay: "Okay!"

George: "All right, anyway. So yeah. I got all of them to come and immediately started crying and I was like, "What, what's going on, you know? What is happening to me?" And uh, then the next day I was suspended and I sat at the coffee shop thinking about it and I just ... (laughs) Somebody came by and said, said, who know, knew my wife, my ex, and she said ... I told her about it, and then she, she told him and he said, "So, I hear you were the lord of misrule yesterday," (laughs).

Clay: (laughs)

George: "I didn't know yet that it was a manic episode." (laughs).

Clay: (laughs)

George: "I don't think it was good street theater. It was, uh, over the top. But the kids covered for me. It was like the Dead Poets Society. They all kind of covered for me and said, "It was mostly our idea, (laughs). He just let us do it. And he didn't know about the silly string."

Clay: (laughs) "What happened with the silly string?"

George: "Well, the kids did ... I didn't know about it. They snuck in and used it on the teachers..." (laughs).

Clay: “Uh-oh!”

George: “You know, they put silly string all over the teachers, and their rooms. (laughs)-

Clay: (laughs)

George: “...when we went in the classrooms. Um, (laughs) clown raid, it's a clown raid. And they'd come in and do nonsense, and then leave...” (laughs)

Clay: (laughs)

George: “But there's a part of me wouldn't give up that experience for anything and at the same time, it's really very insane (laughs).”

Clay: “Yeah...”

George: “But I remember one of the kids turning to me and saying, "Thank you," at the end of it. And that made it all worth it to me 'cause he was a kid I hadn't broken through with yet. So that was interesting. And I'll always remember that. I still know that kid. He's here in LA doing comedy.”

*I could not ask for a better story to place in this study. I simply couldn't. Except, perhaps, for the very next story George told me about his hypomanic episodes, and how they made him a better Jazz Pianist.*

George (written): “The positive aspect of them [George's manic episodes] is that I did some things I'm glad I did, that I might not have done, including sit in and play jazz with people before I was ready. There were times when I went out and just sat in or played at jam sessions when I didn't know what I was doing. Manic confidence.. I was even playing in front of Jessica Williams. She's a professional jazz pianist with, like, cred and records! I was young and I really

hadn't been playing that long but I wanted to show her that I knew some jazz. And, you know, I started to do it, and the bass player (laughs) (it was a guy who kind of didn't like me.), he said, "Hey, get him out of here," (laughs). But Jessica says, "No. He's gonna play some shit." And that encouraged me, you know, to, to do it again. Although I would get lost in the tunes sometimes it didn't bother me.. I felt like these are my people, this is my music... So, I learned everything, you know, from other musicians. And those were, those people became my friends. I think that I was very overconfident, with no, (laughs) nothing to back it up... But I think it also helped that I had all this energy sometimes that I was lucky enough to have an outlet for."

Though hypomania had imbued George with a false sense of confidence, it had likewise given him the energy and passion to sit in with and learn from some of the finest Jazz musicians on the West Coast. George's hypomanic episodes are substantially reduced in the present as a result of his medication, and in reflecting on this incident, he stated, "that would be really hard for me to do, now."

George wasn't the only member of the Magnificent Seven who found his artistry enriched by psychopathological traits. Kitten was likewise able to explain the benefits of her anxiety with relative ease. At the beginning of our interview, she mentioned how she had recently told her stylist that the world would be a better place if more people were mentally ill. When I asked her how mental illness had made her world better, she told me the following:

Kitten: "As an actor, I ... it is my career to be other people, and it's ... it's not even so much being other people as it is being different versions of myself, um, and because of the anxiety, I watch people. I watch people a lot, and you know ... and because of that, it's easy for me to pick up

characters and dialects and speech patterns and postures because inevitably there's going to be someone, you know. Oh I'm playing the role of an emotionally fraught mom? Great. I've watched emotionally fraught moms. I'm playing the role of, you know, very competent high powered attorney? Great, I've watched a very high powered attorney. I ... you know, so because of that constant like watching of the world and the people in it and all of their little ticks and mannerisms and that constantly like trying to figure out what's going on behind their eyes, makes it to where I can do my job pretty well.”

Harley was also able to channel his disorder towards positive ends as an actor. He shared the following story with me, in which he found an opportunity to both enhance his work and continue resolving his post-trauma problems.

Harley: “Um, it was coincidental uh, but uh, I was offered the role of Henry II in "Lion in Winter," uh, back in, in mid 2017 and uh, I did not audition for the part. The director contacted me and said, "Please come to call backs. I didn't see my Henry in my audition pool and I would like to invite you to call backs." This is a character famously old. It's the Lion in Winter, the man repeatedly says he's 50 years old and this director wanted to put me in that part. And he did. Uh, I auditioned against some of the best 50 plus year old actors in San Francisco and the director gave me the part, which then meant I had to play Henry II in the Lion in Winter. Uh, and uh, in approaching that part as this man towards the end of his life, has to struggle with legacy and the very real possibility that he has to kill his own sons uh, there was some incredibly beautiful moments that I had sitting there with that text going, "Oh shit, I can play this part.” This isn't, this isn't so different from me... Uh, so yeah, so doing that a couple of months ago, was, was beautiful.”

Clay: “Are there any lines from the text or moments that you think of, that the really encapsulated your experience, or moved you, or got you thinking about yourself in a different way?”

Harley: “Mm, oh yeah- the moment towards the end of the show, where I have to hold a knife to my son's throat uh, demanding to know why he can't find the balls to kill me uh, that was, that was an interesting one to live in every night. Um, yeah, more and more during the show, when I looked in the mirror- my dad kept a beard his whole life and I grew a beard for the part and, uh, now that my beard's going gray, I just, I see my dad more and more in me. And it wasn't ... I wasn't playing my dad and it wasn't homage to him or anything but there were definitely times where like, okay, if I'm going to have a ghost, uh, it's uh, it's, it's good to have a ghost that uh, that I can tap into for positive reasons. Uh, and my ... The, the, the voice that my inner critic over the past couple of years, has, has taken on the voice of my dad. And uh, that's uh, at first was disturbing to me and now it's just like, no, it's you know, it's a hypercritical Jiminy Cricket. It's uh, cool.” (laughs)

By channeling his trauma, sadness, and horror into his performance as Henry II, Harley was not only able to bend his pain to positive aims, he was also able to process his trauma and re-incorporate the memory of his father in a positive manner.

Patricia described the positive aspects of her condition on two levels. On one level, she thought her disorder came with accompanying benefits such as quick thinking, a strong memory, and heightened creativity. On the other level, she was able to recount a time when her symptomology itself had helped guide her through the longest break with reality she ever endured.

Patricia: “Because you know what it is Clay, we're strong people, given medication- yes, I know I'm still wired a little different. I understand that, but you take somebody like me or somebody else (with Schizoaffective Disorder or Schizophrenia), we are strong and talented people because of the way our brain works, when you put me on medication and I'm not having hallucinations, and I'm not having delusions, or breaks in reality, I'm quick, I got a 4.0 grade point average- I read something once and I know it. My brain continually runs. I only sleep four hours a night.”

Clay: “Okay. Thank you, that's very good. That's awesome actually, just one more question. I know you like the way you think and you say you think outside the box. Can you tell me a story about how you thought outside the box to solve a problem?”

Patricia: “I did not want to make someone else wrong, to be right. I don't fight that way, I don't fight the same way other people fight where they have to make their point be the most important point, and I think that's because I'm so used to other people telling me what reality is, that when I have a point to get across, I'm open to what they think because I could be wrong. So I'm always, if I'm right and I know I'm right, I try not to make other people wrong. Because if you tell somebody they're wrong, they automatically get on the defensive. If you say I see where you're coming from, can you see where I'm coming from? You can change it.”

In the previous passage, Patricia described how she used her experience to identify, perhaps unwittingly, a central foundation of Social Constructionist positions in Counseling- the idea that the counseling relationship has room for multiple realities and many ways to interpret a client's position (Gergen, 2015; Guterman & Rudes, 2008). Later during our follow-up, she told me how a hallucination had, paradoxically enough, helped her overcome a tremendous break with reality:



Patricia: "Do you know what I forgot to tell you?"

Clay: "No, what's that?"

Patricia: "I have tactile hallucinations, do you know what that is?"

Clay: "No, what is it?"

Patricia: "I can touch a hallucination and a hallucination can touch me."

Clay: "You're tactile, oh I didn't know that, okay. Alright, that's good to know. That primes me for the next question. So have your symptoms, have your hallucinations and delusions always been bad, or was there ever a time where you saw something or experienced something that was positive in some way, at all?"

Patricia: "Yes, let me tell you what happened to me. I went into a major, major episode. I was friends with the drummer from Buckcherry, he got into that late in life and before that he was just a biker and we knew each other for years. And I got him, what happened was I went into an episode, it was a five month episode, two months I had four people in this room trying to kill me, for two months. Now mind you, I can touch them, they can touch me, they would grab me by the throat, throw me against the wall, it was horrible. Then I woke up in the hospital, strapped to a gurney, I look in the corner of the room and there's Xavier. Now, I said, when I first saw him, thank God Xavier came, but he was a delusion. But he was on my side for the next three months."

Clay: "Wow."

Patricia: "So it was him and me against those four. I was put into three other hospitals and released."

Even in the depths of her most violent break from reality, Patricia was able to marshal the force of her symptomology for protection- for three continuous months. In this manner, her sense of Duality is similar to George's in that both of them identified times when the positive and negative effects of their psychopathology were present simultaneously.

Like Patricia, Astrid organized the characteristics of her condition to protect herself against unsupportive and hostile authoritative figures. Astrid experienced the duality of her problem in a manner that is common among autistic individuals- she found autism to be a constructive and foundational aspect of her personality (Cascio, 2012). Astrid stated that her autism presents certain challenges in life, but on the whole it is not something she has; rather, it is something that she is- and she is proud of it. In the following passage, Astrid told me what she loved most about being Autistic.

Astrid: "Um ... geez, um, I, I, I, I, I love the way that I hear the world, um, which was also one of the first things I was able to put my finger on concretely and say, I can tell that I am different from other people in this way, is that I always, um, I hear things that other people don't, I'm affected by, by sound in ways that other people aren't. Um, you know, I almost, um, I, I, like, the auditory world is something that I, I feel really deeply and not just hear. Um, in a way that's really layered for me."

*Researcher's Note: Okay, spoiler time. In the Epilogue section, I ask the participants two questions, one of which is, "If your disorder was standing next to you right now, and you had the chance to say one thing to it before it disappeared, what would you want to say? I asked this question of each participant except Astrid, due to the discovery I just mentioned- Autism isn't*

*something she HAS, it's something she IS. I told Astrid about this question and my decision, however, and asked her how, exactly, she incorporated Autism into her overall self-concept. This is what she had to say:*

Astrid: "It's a complicated question. In certain ways, all of the above. The autistic community has fought back hard, and in some ways very rightfully, against a conception of autism as something that's separate or removable from a person. Because a great deal of the mistreatment and abuse historically, and still, inflicted on autistic people in the name of therapy or treatment is conceived of under the illusion that autism is some kind of a shell or an invading entity that's concealing or holding a non-autistic or even "real child" hostage. Many people have been very, very resistant to the idea that you cannot attack autism without attacking the autistic person, because the two are not separable. Julia Bascom, who I think is one of the most fantastic writers about autistic experience, wrote something to the effect of "there is no point where autism ends and I begin." It's how our whole entire neurology is configured to prioritize information differently. There's nothing you can fundamentally alter about that without fundamentally altering a person. Privately, though, it has not always felt that way. Especially when I was younger and had no information or language for this force that was me, but also seemed to defy my own volition or rationality, it was a thing that was very easy to personify as...something else. I don't know if you've ever read Philip Pullman's series "His Dark Materials," but in the universe of those books, all humans have a daemon, which is kind of a physical manifestation of their psyche, in the form of an animal with characteristics closely related to those of the person. Human and daemon are considered to be one being, have uniquely intimate relationships with each other, and everything that affects one affects the other, though daemons can at times act

somewhat independently. And on a visceral rather than a purely rational level, it can feel more like that. It can feel like a creature who is both you and not, who you don't always understand (and again, this is partly a long-term and almost inevitable effect of living in a society that systematically deprives us of language for our experiences and almost forcibly alienates us from ourselves), who you have to engage in a lot of negotiation with, and sometimes just give it exactly what it wants.”

Astrid's statement speaks to the complex and multifaceted nature of incorporating a psychiatric diagnosis into an individual's self-concept. Autism is something she is, not something she has- except for the times when it isn't. Furthermore, this complex and intricate process is compounded by messages received from families of origin, institutional powers, and sociocultural convention. The implications of the multifarious process of incorporating diagnosis into overall self-concept will be further explored in Chapter Five.

Finally, several members of the Magnificent Seven were able to tap into the Duality of the Problem as a direct result of receiving an accurate diagnosis. Harley, for instance, was able to organize his experience and work against his symptomology as a result of learning about the nature of PTSD. He soon found that knowledge of the problem did not necessarily mean relief from the problem, but a proper understanding of PTSD helped him to manage and control his symptomology.

Harley: “I could start to identify what behavior was grief related, what behavior was depression related. What ... And then finding I had triggers and being able to like deal with things as they came because I had a foreknowledge of it. Uh, one incident recently that I've been thinking a lot

about it uh, I was riding BART, which is the local transportation system. You've been here, you know BART.”

Clay: “Yeah.”

Harley: “Uh, so a young actress and I, after a performance in San Francisco, we're about to catch a train and a, a rather tall ... Like taller than me, so like six three, six four, tall guy, flannel jacket, beard, comes up behind this actress and grabs her. And her first impulse is to say, "Uh, help. I don't know this man." And she was doing it playfully because sh- Clearly she knew this guy. I had a surge or adrenalin come through my body and I found myself for the next like two minutes with a metallic taste in my mouth because in that moment, I was going to attack that guy. Uh, and instead of being a very like attentive person, being introduced for someone for the first time, I found myself standing there just like coping with the fact that I'd been triggered to violence. And had to like, I just need to ... And I don't know if I hadn't had a diagnosis, what that moment would have been like if uh, if I didn't know to self-identify like, "No, okay. You've just been triggered. Your body's going to go through this endorphin system." Uh, just you know and man, adrenalin hangovers are the worst. Like-... coming, coming down from that rush is uh, it's an icky feeling. So even post like surge, like the, the train ride was just like, "Uh, I don't like this." But uh, that was all internal. That was, you know, an absolutely internal experience that neither of those people really knew was going on or at least I don't think they knew it was going on.”

Harley's understanding of PTSD may not have been enough to stop the symptomology from swimming to the surface, but it did help in navigating the waters of social interaction.

### **Summary**

Each member of the Magnificent Seven was able to develop and embrace a Duality of the Problem- a sense that their disorder had both positive and negative qualities. For five of the six who identified an Epiphany, this duality was embraced following the revelations of the Epiphany of Identity. For the other member, the Epiphany allowed them to look backwards and retroactively identify times when his psychopathology had helped him. All participants were able to identify times when they had used positive aspects of their psychopathology independently of the presence of negative symptomology, but two members were able to embrace the Duality of the problem even during the most virulent outbreaks of negative symptomology.

### **Development of Empathy**

“They would think about what they're about to say and do, and maybe they'd be a slightly less shitty person because of it.” - Kitten

Each member of the Magnificent Seven related stories of how their struggles had helped them develop a fuller and richer sense of empathy, and they also felt that their heightened capacity for empathy had made them better people. Kitten related the following thoughts and feelings, which had been inspired by a conversation she recently had with her personal stylist.

Kitten: “When you're watching other people react to things, when you're watching other people in moments where they do or say genuinely horrible stuff, you know, the ... the anxiety ridden person inside of me looks at them and thinks like, you know, if that person suffered from anxiety, they would not be doing this, because they wouldn't want to make this scene. They wouldn't want to hurt these people's feelings. They wouldn't want to make it seem like they're batshit crazy. They wouldn't ... you know, they ... they would take a moment before they just lashed out, and they would think about what they're about to say and do, and maybe they'd be a slightly less shitty person because of it. Or you know, e- even people who like aren't shitty people, um, you

know, because we ... we've all occasionally done things in relationships or friendships or whatever else that perhaps were a little insensitive. And because, you know, "Oh well I didn't think it was that big of a deal," we don't necessarily think about the impact that it's going to have on this other person. Well when you suffer from anxiety, oh you think about that. You think about that constantly. Y ... and yeah, it ... it can trip you up. It can be a bad thing, but I ... I have had moments where, you know, I ... I look at people who I know to be good people, and I'm just like, "You know, if you suffered from anxiety or if you suffered from depression, you wouldn't be so cavalier about this thing that you've done. You wouldn't be so dismissive about this other person's feelings. You would truly understand why this person might be hurt by what you said or done." But ... but because they don't have ... they don't have that need to constantly filter and question themselves about it, they just don't do it."

*Researcher's Note: Kitten could single-handedly write a counterpoint text to the DSM.*

Likewise, Patricia felt that her experience with Schizoaffective disorder had deepened her sense of empathy and improved her disposition as a Counselor-In-Training. She also felt inspired by people in her life who had demonstrated empathy to her, and sought to honor their influence on her life through her career as a Counselor:

Patricia: "Like I, I'm quick, and I like that. And I like that this disease made me so empathetic. That I can, I look at other people with disease, with mental health issues, and I think, I can help you. Give me, you know, give me some time, and I think I can help you. And that's why I'm going to school, because I wanna do what Mimi did for me. And having this disease made me be

able to, to empathize with other people who have, and to be able to show them that you're not this disease. This is just something you have.”

*Researcher's Note: I notice that for all of the similarities the Magnificent Seven share, they also have unique and distinct ways of relating their relationship with the disorders. Patricia doesn't want to be called Schizoaffective any more than a person with high blood pressure would want to be called a Hypertensive, but that's certainly not how Astrid conceptualizes her Autism. This tells me that the client's voice should take the lead in shaping the diagnosis through the therapeutic relationship.*

Faith easily described how ADHD had deepened her sense of empathy, as previously stated, stories of her enduring concern for others were replete throughout her narrative. In the following passage, Faith related the first time she truly felt that she was a different type of person than most of her peers:

Faith: “So when we moved to Georgia from Birmingham when I was in the sixth grade, um, it was right after Thanksgiving so, moving in the middle of the year in the sixth grade, that sucks anyway. Um, and the first day that I went to my new school, um, at lunch I was trying to decide who I was going to sit with. And there's this group of girls, and they were wearing their little cheerleader uniforms, and I went over and they're like, "Oh, you can come sit here." And I was like, "Oh, okay." And so I started walking over there, but I saw a girl sitting by herself and crying. And I was like, "Hm, no, I'm going to sit here." So like I sat with the girl who was crying. Um, and that- that set into motion (laughs) for middle school at least, sort of being, not



ostracized, I mean, those, that- that group of girls never bullied me or anything, but it, you know, I had a lot more empathy as a very young person than I think a lot of people that age did.”

Faith then took time to reflect back on this incident through the lens of her post-diagnosis experiences:

Faith: “Um, so I was actually reading, within the last week or so, uh, an article about how people who have ADHD, because the brain is sort of wired a little bit differently or it functions differently, or whatever, um, these, this group, uh, is more prone to being incredibly empathetic. And so we hear criticism harder, um, and it is, you know, stays with us longer. Um, but also that allows us to really put ourselves in other peoples' shoes- .. um, on a, I don't know, I guess on a deeper level, because we really, we're more emotional and sometimes that's a mess, and it's not pleasant. But I like that about myself. Like, I like how much I care about people. And I like how much I want to help people. That's something that, you know, again, going back to that sixth-grade moment, maybe if I didn't have ADHD, I wouldn't have cared, like I wouldn't have seen that girl upset, and I would have just gone and sat with the cheerleaders.”

Though a perceived lack of empathy has historically been a hallmark of Autism diagnoses, recent scholarship has worked to dispute the notion that Autistic individuals cannot experience care and concern for others (Milton, 2014; Rogers, Dziobek, Hassenstab, Wolf, & Convit, 2007). Astrid had the following to say about how her extreme difficulties in finding the support she needed had affected her:

Astrid: “It's like, I just, I just absolutely, like, it crushes me to think, but there are people trying to get a diagnosis and running into this stuff, um, you know, and, and, you know, who have their disability dismissed because they don't have a diagnosis, but they can't get a diagnosis because the very nature of the disability makes it difficult to navigate all of this, like, social red tape.”

### **Summary**

All seven participants in the current study stated that struggling with their disorder made them more globally concerned and empathetic people. For a few members of the Seven, this empathy developed early on, for others, it developed as a result of later reflections on early struggles. The various expressions of empathy, however, were varied and manifested at different points of the participants' development. Some participants sought to spread a message that those like them were more than their disorder, others desired to create conditions that would make it simpler for others to receive a diagnosis.

### **Activities of Difference**

“It was a physical reaction, like vomiting or something.” - George

Each member of the Magnificent Seven spoke about the importance of Activities of Difference; this refers to jobs, hobbies, leisure time activities, and artistic endeavors that helped them manage negative symptomology and capitalize on the positives of their conditions. Two members of the Seven, Faith and Amanda, found the homework assignments given to them by therapists to be activities of difference. Six of the Magnificent Seven found theater work to be an activity of difference. This finding might not be remarkable as five of the participants were recruited through my Facebook page (and I am a former actor); however, it is worth noting that one of the participants recruited through CESNET identified involvement in theater as a vital force in helping her gain confidence and an enhanced self-concept. Though support figures were

generally influential in introducing the Seven to Activities of Difference, the productive work in these activities came as a result of the participants' own self-directed efforts.

Perhaps unsurprisingly, George identified his musicianship as an Activity of Difference. A key element that made this activity remarkable, however, was the process of trial-and-error and George's understanding of his own thought patterns in making the activity work.

George (Written): "Since I was first learning I never set myself goals on piano; I couldn't do that without getting hopelessly obsessive. For example, if I made a mistake on a series of Hanon exercises I would have to start over at the beginning of the book. Once I realized the mistake of trying not to make mistakes, I learned to refresh my brain every fifteen minutes by walking around a little. I would then pretend to be just starting my practice session by working on a different song, or by playing scales instead of arpeggios, or working on rhythms after having worked on harmony or melody. Without realizing it, I learned to channel my manic restlessness into a fragmented series of ostensibly "non-sequitur" activities between which I could move, instead of flitting between less productive habits such as pacing, talking fast, pulling my hair, chewing on pencils or fingers or walking out the door without at 3 in the morning with no destination."

George stated that his proclivity to drawing was equally important in regards to symptom management.

George (Written): "Now that I am drawing again I have a third creative activity that relieves my brain with a non-verbal, non-musical mode of consciousness. I have found this to be a great relief, because even on medication I still have more or less hypomanic periods, just as before

diagnosis I had more or less manic episodes. Drawing slows down rushing thoughts by quieting them. Like piano, drawing is something very physical that helps get me out of my head when I'm experiencing depression, too."

The third creative activity George referred to was writing. George engages in creative writing and keeps a journal, and often finds that his creative endeavors influence and enhance one another. Furthermore, George often finds that the utilization of humor when engaging in and interpreting his creative activities often helps him to process difficult emotions. In the following passage, George explains how the process of journaling recently helped him out of a mild depressive episode.

George: "Like, what's funny about depression is just how bad everything seems when it's not really that bad. And, you know, and, and when I would ... So, I would think that, like, a trip to the store and, uh, I knew that, uh, I knew I was depressed because I was like, every single time I come here I get a cart that makes noise, so everybody looks at me. You know, that's my first thought, not what I need to get at the store, or..." (laughs)

Clay: "Yeah." (laughs).

George: "... anything like that. And, and then I, I go down an aisle and I suddenly realize I'm in the aisle with, where all the Depends are and everything. And I'm like, "Am I here ... Is this some, does this have some meaning?" (laughs)- ... to me that, you know, (laughs). And so, you know, at the time I'm depressed and I'm thinking, "Oh, I have to go to the bathroom. No, you know." And but, as soon as I wrote it down, it made me laugh."

Clay: (laughs).

George: (laughs). And so, you know, at the time I'm depressed and I'm thinking, "Oh, I have to go to the bathroom." And but, as soon as I wrote it down, it made me laugh. Uh, that, you know, the difference between going when you feel good and going when you're depressed to the grocery store, that's funny." (laughs)

Taken together, the three Activities of Difference help George manage his symptoms while capitalizing on the impulsive, creative energies that are frequently associated with Bipolar Disorder (Carson, 2011, 2014). George also identified physical activity as important in helping him manage certain difficulties related to his Activities of Difference.

George: "Over time I have learned to pick up the thread of writing again after playing piano or walking or drawing, whatever physical activity broke up the intensity of sitting and trying to keep up with my thoughts on paper. Sitting has often been a problem. It becomes physically and mentally painful for me to stay in the seat at a certain point. I get excruciatingly restless legs if I try to force myself to remain seated. This has been a problem for me on airplanes, in theatres, and when working on a deadline."

Harley also applied his creative nature to coping skills and activities for PTSD that enrich his life and help him grow as a human being. In the following passage, Harley describes how undertaking a creative craft formerly enjoyed by his father helps him to process trauma and reintegrate the traumatic experience into his whole identity.

Harley: “I haven't had a day of paid work in about three and a half weeks but what I have done is I've started cultivating some hobbies that put me in direct contact with my father's tools and specifically his knives. So I realized just how many blades I inherited from him and my brother and I split my father's tool collection in half and so I've been actively buying tools to complete my collection, the tools that end up with my brother that I need to have a full functioning shop and I've started restoring my father's blades. So a 1945 military service machete with just years of tarnish on it, my father's own Boy Scout hatchet, polishing that and didn't even know it was a Boy Scout hatchet until I polished it well enough to see the engraved Boy Scout emblem on it ahm, and these are moments that I'm finding the ghost is just a warm presence in a way. There's no voice. Aah I'm doing something for myself that engages me in, in habits and practices and physical objects that my father had a relationship with ahm but satisfying to me for my own sake. Aah I spent the whole bunch of hours watching YouTube videos about knife making and now I think I want to get a little tool shop together and make knives and make little I don't know decorative wooden boxes and picture frames and I want, I want to make stuff that that lasts.”

Like George, Amanda also identified physical activity as being an important element in keeping her symptoms managed and maintaining a healthy self-concept. The members of her extended family often struggle with their weight, and she too finds weight management to be an occasional challenge. In working to keep herself healthy, Amanda enjoys the benefits of an Activity of Difference.

Amanda: “I always have some sort of like eating program or some program that I'm doing like Weight Watchers or something like that. Um, and when I'm doing well and I'm losing weight,

it's, it's very much a high time. So I'm doing well, I'm losing weight, I'm going to therapy, everything's wheels, you know, cogs, everything's working together.”

The positive effects of exercise and a proper diet on mental health have been extensively researched (Cheng, 2015; Lovallo, Farag, Vincent, Thomas, & Wilson, 2006; Naves-Bittencourt et al., 2015; Sørensen, Anderssen, Hjermerman, Holme, & Ursin, 1999). For one member of the Magnificent Seven, an Activity of Difference was decidedly less conventional. In fact, Astrid was able to identify the exploration of her limited autonomy in the face of negligible social opportunities as a protective factor. Astrid quoted research to me on the high rates of suicide and depression in the adolescent Autistic community, and when I asked if she had struggled with suicidal feelings, she responded in the following manner:

Astrid (Written): “I think there was also, ironically enough, something of a protective effect of being so socially alienated. Like, I wasn't getting offered drugs and alcohol. I wasn't invited to the kinds of parties where those things were readily available. We lived in a somewhat isolated neighborhood, and I'm sure it was possible to get drugs outside of the party scene, but I literally just didn't know how.”

Astrid went on to explain how the genesis of her relentless pursuit of liberty and autonomy was likely born from her adolescent social isolation. Knowing that she had to entertain, maintain, and advance herself through developmental challenges was highly motivating for her, and she fully committed herself to behaviors that maximized her potential for greater autonomy.

Astrid: “I spent a lot of time thinking I could figure out how to follow directions or pay attention well enough to stay out of trouble with people, and I think I started down a road really young of trying to be as self-sufficient as possible, because adults weren’t reliable sources of help.”

For Astrid, the lack of early social support was, interestingly enough, a blessing in disguise.

Like Astrid, most of the Seven identified Activities of Difference that were tied to very serious and heartfelt issues. For a few of the Seven, however, Activities of Difference also included engagement with the comedic and absurd. For instance, George found watching and enjoying absurd cartoons to be a profoundly effective and long-lasting Activity of Difference. In the following passage, George describes how watching a simple Looney Tune profoundly affected how he dealt with stressors and challenges.

George: “I had an, I had an, uh, an appointment to go and write some children's, music for children for a public, uh, uh, you know, a versed guy who was published a lot who had made a lot of money. It was an opportunity maybe for me to get, you know, some royalties and actually publish some music, even though it was, you know, children's music. Well, I did a whole bunch of cocaine and alcohol the day before I was supposed to go. And, I didn't go, of course. And, uh, the next day I was feeling so down, and my friend, Michael, uh, who's a drummer, he said, uh, "There's cartoons on. You wanna watch cartoons?" And I said, "Yeah." And a, a Daffy Duck cartoon came on. And it was Daffy Duck Slept Here, the one where, uh, he and Porky have to share a room as there's a convention in town. And it was the funniest thing I had ever seen in my



life. And little by little, I started to laugh. Um, but every time I s-, I would get sad, I would think about that. I, (laughs) and that's why I have little Daffy Ducks around, is because that was the, a really powerful thing. That laughter got me out of that place I was in. He says, "Hey." He's talking to somebody who's not there, Daffy, he's a drunk. He comes, he's, "I thought I'd never see a woman get ..." and he's, he says, "This is behind me. He's six feet of kangaroo." And Porky's over there going, "There's no kangaroo there." And Daffy gets into an invisible pocket and begins to hop around the room, just his head. And he says, "Oh yeah? How do you think I'm doing this?" And I just burst into laughter. I rea-, (laughs) I remember it really well. It was like a, uh, physical response, like vomiting or something, you know. And I felt better. I, and I was like, "Oh, well, I guess Daffy Duck cartoons are pretty good meds."

The preceding passage also illustrates how members of the Magnificent Seven were motivated to embrace themselves and learned to cope with stressors through works of art. In the following exchange, George explains how the music of John Coltrane inspired him to think and feel differently about himself.

Clay: "So, was there any figure like that for you, someone either real or fictional that you really attached to, that helped you get through the hard times and feel differently about yourself?"

George: "John Coltrane."

Clay: "John Coltrane. Okay. Very good. Can you talk a little bit more about how you identified with him, what it was about his music or his story that really spoke to you?"

George: "Yeah. I, I, it was a f-, it was a feeling, uh, of, you know, striving to be a better person, striving to be a better musician. Uh, the, the example of the fact that he didn't care what, what,

uh, what critics or anybody said. He, he knew what he was doing, and he was, he was gonna go as far as he could go with it. And I, I really, I admired even though I didn't, at that point, really dig his later work, uh, I knew that it, it was heavy and that it was important. And, um, and, I, I, I was, you know, um, I was sh-, I was spiritually kind of touched by his music. I didn't go to church anymore. Um, but, there was God in what he was doing, and I felt it.”

The ideas of always striving for self-improvement and ignoring critical voices that run counter to personal aspirations is replete throughout the Seven’s narratives. Directly after this exchange, George explained how Henry David Thoreau wielded a similar influence in his life narrative:

George: “Thoreau was kind of like that for me before I had discovered him, when I was in my teens, Thoreau was my hero. And uh, I, I learned from him that if you simplify your life, you have time to think and do things that you might wanna do, and what's wrong with that, you know, (laughs). Why should you toil at something you hate?” (laughs)

Amanda also took time to explain her love for the arts and how they influenced her behavior and self-concept. In fact, she informed me that her interest in literature and Narrative Therapy was a driving force in her decision to join the current study. In the following passage, Amanda explains the meaning and inspiration she takes from multiple forms of artistic expression.

Amanda: “I like metaphors, I like stories, I like movies. Um, I very much like reading, I love to read. And so I think I can think of any number of um, like literary characters or um, you know, people in my life. I-, it's almost like I see, cause I think there are, everybody, that every character has something that they do exceptionally. Um, and it's, it's like I see that and I, I want to emulate that part of that person or that character.”

Similar to George, Amanda identified with fictional characters and artistic creators whose life narratives served as exemplars for her own self-concept.

Finally, members of the Magnificent Seven learned to cope with their issues by adhering to self-created boundaries. In her first foray into the human service field, Patricia took a job as a support specialist for autistic men in a community home. Due to her agreeable and hardworking nature, Patricia soon found herself saying yes to multiple requests for overtime work. The added hours compounded the difficulty of an already stressful job, and Patricia eventually decided to quit as she felt the constant pressure was enough to trigger a psychotic episode. In reflecting on the experience, Patricia expressed how she learned from the experience and how it would inform her decisions moving forward.

Patricia: “I'm getting back in the work force and I tell you that's something that's gonna be a major thing for me, I think that's gonna be, I'm going to really need to work on some skills to get that going. I'm not talking because I don't get along with people because that's not the problem, my problem is that I try to please them so much that I get myself screwed up. Because I'm so worried that I'm going to lose the job, that I, yeah, I'll work 60 hours a week, Patricia can't take 60 hours a week... You know, I'll do whatever you want, you know, and you know it seems that

the more they like me and the more they depend on me, the more stressful it gets for me. But I think that this time might be different, because I'm walking in, knowing what I'm doing.”

Faith likewise learned what she could and could not manage in the world of work and has attempted to shape her career trajectory accordingly. As a young adult, her industrious nature led her to pursue multiple part-time jobs in addition to full-time work. In the following passage, she reflects on what she learned from the experience.

Faith: “And I know, like I know that working a 20 to 27 hour a week job on top of a 40, 50 hour a week job is not healthy and it's not wise. So, I've learned from it and it sucks, but you know, it is what it is.”

The idea of people with mental health issues setting their own limitations- and the boundaries that prevent them from doing so- will be discussed in the fifth chapter.

### **Involvement in Theater**

“We Tell Stories so that we Can Share our Experiences, or so that we can Escape from Them” - Kitten

Six members of the Magnificent Seven identified involvement in theater as a key Activity of Difference. While this may not be a unique finding due to the snowball sampling procedure, the richness and fullness of participant narratives of theater cannot be overlooked. All sorts of theatrical endeavors were meaningful and fortifying to the participants, including Stage Management, Lighting Design, Acting, and Playwriting. Some members of the Seven found a supportive sense of community in the theater, some found ways to keep their troubles in check, and some found ways to celebrate themselves and their talents.

Amanda, who was not a personal acquaintance prior to this study, fell into the third category. As previously stated, her early years were marked by timidity and a reluctance to draw

attention to herself. This sort of behavior is perhaps to be expected given her lifelong inclination towards anxiety. In the present, however, Amanda identifies herself as an extrovert, and during our first interview she laughed at “how far away that old behavior is from those who know me” in the present. When I asked about what empowered her to becoming more outgoing and sociable, Amanda spoke of both her Epiphany of Identity and her adolescent involvement in theater.

Amanda: “I started doing theater and I wonder if that had something to do with it. Cause now I was on stage, singing and doing stuff and it wasn't this terrible experience. So I think that for me was the start of, I think owning up to yeah, kind of owning up to who I actually was. Cause I think me being quiet, me being in the corner was all things based off of being ashamed or not wanting to be told that I was bad or I was doing something that wasn't cool or good.”

George also found enhanced self-confidence through theatrical endeavors. At the midway point of our first interview, George discussed the boldness and vigor he had shown in his musicianship by seeking out the company and collegiality of Jazz musicians who were considerably more experienced than he was. I asked George about what had empowered him to throw in with such August circles; this question initiated a conversation about his understanding of the Duality of the Problem. He had more to say on the subject, however, as is illustrated in the following passage.

George: “And I think that that, I think that that on the, the reverse side of that is, uh, has to do with, uh, my involvement in theater too. And, uh, I have stage fright, both playing music and, uh,

on stage every once in a while, not often but it, it's debilitating when it happens. And uh, and I think, uh, being in, uh, doing some theater, doing children's theater and stuff, uh, in my late teens and early 20s, um, that that really also was a support group that kind of helped me, but I don't think I would have done it if I wasn't a little bit an- an- animated most of the time, you know.”

Though George's hypomanic tendencies may have nudged him to get involved with theater, he was quite clear in explaining that his theatrical endeavors brought benefits of their own.

Surprisingly enough, the socially ostracized Astrid also found self-confidence through adolescent acting endeavors. Early in our first interview, she spoke of a desire to perform on stage that was sparked in her early childhood.

Astrid: “Uh, you know, I just had this overwhelming, um, conviction, that, like, oh, I'm supposed to go do this now. This is obviously what I'm supposed to go do now, but it's like...from the time I was a little kid, like, I was always, um, begging for chances to act and to be on stage. And, um, which I never got, because as far as my parents were concerned, I didn't like talking very much. Um, and so, uh, you know, they were always like, no, this isn't, this isn't a thing you can do, this isn't a thing you really wanna do, and kind of brushing it off, and I could not explain that I knew that talking and acting were very different things.”

*Researcher's Note: An opportunity was blown here because of my limited experience with Qualitative Research. I think a seasoned interviewer would have known to follow up on that very interesting statement right there in the moment. This is my first Narrative Analysis,*

*however, and I was so focused on letting Astrid drive the conversational car that it didn't occur to me to ask her to explain this statement more in depth. Luckily, however, the statement that "acting and talking were very different things" did not escape my attention during the Phase Three transcript review. I asked Astrid to say more about the subject in the follow-up interview, and she shared the following:*

Astrid (Written): "This is something I instinctively sensed really solidly when I was little that I was only able to break down and explain much later. I think there is a central paradox, layered on top of a common central misunderstanding of autism, involved. Autism is really commonly conceived of, at heart, as a failure to connect with other people or a fear or aversion to doing so. And autistic kids are commonly trained or punished out of autistic modes of expression and into more conventional ones in the name of improving their ability to connect with others. The problem is that that isn't really what it is, that's just what it looks like. As research more and more starts to look at what the core processing differences involved in autism are and not just kicking the dead horse of social deficits, one of the things that's been found is just that we're processing more information, more detail, more environmental variability, all the time, than non-autistic people are. This goes a really long way towards explaining a lot of the difficulties of autistic people involved in social communication disconnects: multitasking difficulty, fear of unpredictability, auditory processing issues, etc. We use language differently, we have a really different and more intense sensory experience of the world and our bodies in it, which leads to having different body language, which all adds up to we're trying to make connections to other people but we're operating from a very different framework of social communication than most people are. [This is anecdotally noted a lot, though not well-studied, but one way this shows up is

that autistic people are often thought to be unable to understand sarcasm. But autistic people frequently report understanding each other's sarcasm more easily than other people's sarcasm. Because sarcasm relies on shared perception of what is obvious and what is not—we miss sarcasm when what one party is assuming is obvious is actually not, but do better when we do have shared perceptions of the obvious vs. not-obvious.] Acting mitigates a lot of those issues, and with them, a lot of the anxiety inherent in everyday spontaneous interaction. You know what you're supposed to say, because it's written down and you memorized it. You know what somebody else wants, because you decided together. You know what this conflict is about. You know where you're supposed to be, what you're supposed to be doing. A lot of the fear and insecurity that comes from knowing that you don't know what you're doing is lessened, because you know you do know what you're doing. There aren't opaque, unspoken expectations in the same way. Acting required, although I didn't have that word for it at the time, re-embracing a lot of very autistic modes of engagement that I had been embarrassed out of or trained myself out of over the years: Ritualization, taking pleasure in repetition, the expectation of predictability, use of scripted language. It's incredible for motor planning practice because that's what rehearsal is for—that you take the time to plan an action out, try something awkward, see if it doesn't feel right, try a different way. Acting is thought of as artifice, but the mechanics of it are things that were actually more genuine to me, and I was, seemingly paradoxically but also not, more successful making human connections that way than in just trying to not be what I was.”

*Researcher's Note: Sometimes I think that Astrid should be writing this study instead of me.*



In the endeavor of acting, Astrid was able to re-embrace modes of communication and understanding that had been stripped away by authority figures in her early to middle childhood. As evidenced by her statement in the Prologue, Astrid hasn't forgotten about the rejection of her identity by the educational system in the least.

Like Astrid, Harley chose to become a professional theater artist. Also like Astrid, theatre helped Harley compensate for deficits and losses he suffered early in life. An itinerant soul by conditioning, Harley followed his military family from place to place early in life. This pattern instilled a love for wanderlust in Harley, but it also made it difficult for him to generate a working support system.

Harley: "Seventeen years in California and then I did seventeen years in Atlanta uh, and during that time uh, traveled to Indonesia and performed there. Traveled to Russia and performed. I performed at the Scotland ... Uh, the Edinburgh French Festival. Uh, Atlanta just had a really low cost of living, that made me realize that I could just, I can have a two bedroom house on my own and keep my stuff there and do whatever I wanted anywhere else."

When I asked Harley how he coped with his family's frequent moves and the social limitations imposed by his travels as an adult, he shared the following.

Harley: "Speaking of creative, I mean and uh, and you, you will know of this first hand yourself, the, the, the transitory nature of the, the relationship you have with cast members- You understand that we're only going to be together for two to three months but at...During that time, we need to be a family."

Though these family units flowed and faded throughout his life, theater helped Harley find the support systems he needed as he developed his craft.

Kitten had more to say about how the reciprocal link between artist and audience had led to positive personal development. In a conversation about her favorite memories as a professional actor, she stated the following.

Kitten: "A lot of them [favorite memories] don't really happen onstage as much as they do off. And being able to do a show and have somebody come to you afterwards and be like, "I was moved. I was having a really bad day and I came to see you in this comedy, and you're hilarious, and being able to laugh really did a lot for me." Um, doing a lot of touring kid shows, in dealing with sensitive subject matter like abuse and drugs and, you know, sexual pressures and things like that, and having these kids come to you afterwards and want to talk and want to open up, and want to get help, those, those moments stand out. Um, because as, as an actor, the, you, you want to be a storyteller. And we tell stories so that we can share our experiences, or so that we can escape from them. And if we tell our stories well, then other people feel either not as alone, or they feel released from whatever circumstance they were in, even if it's just for a little while. And, and that's what I do for people. And it's really, really nice when you know those things are working."

For Kitten, the act of helping others reach catharsis was a spiritually fortifying reward in and of itself.

Two members of the Magnificent Seven experienced an Epiphany of Identity as a result of their involvement in theater. Shortly after Harley endured the loss of his father, he began funneling his grief into works of playwrighting and acting. Like Kitten, Harley experienced profound encounters with individuals who were impacted by his artistry.

Harley: “And before I was seeing a therapist, I was writing five minute plays about what I'd done and performing them in front of groups of strangers. And uh, I had, I had people approaching me after the show, to like thank me for my bravery and to like ... You know, like medical professionals. Young, young, young doctors coming up to me and going like, it ... You know, I know we had just voted for all the legislation [for legalized euthanasia] but it's like you know, what you're talking about is super important- and like I would find myself crying in front of them. And uh, it was like, "Oh shit, I'm, I'm putting this story out there, without having dealt with this story being a fact of my own life." Um, and uh, still with my girlfriend at the time, I was able to uh, find a therapist that uh, worked on a sliding scale and specifically had started working with a bunch of actors in the Bay Area.”

After seeing the effects of his trauma mirrored back to him, Harley was inspired to halt the deleterious course of his symptomology and seek professional help.

Astrid also experienced an Epiphany of Identity as a result of her involvement in theater, but she experienced this discovery in a completely different manner. Astrid's undergraduate experience was a highlight in her narrative, as it allowed her to act with autonomy in a manner that had long been obscured to her. Knowing that Astrid was a professional Stage Manager and

frequently involved with the college theater club, I asked about what inspired her to become a professional theater artist. She stated the following:

Astrid: “Um, in terms of identity, I remember, I remember sitting in, uh ... I was a freshman still. And I was sitting in Christopher Norfolk’s Intro to Drama class. And Henderson Pulleay, uh, was with a, uh, production in the area at the time. And he and the whole cast were in as guest speakers to the class, and, um, Christopher asked him to talk about stage management, which he had experience in, and so he did, and I remember him saying, um, it's basically keeping track of everything that nobody else wants to. And, um, it, that was an incredible moment, because I, like, I just went to myself ... but that's what I do. But, like, but that's just what I do, and what do you mean that this is something that I could get paid to do, um, because currently this is a thing that I just do, and nobody else likes or appreciates it all that much. Um, so, um, like, it, it, it, it, it seems completely unbelievable, like, to even think it now, but it's like I really knew in that instant that that's what I was supposed to be doing.

Clay: “Okay. That is definitely something that's gonna make the final cut, the things that nobody else cares about.”

Astrid: (Laughing) “Yeah, um, I, I'd never heard anybody say that before. Um, I had never heard anybody, you know, identify a character trait like that before, and me be able to go, wow, yeah, that's who I am. That's, like, that's what I do.”

Faith also identified her involvement with theater as an important Activity of Difference. While many undertakings with her high school drama club had been deeply influential for her, Faith remembered one acting endeavor in particular that continued to affect her in the present. What made this particular role- Chris in *Dancing at Lughnasa*- so important was that it allowed her to channel and process negative, internalized feelings.

Faith: “Okay, so Chris is so, like she had such a deep sadness, and the whole thing with the dad that just like waltzes in every three years or whatever, and then disappears again. That, like getting to feel that heartbreak, um, but like put on, try and put on a good face for- for her sisters, it- it was so cathartic to be able to do that, but be somebody else while doing it. Does that make sense? Like I knew that heartbreaking feeling for different reasons, but to be able to put that with someone else and feel it, but feel it honestly, it was just so, ah, it was just so good. It was powerful to me in that way.”

This event is remarkable in that it granted Faith a moment of catharsis, a chance to purge the bitter feelings she had internalized throughout her early struggles with the problem.

### **Summary**

Each member of the Magnificent Seven was able to identify activities, endeavors and pastimes that helped them curb their symptomology, profit from the positive aspects of their conditions, or purge and process difficult feelings related to their conditions. For some, these activities were self-taught and self-directed, for others, encouragement and participation in a community endeavor was essential. Though almost all of these differences involved some form of art appreciation or artistic expression, six out of the Seven identified participation in theater as

an Activity of Difference. The different theatrical disciplines represented were Stage Management, Acting, and Playwriting; furthermore, several members of the Seven benefitted from the sense of community generated by collaborative theater work..

### **Persons of Difference**

“Freaks can be some of the most die hard, truest friends you'll ever have” - Kitten

The narratives of the Magnificent Seven are rich, outrageous, and engaging, therefore it stands to reason that the company they keep should make for equally lively storytelling. Each member of the Magnificent Seven readily identified other people who had been instrumental in the evolution of their self-concepts. For some of the Seven, specific individuals were most important, for others, whole communities had been indispensable. Most of the Seven were able to identify helping professionals that had assisted them in positively reframing their respective disorders. The common thread in each of these narratives, however, were relationships that did not view the participant as aberrant or broken, no matter the severity of participant behavior. These relationships went beyond normalizing and validating in viewing participant behaviors as logical reactions to environmental stressors; furthermore, they celebrated the members of the Seven just as they were.

### **Friends, Family, and Community**

“Nos comedere ova et lardum!” – George’s Latin Class

Shortly before joining her current doctoral program, Amanda endured a traumatic experience. Though she greatly enjoys her program, she quickly found herself far less happy about the cultural climate of where her school is located. These twin developments caused an upswing in her anxiety, and true to form, she was reluctant to reach out for help for fear of burdening or upsetting others. In the following passage, Amanda explains how things began to turn around for her.

Amanda: “My family and friends back home, it was hard for a long time last year cause I didn't feel like I could ask for help. Like, I just kinda pretended like everything was okay for people back home- especially my mom. My mom is also very anxious. And she hates when one of her babies is upset, like, she hates it. So I spent a lot of time pretending like everything was okay, even though it really wasn't. Even when I would talk to my friends on the phone or over Facebook I'd be like "Oh you know just going to school and la la la" and not be like I am literally about to have a heart attack I am so stressed out. I think cause my mom ended up spring last year, not this past February but the February before that, came to visit me cause she had, she's a school teacher so she February break. She was like "Oh let me come visit you" and like I really couldn't hide and I didn't really anticipate that it was gonna be such a truth revealing moment for me or for her I guess. But she could definitely tell that something was wrong and so I just ended up telling her how stressful and awful it had been. She was like, "why didn't you tell me?" And we just, that week was so life bringing to me. It was like having your mom cook you a meal. It was just someone care taking me for the first, and me allowing someone to care take me, cause I had been pretending nothing was wrong. So it was like the first time that someone was like "I am so sorry you are having such a hard time. Tell me. What can I do." It was just, it even makes me want to cry a little thinking about it now. But it was, that was a big moment for me.”

*Researcher's Note: This is a lovely story, isn't it? I'm glad I was able to bracket my feelings from the first interview; otherwise I never would have gotten this from the follow-up. I'm beginning to notice a pattern about the Seven- most of them have related a story of their younger selves enduring damage or abuse suffered at the hand of their parents, but at the same time, they*

*love and trust their parents in the present and are not resentful of past experiences. Like, George told me that he confronted his father years later about the time he got hit, and it turned out that George's dad remembered every last detail about the episode. All he could say to George was, "I never did it again," a statement that George validated. So, what's important here? The ability to see support figures and complex and flawed while recognizing their strengths and good intentions? The ability to be compassionate? Forgiving? Accepting? I hope they have more to tell me during member checks.*

Supports that proactively support the participant and allow for nonjudgmental processing of feelings are not unique to Amanda's case; in fact, each of the Seven spoke of supports who never made them feel judged or defective when they needed time to discuss difficult feelings. Specific to Amanda and Kitten's narratives, however, are communities and supports who share their symptomology and assist them in processing and responding to difficult situations. Ironically, for both participants this process was empowered through the introduction of diagnosis and its descriptive symptomology.

Kitten: "The medical community itself never really helped me beyond giving me names for what was in my head. And...and there's sort of that idea I guess like that, you know, the ... the...a lot of Asian beliefs say that like, you know, oh once...you know, once you name a monster, you can control it. Um, and...and having names for things certainly helped, um, because they gave me a little more control over how I reacted to things because I was able to sort of filter."



Kitten's statement regarding her ability to filter refers to her method of conceptualizing, classifying, and prioritizing the discrete natures of her various anxieties. Kitten's filtering process allows her sort her anxieties into a type of rank order; this stratification allows Kitten to concentrate on remediating anxiety-provoking matters with immediate ramifications for her life while deprioritizing or mindfully accepting anxieties that seem to be part and parcel of her apprehensive nature. To make this process work, Kitten consults with a trusted support figure who also lives with generalized anxiety.

Kitten: "I mentioned like I was having that conversation with my hairstylist, um, because she too suffers from a collection of mental illnesses, and she and I occasionally, um, because we'll have these ... we have these moments where like we know we don't necessarily filter information or situations the way a healthy brain does. Um, and ... and because she and I have similar anxieties and whatnot, we'll occasionally check in with each other to be like, "Hey, here's this situation. Am I completely off base in thinking...or in feeling ...?" Um, and...and in that, like it's...first of all, it...it's nice to sort of have like a counterpoint there for that."

Amanda described a relationship with her anxiety and a system for coping with and managing it that was nearly identical to Kitten's. This finding is remarkable in that though they share a diagnosis, Amanda and Kitten have radically different experiences of spirituality, privilege, developmental environments, and developmental support. In the following passage, Amanda talks about a cartoon about anxiety that encapsulates her relationship with anxiety and binge eating.

Amanda: "It's this giant black monster that's like consuming your life and you're like, "What's going on?" So I'm like in that stage kind of through high school that, and then once I get into college and then the second part of the, the comic strip is the girl sitting there and like the anxiety monster comes up and like taps her shoulder and she's like, "Oh hey, how's it going?" So it's this process of first you have no idea what the hell's going on... after a little while you get to know the anxiety, you get to know the binge eating disorder and it's just kind of like, "Hey buddy, how's it going?"

In the next passage, Amanda describes how receiving her diagnoses sparked a turning point in her ability to understand and cope with her anxiety.

Amanda: "I got to a point where I was like, "So what, in your notes, like what, what am I? Like wh- what do you write down or what kind of is your, is your thoughts about where I'm at or what, what I am going through?" And that's when I remember her saying, "Well, I have you down for generalized anxiety disorder." And I was like, "Oh, okay." And then she sa-and then she said, "And I have you down for um, a binge eating disorder, binging without purging." And I was like, "What?" Like eating disor-, that one was harder for me to swallow. Um that, I didn't not mean to make a joke."

Amanda went on to explain how diagnosis had granted her clarity and understanding of things she didn't have a language to describe before.

Amanda: “Like it was like this whole paradigm shift and my world is like everything's hard, everything that constant just weight on my chest. It's like I, why do I feel this way? I don't understand. I don't understand why I'm acting this way. Um, people don't understand why I'm acting this way. Like I just didn't have any names for it, and for me naming something's really important.”

Amanda's case was rare amongst the Seven in that most of her encounters with helping professionals were generally positive; the insights gained from these encounters will be discussed later in this section. Amanda was similar to Kitten, however, in that she sought out like-minded individuals for help in conceptualizing, classifying, and prioritizing her anxieties. In the following passage, she describes the process of talking with her doctoral cohort members- some of whom also struggle with anxiety- as a sounding board.

Amanda: “So I spend most of my time with three other people. Like day in, day out the four of us are always together. And they have been such a big source of um, clarity for me in moments where I'm like, "This is crazy." And they're like, "It's not." Um, and, and one, one girl in particular, one woman in particular I should say um, she also has anxiety. It's a little different. So it's really nice cause we can go to each other and be like, "Okay sh-, like I'm having an anxious moment." Like, "Is this real or not real?" And we can talk to each other about it and um, really just li-, we understand each other so like when I call her and I'm like, "I'm freaking out. Here's why.", she's like, "Girl, you don't have to explai-, or like you don't have to feel bad about it. I understand. Here's what I'm seeing." And we can just sort of talk ab-, we can talk about it in a way that's informed and open and, and empathic and understand to each other's experience.”

Similar to Amanda, Patricia identified both of her parents as primary supports. Her story illustrates a paradox inherent to her overall narrative. Though Patricia's inability to successfully communicate her needs during her Emerging Awareness of Difference made her struggle more difficult, she also stated that her parents' insistence that she meet normative standards of adolescent behavior was a benefit to her development.

Patricia: "But you know what it was, I wasn't a problem kid. You know, I got good grades. I had friends...[but] I couldn't hold a boyfriend. I'd drive them insane. I always thought they were cheating on me or accuse them of things that I thought was going on that wasn't. You know, that kind of stuff was going on."

Clay: "While that was going on, how did you learn to be so, I don't know, focused on meeting the activities of daily living? Like a lot of kids who have clinical mood disorders, they can't get out of bed, they can't go to school, they do have flagging grades. What happened, or what were you able to do to keep yourself afloat in spite of all those challenges and the, uh, mood swings..."

Patricia: "I had a father that would flip my mattress if I didn't get up for school."

Clay: (laughs)

Patricia: "My parents were diligent. You come home, you do your homework. When your homework's done, you can do whatever you want until 9 o'clock, then you're back in this house. So I had very strict parents that made that happen. And I think because, from when I was young,

they made it happen, and I kind of just got used to, you know, I have to get up and go to school. It's not an option not to."

Clay: "Well, in spite of the fact that they were strict, just hearing you talk about them, it sounds like you were close to your father, or you had positive feelings toward him."

Patricia: "Oh, my whole family is very close. I think that that's another thing I, you know, I have that a lot of people don't, is I have a lot of people telling me, "You can do it."

Faith identified her closest friend as someone who both enhanced her self-concept and served as an empathetic, non-pathologizing figure.

Clay: "Um, now looking back, uh, before we move back into, you know, the recent past and your adulthood, um, were there any people in your life as a child and then, uh, later as a teen or young adult that were really important in terms of, uh, how you came to identify and understand yourself, who made a difference? And if so, who were those people and what did- what did they do or say that helped you feel better about yourself or get in touch with your strengths?"

Faith: "Right. Um, hm, that's a really good question and I'd have to think about that. Um, I know like, um, my best friend who's still, we're very close even now, um, I always knew that, you know, I could talk to her about anything. She was- was and is like a very mature, you know, put-together person. Um, and so she... and she's also like the most organized human being I have ever known. (laughs) So she would sort of, you know, give me some help, um, and- and kind of help me stay on track a little bit."

Though Faith's friend may have helped her overcome some challenges innate to Faith's ADHD, she did not treat Faith in a manner that recognized her ADHD symptoms as weaknesses. Instead, Faith's friend likewise saw them as reasonable and logical responses to environmental stressors and honored Faith's coping mechanisms.. Faith illustrated this point through the following story.

Faith: "Um, so, Mary and I had gone to see ... Oh, shoot, what was that movie? The Aviator, The Aviator? Is that with Leonardo DiCaprio? So, we had gone to see that, um, and it was literally like me and Mary and then this couple about four or five rows behind us, and that was it in the theater. And the girl half of the couple behind us kept like chewing something, which is infuriating. But then she was also doing, "I'm bored. I'm bored." (laughs) And I was sitting there thinking, "Girl, I am also bored, but you have got to shush. You are not in the living room." But like she was smacking so much, that I finally turned to Mary and I said, "Mary, I have got to leave. I'm so sorry." And she said, "No, no, no. It's okay." So like I left, because I- I just, I could not. I was raging. Um, so I- she called me afterwards and made sure I was okay. But she wasn't mad and she, you know, let me- and I know that crazy is not PC, but she let me be crazy, and was like, "That's fine. That's part of you. You got to do what you got to do." So. It was nice to have somebody not get angry with me for that. And she was just, she understood. And that, she was like, "Do you want me to leave?" And I said, "No, no, no. You're like, you want to see this. You're fine. I don't know how you cans sit in here and listen to that, but you're fine"... Um, another thing about that experience that was so positive for me was that I knew she wasn't going to make herself unhappy just to ... Because I could handle myself. I just needed to leave. And she wanted to see the movie. So I didn't have to feel guilty about her leaving this movie that she

really wanted to see, because she wanted to see it so she stayed. I didn't have to feel bad about it. There was no ... Like I look back on it and I just think, I'm so glad that that is exactly how that all that went down, because it could have been awkward, and, you know, bad feelings and all that, but there was none of it.”

When I asked George about people who had contributed to his ability to view his disorder as a strength, his mind again turned to Jessica Williams. Though George connected with her during a time when his mania was at its height, Jessica encouraged his artistic development and refused to penalize or blame him for the less than sociable aspects of his mental status.

George (Written): Jessica was a big help to me. She didn't take me seriously as a jazz musician until one night when we were listening to Miles' *Filles de Kilimanjaro*. On a tune called "Felon Brun" (Brown Hornet) Tony Williams plays some complex rhythms that seem to defy the beat, which is being kept by everyone else. At about 4:52 he plays a "solo" with some of the strangest rhythmic figures I have ever heard. I knew this spot well and was able to vocalize the rhythm in unison with Tony, something like "Blap. BupupBBlap puppa blap!" Jessica quickly looked my way. From then on, she knew I had talent and ears. After that I felt comfortable trying to play around her, and she let me actually "sit in" on a couple small gigs she had in Sacramento. She loved my *Dracula* music and some of the other things I composed for theatre in those days. I think I already told you a story about how she "protected me" from people who didn't want to hear me. One night I said I wanted to sit in and called the tune "Old Devil Moon." I don't know what I was thinking, but I "went up" on the form and changes, since in those days I played everything practically from memory. When manic I thought I could do anything, when I got lost,

Jessica came back up on the bandstand and whispered to me in a gentle tone, "I'll show you how it goes" and took over. I must have been manic that night because I remember not minding at all that I screwed up in front of people. I also passed up an almost sure thing date to show up at Jessica's gig.

The idea of receiving gentleness, encouragement and understanding during times of mental duress is a common characteristic in the Magnificent Sevens' Persons of Difference. In the following passage, Amanda explains how a former supervisor provided these supports during a particularly stressful time in Amanda's life.

Amanda: "Um, I, so when I was working as a clinician before I got into my, uh Doctorate program um, I had gone in and was working full time at the place that I had interned at. Under this woman named Holly. Um, and she actually was very integral in my growth as a clinician and my growth as a person. Um, she, a- and in my time working in those uh, nine, 10 months before I went into my Doctorate program um, I was, like I was speaking to before, was very much moving through my trauma and was processing through that at that time. Um, and so um, I, I and I didn't, you know, it never really leaked into my work in a way that made me incapacitated. I think there were a couple of times where it was like, "Jesus, I'm like ..." You know, you're sitting in session with someone and you're like, "Uh, maybe I'm not ready for this." I remember one day really, li-, it was literally the, and it was the only day that I really ever, it, this thing that was going on ever leaked into my work. Um, I had, cause I used at that point like to go into my work and talking to my clients was almost an escape. Like I could escape into someone else's world and someone else's story and I didn't have to deal with my own. Um, and so I o-, it was one day



where like a few clients had canceled on me. I had a few hours open like with nothing to do. I had done all my paperwork and like I was just like, like ruminating over everything like I always do. Um, and I remember just like she came in, cause she would check in on us. She'd be like, "Hey, how's, how's it going?" And we'd be like, "Oh, it's good." So she came in and she goes, "Hey, how's, how's it going?" And you know when someone asks you, like you're trying to hold it together and then someone asks you how you are?"

Clay: "Yeah."

Amanda: "And you're like, "Don't ask me that question."

Clay: "Yeah."

Amanda: "And so I just remember being like, "I'm okay." and so she, she was like, "Okay." And so she like comes in. She's like, "What's going on?" Um, and so I was able, and you know, I didn't, you know, talk through the whole thing with her cause she's my employer. But um, but really was able to talk with her and she was so supportive and so kind and so um, uh, uh and really um, because it was, I think I was having that anxiety and like it was that pit in my stomach um, moment. And, and she really was able to help talk me through it a little bit. And then um, I, I think anytime, and I, I feel like I've gotten off your question a little bit."

Clay: "It's okay."

*Researcher's Note: She wasn't. Off the question, that is.*

Amanda: "The, the, the moral of the, the message is that I've had these integral people in my life who when I lose sight of kind of my role or my strengths or the ways that my anxiety helps me to be a better clinician, I have someone there to bring me back and say, like to have this clarity

moment of like, "Stop judging yourself." Like, "This is hard. Th-, I'm not surprised that this is what's going on with you and you're doing your work and you're..." You, you know, like, "You are ..." You know, someone to take me out of this sort of realm of like, "I'm the worst and this is the worst."

Again, the introduction of a figure who sees participant behaviors as natural responses to environmental stressors rather than pathological traits is vital to a participant's identity development.

Each of the Magnificent Seven were able to identify individuals who had supported positive identity development; however, most of them also spoke of whole communities that had provided support and enhanced self-concept. George recounted a story from a country day school he had taught at, which had an environment that rolled with his creative impulses rather than punishing him for stepping outside the boundaries of normal practice.

George (written): "In Latin class, I had them memorize and act out little scenes (I used *Auricula Meretricula*, a play some Classical scholars wrote for beginning Latin. Her name translates to "Little Ears the Little Whore." It's baby Plautus.) I translated things for them that they wanted to say, because I knew they would remember them and maybe even the reason why a word was in the dative case or something. One of my Latin classes was early, I think at 8am. That is the one that I basically let them teach each other. I told the students I wished we could eat breakfast together and one of my problem students, Liam, brought in electric grills and a coffee pot and made us all bacon and eggs. All the other teachers poked their heads in when they smelled the

bacon. They asked me how to say, “We’re eating bacon and eggs” in Latin. Nos comedere ova et lardum, they shouted.”

Kitten contended that her empathy actively attracted her to individuals who were considered defective or deviant according the immediate social standards. Though Kitten sometimes found that her empathy was easily taken for granted, she denied that forging bonds with outsiders drug her down or further entrenched deviant identity markers, In fact, Kitten’s meshing with fellow social outsiders uplifted her and provided a sense of belongingness rarely found in her own family. In forging communities comprised of outcasts, Kitten made her life richer and more fortified.

Kitten: “Um, so I could be very empathetic... and because of that, you know, yeah, I've had ... I've had some right fuck ups in my life who completely took advantage of that empathy and that compassion, but it's also made it to where I've ... I have a lot of really beautiful amazing people in my life that I might not have otherwise, um, because other people sort of like shove them to the wayside of, you know, being the marginalized freaks. And freaks can be some of the most die hard, truest friends you'll ever have.”

Faith told several stories about her high school drama teacher, whose leadership and community building skills encouraged her development along with that of many other students.

Faith: “And our high school theater program is like national, well, it was at the time, nationally recognized. Like we won all the awards. Um, we have several of the people who were in that

program are, you know professional actors. Like Kelli Later Giddish, who's on some Law and Order something, something. One of those. Like she ... I studied with her- ... um, under Yatesy Harvey. So that's, when I got back into that I felt, I felt like I had a place where I could belong and be weird and it would be okay, and these people maybe also weren't great at math, and that was fine, because it was all about the stories... “

*Researcher's Note: It certainly is!*

Later in the interview, Faith took more time to speak about Yatesy and the Drama Club.

Faith: “Um, Yatesy Harvey, who was my director at Forsyth Central High School. Um, she, I- I, there's a solid chance I'm gonna cry when I talk about her, because she changed my life. She, so they ... At that school, we had, um, a theater fraternity, and it was called The Masquers. Um, so she would pull ... What- what everybody was always told is that she would pull the people who had the, you know, strongest performance ability and that kind of thing. And a lot of us were, you know, strong performers, and good actors, and great at talking to people and all that but she also ... There would always be a couple of people that were in there, um, that weren't actually good at any (laughs) of that. Um, but looking back, it was people that she knew were struggling, and they needed a family. And so she would, you know, have these spectacular performers, but then these other people that needed a family got to have a family. Um, so they would do backstage and stage manage and that kind of thing. But they got to shine. Um, so that was, I mean, that- that's remarkable to me. Um, in any field to give someone that gift without like

rubbing their face in the fact that, "Oh, hey, I can tell you're sad. Let's all look at the sad kid." You know, like, it wasn't that. It was, "You're remarkable, come with us."

In her follow-up interview, Faith gave a specific example of how Yatesy's support and community building skills made a difference in the lives of two troubled students.

Faith: "I know there were a couple of kids who were, I mean they were smoking pot, nothing big, but you know it's illegal, so there's that whole thing. And when you're 16 or 17 and you're doing it on school property, you're going to get in trouble for it. So, I know that there were like in my time there, I can think of four people off the top of my head that she was like, "I can see that you have a light in you, um, just come here, just, just come be involved in something that's bigger than you are." Um, there was a kid named Gunter and he, um, he was in band... and, uh, she cast him... it turned things around for him, because he, he was being praised for something that he had really worked on. Um, and I, I think that, that would ... I mean as an adult looking back, and looking sort of from the outside at the situation. I, I think he needed to see that he could do, he could do something that would garner praise that wasn't harmful to himself."

Kitten also identified a specific support figure from a theatrical community who helped her take a stoic stance towards matters that were beyond her control. In the following passage, she describes how a community theatre board member from her youth left an indelible impression on her take of the world in general.

Kitten: “Um, at the community theater in my old hometown, there was a woman named Mary McCall. Um, and she was ... she would sit at the cafeteria/restaurant that she owned and the theater folks would go out and do coffee collection in the morning, and she had her white coffee cup with the like swatch of like dark lipstick stained across it and the cigarette constantly hanging out of the corner of her mouth. And she was a curmudgeon, and was just the most amazing thing about it. (Laughs) Um, because she would have times like people would be complaining about stuff going on with the shows or stuff going on at the restaurant, and ... and Mary would be like, "Yep, sometimes it sucks." And ... and that of all things like, you know, it was that kind of validation is important. Um, I think ... I think we all spend entirely too much time desperately trying to be okay, and you know, people will complain about something in their day and reflexively other people will try to fix it, and be like, "Oh well, you know, but it could be da, da, da, da, da," and ... and sometimes, you know what, sometimes it just sucks and that's it, and it's fine.”

Not all of the Seven's support figures and communities were grounded in the arts, however. Two members of the Magnificent Seven spoke of faith communities and spiritual figures that had positively influenced their self-concepts and social support systems. Amanda shared the following story with me, which took place shortly after she endured trauma and relocated to the Midwest for school.

Amanda: “When I experienced my trauma and, like I was saying before, I was a mess. I was an absolute wreck. And so um, that's really when I got connected with God on a spiritual level. I, I saw God for, it, it was like the, the sheen of judgment kind of like pulled away, um because I felt

so shitty. I was like, "I am terrible. I'm the worst." I felt so bad about myself. Uh, and that's when I had my um, my, one of my pastors at my church, Janie, I reached out to her and I, I was like, "I don't know what to do." Like, "I'm just, I'm so lost. Please help me." So we started to meet up and talk and she really was integral in me understanding the grace um, that grace and love comes first. And I believe that God is synonymous with love. Um, s-, and, and that's when I really developed like that. In that moment when I was just a mess, um it, yeah, Janie really helped me to see who God was without the film of self-judgment that I had been putting on myself. Um, so uh, now m- from that point forward, my relationship with God has really changed a lot um, and has gone from something that's wrought with a lot of um, like misunderstanding and bitterness and now I just see grace and love. So it's really um, where I go back to in times of high stress.”

Astrid also identified a Christian faith community that served as a vital social support. When she stated that the church fostered an atmosphere that communicated “whoever you are is truly okay,” I asked her to tell a story that illustrated the church’s culture. The following passage was her response.

Astrid (written): Less so than there being one specific incident, it’s more about the overriding atmosphere and ethos of the place. When you’re developmentally disabled, even if people around you don’t explicitly know that, or know your diagnosis, there is a way that other people very subtly, pervasively, treat you like you’re not quite a real adult or a social equal. Ways that they subtly talk to you like you’re a child, or interfere with your personal space, or undermine your ability to do your job, or make it their job to push you into being more involved in kind of intrusive ways. And that thing was just completely absent from the atmosphere there. Nobody

did it. I went home after the first night I attended and was confused for hours about what felt so differently good about being there before I realized it was that. There was also a quote that came up in a community meeting one night that has come to kind of typify what we aim to be as a community, and it's this: "When folks gather around a system of shared beliefs, the price of acceptance in the group is usually agreement, which means the greatest value—stated or not—is being right. Unfortunately, this often creates an atmosphere of fear and performance, which in return invites conformity. But when people gather around a shared need for healing, the price of acceptance in the group is usually vulnerability, which means the greatest value—stated or not—is being real. This tends to foster an atmosphere of safety and participation, which in turn invites community."

### **Help that Makes a Difference**

"Like eating disor-, that one was harder for me to swallow. Um that, I didn't not mean to make a joke." - Amanda

Each member of the Magnificent Seven were able to identify counselors and helping professionals who had made a difference in their lives. Some members were reluctant to seek help due to previous, negative experiences with counselors, others claimed themselves fortunate to forge positive connections with helpers early on in their stories, and others didn't have much choice in the matter. Amanda stated that she was fortunate enough to connect immediately with one of the first helping professionals she met.

Amanda: "And so once I got into therapy I think the first little bit um, was just her sitting and, you know, building that rapport and listening and, and then she started to um, it was kind of this combination of I, you know, s-, kind of gentle CBT because I was so sensitive to everything... Um, but I got to a point where I was like, "So what, in your notes, like what, what am I? Like wh- what do you write down or what kind of is your, is your thoughts about where I'm at or



what, what I am going through?" And that's when I remember her saying, "Well, I have you down for generalized anxiety disorder." And I was like, "Oh, okay." And then she sa-, and then she said, "And I have you down for um, a binge eating disorder, binging without purging." And I was like, "What?" Like eating disor-, that one was harder for me to swallow. Um that, I didn't not mean to make a joke."

This part of Amanda's narrative speaks directly to the positive aspects of diagnosis. Once Amanda had a name for her problem, she began to study it and observe how it affected her.

Amanda: "It was a very clarified moment. And I think from that point on, like before that I kind of was just involved in the magic of therapy, like I just was me and I wasn't questioning the process of therapy, I was just letting it work."

Amanda had more to tell me about what made her first counselor so effective.

Amanda: "I was just a 15, 14, 13 year old girl going, "Here's what it is!" And, you know, she's doing her therapy thing but when I asked her about my diagnosis, that was really the first time I we- went kind of meta on it. Like meta processing what was going on between her and I. Um, and that really was when I, like she had been working for a little while on, on kind of managing my cognitive distortions... But s-, but she would say, you know, she would challenge by catastrophizing or my black and white thinking or all these things. Um, and when I, a- and that's when I started to get some clarity, I started to get a little bit better with the anxiety."

In addition to the meta-communication regarding the therapeutic relationship, Amanda also stated that the way her counselor helped to conceptualize her behaviors led to progress, understanding, and self-acceptance.

Amanda: "So we spent a long time in the her just not judging. Like she spent a lot of time normalizing cause a- after everything I'd say I'd be like, "I'm so so-", like "I know I fucked up." Or I know I messed up and I'm sorry." And I, spent a lot of time um, like qualifying to her that I understood that what I did was wrong and I'm sorry and, and it was really her just going, "I don't ...", like "Okay, so you ate this, so you had a weak moment. So what?" ... Like I was just like, "What?" Like I can literally come in and say anything, like I could be like, "I ate an entire cheesecake." And you're just going to be like, "Okay, like what do we, what do you think about it?" Like it was, it was mind boggling to me that I could just be who I was and that was enough. Um, and so she was a huge part of, of me getting better."

Patricia identified two helpers who had been particularly helpful in her identity development. Unfortunately for her, however, she didn't find these helpers before she had already encountered authoritative and unhelpful helping professionals.

Patricia: "And it wasn't until I met Mimi, my therapist, who told me, you are not this disease. She was somebody different, she was the only one, out of everybody I've seen and that's scary. I got lucky, other people didn't, they didn't get her ... And let me tell you, I put that woman through hell because I did not want her when I first met her."

In her first interview, Patricia spoke in depth about the traits that made Mimi an effective counselor.

Patricia: "She was a no holds barred, no excuses, you know, and she was the first counselor that I saw, 'cause you always had to see a counselor to see the doctor at Family Guidance Center, um, that told me I wasn't my disease. She was the first counselor who said, "You have schizoaffective disorder, but the medication is taking care of that. Let's talk about what else is bothering you." And she was the first one who said I had other problems and realized that I had other problems other than this disorder. Because a lot of times, you go to a counselor or a psychologist or a doctor, you say schizoaffective disorder, that's all they wanna talk about.... They figure you have no other problems. That if this disease was gone, your life would be perfect. There's no such thing as that."

Clay: "No, there's really not. And when Mimi said that to you, what else do you wanna work on, what sort of problems or ideas came up? What did you work on with her?"

Patricia: "What I was gonna do with the rest of my life. I was like, I, I don't wanna push carts."

Clay: "All right. So, but then you meet Mimi, she says, "What else do you wanna work on?" And you say, "I wanna have a life. I don't wanna be a Walmart greeter for the rest of my life."

Patricia: "And she said to me, "Patricia, you are not, um, you are not a disease. You have schizoaffective disorder. You are not schizoaffective. The same way you have high blood pressure, we don't walk around calling you high blood pressure"... So she was like, "This is something you have. There's no stamp on you that says you can't be educated, you can't work. It's up to you to get the skills to do what you wanna do." And that's what we worked on until Mimi retired."

In Patricia's follow-up interview, I asked her how Mimi had earned her trust after all of her negative encounters with helping professionals.

Clay: "Now going back to Mimi, can you tell me how she like, I remember you telling me how you called her a bitch and you didn't want this, and you didn't want the other, how did Mimi earn your trust, how did it get to the point where-"

Patricia: "Do you know what she did, Clay? Never came back at me, I could call her every name in the book, scream in her face, tell her she was a bitch, and she'd just say, I don't think that way about you. I'd really like to help you, and that's how she was the whole time, so finally what started happening, is my rants would get personal, I would rant at her, but I would spill my guts too. You know what I mean, and I'd be like if my Dad could do this, this and that then I wouldn't do beh, beh, beh, beh, beh, you know, and I started getting it out, and then we just started talking. Over the course of a year, we developed something really close, and I had her for years and she really helped me. I wouldn't be where I'm sitting right now, I wouldn't be in my last year of college about to be a therapist, without her. Because everyone before her told me don't worry, you don't have to work it's too stressful, work is too stressful for somebody with your disease."

By showing Patricia unrelenting understanding and patience, Mimi was able to, almost unperceptively, shift Patricia's thinking about the therapeutic process. Though Patricia's encounters with psychiatry were largely negative in terms of interpersonal interactions, she did speak of one psychiatrist who was a helpful support to her.

Patricia: "I had a great relationship with Dr. Groves. He, he's awesome, you know. But it was a ten minute appointment. I come in, "How you feeling?" "Feel pretty good." "You need refills?"

"Yup." "Okay, anything you need to talk about?" "Nope." "Okay, bye." I did have anxiety for a while, um, anxiety and sleep problems...But Dr. Groves decided we weren't gonna take any medications for that. He was a very low dose doctor, and I liked that too. And we didn't take anything I didn't need to take."

Clay: "What sort of things did he do to earn your trust, to show you that this was a different, different thing?"

Patricia: "Well first of all, just his personality. He's from Jamaica. So he was like, "Oh, wa gwaan, man?" you know, (laughs) And I just liked him. His personality was, was good. And you know, I liked that, I was on Medicaid- And I liked that he had his own practice in Princeton, but he drove all the way to where I am two days a week to work with Medicaid patients, and I liked that about him. And he was very like, he wasn't, he's the same way as Mimi is. Like he, he didn't think that a mental illness should hold you back. You know, he would always tell me, "Oh, that's great. Do that," you know."

Faith likewise benefitted from nonjudgmental, normalizing approaches from a helping professional. After being sexually assaulted as an undergraduate, Faith spiraled into a depression that nearly halted her ability to complete activities of daily living. Faith sought help from a counselor at her college, and found that her helper's understanding approach was of great benefit to her.

Faith: "This probably sounds silly, but, um, she never made like a judgmental face at me or whatever. Oh, oh, another thing that happened while I was seeing her. I was in such a deep depression that like if my professors would speak, my male professors in particular, if they

would speak loudly, they weren't yelling, they were just like emphasizing a point. But it would look like their eyes were bugged out, like I had started hallucinating. Like, this was a very serious depression, so, um, when I said things like that to her, I would watch her really carefully to be like, is she going to roll her eyes? Is she going to look shocked, like is she going to look like I'm a lunatic? And she never did. And feeling like that was really a seriously safe place for me to be was, I mean, that's the reason that worked.”

Unlike most of the Magnificent Seven, George didn't seek or encounter professional help until his early thirties. George did, however, benefit from his counselor's warm and nonjudgmental approach to the therapeutic relationship. Additionally, George's counselor helped him navigate the waters of his diagnosis in a constructive and supportive manner.

George: “I had never been in, in a safe place like that where I could talk about everything. It was kind of a shock to me that I'd never experienced that and that it was so helpful, just to be someplace where I could talk and not be interrupted and not be judged, and especially because I was always interrupted and judged by the woman I was with then. The therapist mainly just got me to talk about things, about my sadness and moods. She asked me all the right questions, you know, like about my sleep and everything. And I said, "Yeah, I went through this period, earlier this year and I've done it before where I woke up every day at like 4:00 AM. And I began to actually fear the clock being at 4:00 AM when I opened my eyes because I knew that I was gonna have to struggle through that day. And, uh, so, when the therapist heard that, she said, "Okay, you really need to be on some medication.” (laughs)

George's counselor also served as an advocate and helped him to identify abusive behaviors in his partner at the time.

George: "She also told me that I was being abused in my relationship, which I knew sort of knew, and thought was my fault. I knew that it wasn't good but I didn't really think about how much stress that causes."

As previously stated, Harley's Epiphany of Identity encouraged him to seek professional help. Though his initial attempts at finding a counselor immediately soured him on the process, he was eventually able to connect with a counselor who convinced him to give therapy a try.

Harley: "It took me three sessions before I told her my truth. Uh, I had to feel her out and uh, and I talked around it and when I finally said it, she like you, you know, thanked me and it was just like, "Cool. All right. We've got this," 'cause I'd done phone introductions to two other therapists and I'd like jumped right to the truth and I could gauge their reaction on the phone. Just like, "Uh, wow. Uh, uh, this is going to be expensive and involved."

In addition to providing a positive and welcoming presence, Harley's counselor also helped him through the therapeutic process by honoring his autonomy.

Clay: "What were her behaviors or her mannerism or her ways of being with you, that sort of opened that door? Be like, "Okay, it's okay to progress. It's okay to progress. All right, now I can talk about it." How did she help open that gate?"

Harley: "Um, she invited me to try a lot of therapy techniques and then when we recognized that like, I wasn't going to connect with them, she didn't like double-down or you know, try and like ... She just ... She allowed us to, to ... You know, like asking, asking actors to role play or you know, to treat a pillow as like a, a, a person and it's just like, "Yeah, no. Uh, uh, I- I'd much rather just like talk."

Harley did, however, take his counselor's advice to engage in bibliotherapy, which became a critical element in his healing process.

Harley: "Uh, so she committed to just some serious talk with me and uh, and at times, you know, it would spin into like, you know, "Have you read this book? Well I really should ju- Bring you this book." And so I ended up leaving a, a lot of sessions with her with like reading lists and ended up reading a lot of uh, texts and uh, yeah, got, got my hands on some good literature to, to read."

Kitten's encounters with helping professionals mostly occurred within the realm of psychiatry and were almost uniformly negative; these stories will be explored in the following section. Kitten was, however, able to identify encounters with one counselor that made a positive difference in her narrative.

Kitten: "I have had a couple of positive interactions with counselors... sadly never psychiatrists, um, because they tend to be just a little like, "Here's the medication," pat you on the head and



send you on the way. Um, but even like in ... when I was in my teens, uh, I was going to Emotions Anonymous. Um, and there was always, you know, an official like adult mental health professional, like a counselor there. Um, and ... and there were quite a few times in ... in moments with them where just being able to see them take these moments of pause and actually listen to what myself or some of the other kids were saying and not just chalk it up to, "Oh well you're a hormonal teenager. Oh well you're just a kid and you don't know," and a lot of adults do that, um, mental health professional or otherwise. Um, so it was sort of nice to have those moments with them where even if they didn't necessarily agree with the viewpoint, they were at least able to validate being the, you know, "Okay, you're a human being and you're entitled to your emotions. Um, and ... and that's ... that has sort of been the thing, and I still work on this now, is that, you know, I ... I recognize with my depression and my anxiety sometimes that my response to things may not be rational or it may not be what the healthy brain would do, but it doesn't make my response less valid. And ... and occasionally like I have to take the time and stop and be like, "Okay, I'm going to take a little bit of time out, and I'm just going to sort of honor my emotions. I'm going to honor my thought processes," because I spent so many, many years just taking it all and shutting it down and sublimating it to other peoples problems and everything else that it just ... it ... that doesn't work."

As was the case for every other member of the Magnificent Seven, Kitten valued relationships, therapeutic and otherwise, that honored her emotional processes regardless of how tempestuous or puzzling they might seem.

### **Summary**

All members of the Magnificent Seven spoke at length about support figures who helped them retain a positive self-concept while keeping their troubles in check. Whether the support figures were professional helpers or family and friends, all of them shared a number of features. These characteristics include a nonjudgmental stance, a normalizing and accepting attitude towards psychopathologic symptomology, and a willingness to act as a supportive sounding board when participants were experiencing difficult emotions, and a desire to help participants expand and actualize possibilities while enhance personal strengths. Persons of difference also served as advocates for the Magnificent Seven, and encouraged them to examine relationships that were harmful or draining.

### **Linking the Personal with the Political**

I said, "The cops are after me." They said, "Don't say that. Don't ever say that." - Patricia

In some way, shape, or form, each of the Magnificent Sevens' narratives were shaped and influenced by dominant institutional forces. Astrid's narrative was consistently influenced by the restraints and traditions of the educational system, Kitten's narrative was frequently shaped by her battles with the Medical Model, and most all the narratives were crafted through the lens of traditional gender roles. In this section, I will conduct an in-depth exploration of how institutional power served to impact the contours of participant narratives.

### **The Magnificent Seven and Gender Discourses**

"My dad hit me and said nothing's wrong, "You're just sick," or something like that." - George

"This is what you are fucking wearing and this is what it is right now. It doesn't fucking matter. It doesn't matter." - Amanda

An analysis of participant narratives revealed that each of them were shaped in some way by societal notions of masculinity and femininity. Among the seven narratives, the two men faced opposition and influence from traditional notions of masculinity that privilege hardiness, autonomy, the denial of weakness, and sacrifice from supportive females. For instance, when George reached out to his family for the second time in an attempt to understand what was happening to him, he was physically struck by his father.

George: "My dad hit me once. Uh, it was the last time he ever hit me... We were in a motel and I did almost exactly the same thing. And I went over and knelt at my parents', uh, bed and said, "Something's really wrong and I don't know what it is. And, uh, you know, I don't feel good and, and uh." My dad hit me and said nothing's wrong, "You're just sick," or something like that. And, that was pretty much the end of me talking about it... I went back to bed. Years, decades later, I finally talked to my dad about this incident. And uh, and he said, all he would say was,

"Well, that was the last time I hit you and I remember the name of the town and everything." Uh, he remembered a lot more about it than me, (laughs). So, it was obviously something that he felt bad about, and that it stuck with him--"

George's father understandably regretted reacting to his son's plea for help in a forceful manner; however, his immediate impulse to strike his son is reflective of narratives of toughness, the punishment of vulnerability, and solving problems through force that are endemic to traditional notions of masculinity (Kupers, 2001). It is unsurprising, then, that George forged his own trail through mental illness and did not reach out for professional help until his early thirties.

Harley's story was also influenced by traditional concepts of gender; however, his story was marked by the theme of feminine sacrifice for the sake of serving masculine interests. Without meaning to or even wanting to, Harley found himself living with a partner who repeatedly sacrificed her own needs in the attempt to help Harley. On the other hand, she was also willing to punish him in the pursuit of provoking a desired response.

Harley: "She uh, she, she suffers from severe ... Yeah. Uh, present tense, she still does ... She's just not my girlfriend anymore. Uh, she's a depressive and has had lots of therapy for depression and she was applying her toolbox from depression to me and so like, the night that I told her I killed my dad, she tried to like coddle me and she ended up taking me to bed and trying to like initiate sex with me. And that was literally the last time that she and I ever had sexual contact, that wasn't like traumatic to me and uh, I don't blame her. I mean, I became asexual inside of our relationship. At uh, yeah, when she walked out, I realized like, "Wow, that's a woman who

stayed with me for nine months with no sex and no, no emotion coming from me." Uh, so when she walked out, it was the best thing that could have ever happened to her."

In Harley's pre-recorded follow-up, he spoke more in-depth about his girlfriend's attempts to affect and support him following the traumatic incident. One of my questions struck on the contrast between his connections with his girlfriend and his therapist- Harley's girlfriend had attempted to help the situation by applying lessons from her own experience, which merely caused him to retreat further into emotional and sexual isolation. Harley's counselor, however, was successful in her attempts to connect with him via self-disclosure. I asked him what he thought might have accounted for this difference, and he responded in the following passage.

Harley: "Interesting. Wow, that is an interesting contrast, um, and those were happening concurrently as well so uh, well I was living with Megan and, ah, there were things that Megan was doing in sharing her personal experiences that she was using to justify or rationalize, um, punishing me or, or aah speaking negatively to me that like here are, here are tools I've used to get better so get better or when she realized that I had just withdrawn, she made an ultimatum. I had signed her up for a mystery package gift cycle where every month for several months, you're sent a package that's really just beautifully designed to seem like an artifact that's been accidentally sent to you by or, or sent you on purpose by a mysterious relative or something. But as you realize that these, these this penultimate and then ultimate gifts were coming to her, she started stacking up the boxes unopened and literally said, you know, I'm not going to open these gifts. I'm not going to receive a gift from you until we're having sex again, and then these boxes

just lived in our co-shared living space. We had separate bedrooms at that point, but she would just leave these boxes stacked up in the living room.”

Thus, Harley’s interactions with his girlfriend at the time reflect traditional notions of gender dynamics. The more Megan pursued Harley and sacrificed for him, the more Harley pulled away from the relationship. The more Harley pulled away from the relationship, the more Megan alternated between acts of sacrifice, acts of punishment, and acts of negotiation in the attempt to heal him.

The narratives of women in the Magnificent Seven were likewise shaped by dominant discourses on gender. Unlike the men, who reacted to messages of masculine toughness and female sacrifice, women reacted to messages that villainize female sexuality and hold women responsible for the vagaries of masculine sexual desire. For example, during Kitten’s teenage years, she found herself caught in a household dynamic that left her in a no-win situation.

Kitten: “Uh, and my sister was finally discovering some popularity. Um, but yeah anyways, so my sister was always bringing like, a whole bunch of people over around to the house. And, you know, and for some reason these guys who were, you know, my sister's friends, she was only a year and a half older than I was, so most of these people were only like, two to three years older than me, um, they, they liked me. I was precocious and I was outgoing and I was into gaming and all the other geeky stuff that they were into. And the fact that they wanted to be friends with me, and the fact that some of them wanted to be more than friends with me, um, really upset my sister and it caused all these fights in my family. And all these fights with my sister, and her boyfriend and my sister, and her friends and my sister's boyfriend, and friends with my parents.

Um, and my mom came to me at one point and was telling me that like, all this horrible stuff was going on, all of these people were fighting, and they were all mad at each other, and that it was entirely my fault. Um, so I ended up taking a bunch of pills. Um, and not long after I took them, uh, and I was in my bathroom vomiting my guts up, uh, one of, (Laughs), my sister's friends actually came to the house looking for something and found me, and took me to the hospital. And my dad came and my mom came. And, you know, and after they pumped my stomach and everything, and, uh, the therapist was in there talking at the time and they had asked me what led to all of this and so now my parents were hearing they're like, "Oh, well you said this and you said that like, your mom said it was all your fault", et cetera, et cetera. And my mom just sat there in the corner and nodded."

Kitten had no control over the unorthodox and damaging social dynamics set in place by her parents, and was doing her best to establish a healthy support network within the parameters that confined her. As a result, Kitten's parents asserted that the household conflict was the result of her out-of-control, nascent sexuality. Kitten then recounted what her mother said to the hospital staff arrayed at her bedside:

Kitten: "And, you know, and my mom's like, "If she wasn't trying to always be the center of attention and if she could maybe just get her shit together, then other people's lives wouldn't be so messed up." Um, yeah.

Amanda was also negatively affected by oppressive discourses of female sexuality. In her follow-up interview, she explained the circumstances that gave rise to her Epiphany of Identity.

Amanda: "I am trying to think back to that day. Right before that had happened one of my teachers, I was walking down the hall, and she her name was...Ms. Barrett? No, not Ms. Barrett. It was something like old, old crotchety lady, Ms. Guzowitz. Or something, like, crotchety and German. I was walking down the hall and I had shirt that was kinda low cut and not--"

Clay: "Obscenely, but- "

Amanda: "Not in my mind inappropriate or obscene. But, definitely was lower cut and she made this comment about it like being super inappropriate or you should consider your clothing choices when you are getting dressed in the morning or she said something like that. And I remember walking down the hall and at first I was like super ashamed. Cause I am very and I think in some ways I still hold onto that people pleasing stuff even when I don't want to. So, and this was like an authority figure. I was not the kind of child that tried to get around the rules or when someone put a rule in front of my I automatically took it as law. I was, I never got detention, I was very in the rule book. So when she said that to me, at first I was super ashamed. I can remember, my face doesn't really get red, but I could feel my face getting hot and I was like "Oh my god, have people been looking at me all day?" Thinking this, thinking I, I don't know, I look dumpy and like or I don't know. I just remember feeling very ashamed. And then it was like, I don't know if it was out of necessity of just being like "I need to not care about this. I just don't have the time to ruminate over how everyone has been looking at me. I just don't have the time of day right now." So I just remember telling myself "It doesn't fucking matter." She didn't send me home. She didn't make you put on a t-shirt. This is what you are fucking wearing and this is what it is right now. It doesn't fucking matter. It doesn't matter."



This episode ultimately gave rise to an empowering event in Amanda's life, however, the influence of oppressive gender norms on this moment is undeniable. Many authors have examined narratives of femininity that unfairly blame the female body for provoking masculine desire; this narrative is currently the focus of many contemporary episodes of social activism (Finzsch, 2008; Sullivan, 1997; Yahya, Rahman, Zainal, & Gaze, 2010).

### **The Magnificent Seven and Institutions of Mental Health**

"You fucking write it down. I am done." – Kitten

"I almost died of irony" - Astrid

The narratives of the Magnificent Seven are replete with encounters that were shaped by dominant forces in Psychiatry and the Medical profession in general. Though most of the Seven identified the act of diagnosis as helpful or at least instructive, almost all of them recounted negative interactions with the medical institution. Members of the Seven frequently encountered helpers who enforced harmful limitations or delivered ineffective, uncaring, or disorganized service. Some of the seven recounted cold and dismissive encounters with professional Counseling. Kitten, for example, had much to say about the brief experience with Counseling that followed her suicide attempt.

Kitten: "Uh, so yeah, so, uh, because of that, um, I had to go to therapy. Uh, had the first meeting with the counselor, and it was very just across the board of, "Why did this happen? What are some of your influences?" Nothing interesting. The second time we went, um, the counselor didn't even recognize me. And I'm not quite sure why that was. I mean, we sat there in the waiting room and we watched the, the counselor like, walk in and out a couple of times and

we're just waiting to be called in. And then finally like, 30 minutes after my appointment should have ended and my parents went up front, they're like, "Oh we forgot you were here." So that was encouraging. Um, and then finally like, the third or fourth time I went back, and I was talking to them about all the stuff in my life and I was like, "I did this because I felt isolated and I felt like I was causing all these people I cared about pain. And it was being expressed to me that if I wasn't around to cause them pain, that this pain would end. And I took that in very deeply because I was always raised to believe that I'm supposed to be there to help people and not to hurt them." Um, and I talked about the transitions of moving from a fairly normal life and, at least my perception, and childhood of being, I don't know, popular enough. Um, and, uh, and having to go to a point where I was now suddenly being bullied and being an outcast and doing all of this at a time when I was dealing with all of the hormonal changes of becoming a teenager, and trying to find my place in the world as my own person and not just an extension of my family. Um, yeah, and from all of that the therapist is like, "There's, there's nothing we can tell you. You know what happened and you know why you did these things, and you sort of recognize why what you did wasn't necessarily the best response. You're entirely too self-actualized. I can't help you." Um, so yeah, that was swell." (Laughs)

Most unfortunately for Kitten, this encounter was predictive of the service she received from most helping professionals she worked with as an adult. Her story is sadly replete with encounters with byzantine bureaucracy, cold and impersonal care, and fruitless treatment. As she continued to internalize her problems throughout her young adulthood, she began to experience physical symptoms that drove her to seek help. It was then that Kitten encountered an industry

that was all too keen to tell her exactly what her problem was, despite her personal experiences to the contrary.

Kitten: "Um, so when I started having all of the pains with the fibromyalgia and everything else and started going to doctors for it, um, of course with my history they're like, "Oh you just ... y-you're just suffering from depression." And I was like, "No. No, no." I've ... I've done the depression thing. I know ... I know what that is this is ... this is something else. And then they'll sort of be like, "Oh well, you know, oh it's chronic fatigue. Oh, you know, it's all these other things." I'm like, "No, I don't ... I don't think it's chronic fatigue." So they kept just bouncing back to the depression, and at that point I was finally like, "Okay, well if this is what we're going to fall on, let's do something about this." So if we can treat the depression and make that better, then in theory all of these physical pains and everything else should get better too. And they didn't. (Laughs) Um ... uh, yeah, at the various ... I went through a few different rounds of meds for the depression and nothing worked. Um, and all of that was stressing me out a lot, and then finally after going to like a third or fourth doctor, they're like ... you know, and I was talking about various things, they're like, "Oh, we also think you have general anxiety." And I was like, "Well I told you that. I told you that going out makes me anxious. What? Why do you think this is new?" Um, so then they started trying to treat the depression and the anxiety, but still not looking at any of the other physical symptoms. And ... and that right there, like when you're ... when you're dealing with medical professionals, and they aren't taking the time to actually have a conversation with you, when they aren't actually taking the time to listen to and/or read the information that you give them, and they just want to spend 10 minutes in the room, throw a

bunch of pills at you and then walk away, that is a surefire like straw on the camel's back when dealing with mental illnesses.”

After innumerable appointments with doctors that proved unhelpful, dismissive and disorganized, Kitten eventually reached a boiling point that spilled over on a hapless medical secretary.

Kitten: “So the fact that they weren't paying attention to me for any of the other things really was what sort of made me have this, like, walking into my doctor's office one day and they always do that thing like they call you, they give you your little reminders, and they're like, "Make sure you bring in all of your medications." Only a couple of which I was taking because I had two ... I had three different doctors at the time, and even though they were all in the same building and in the same network and had all the same computer stuff, they clearly were not looking at anything else I had been prescribed. So I had this moment where I just couldn't deal anymore, and so I would go and I'd check in at my doctor's office, and the poor little receptionist, I still feel bad about doing this to her, she's like, "Oh and ... you know, and remember to write down your medications," and I just had this grocery bag full of prescription bottles and I upended it on her desk and I looked at her, and I'm like, "You fucking write it down. I am done." And apparently that kind of hostility, um, is not well met in doctor's offices.”

Predictably, this incident did nothing to improve the quality of Kitten's relationship with the doctor in question. However, this incident was part of the series of crises that led to her

Epiphany of Identity. Indirectly and ironically, this incident did lead to a marked improvement in her struggle with Anxiety.

Astrid's story is also well-fortified with stories that illustrate the baffling and endlessly complex world of medical institutions. While reading a newspaper article about an individual with sensory processing issues, Astrid realized that the account she was reading frequently reflected her own experience. Invigorated by this discovery, Astrid sought out to acquire professional help and hopefully receive an accurate diagnosis.

Astrid: "Um, so the year in which I went about trying to get this diagnosis was the most absurd wild goose-chase of my life. Um, you would think that in the biggest, um, city in the country that it wouldn't be that hard to find one professional experienced with, you know, autism spectrum conditions in adults, and, and that would be not the case."

Thus marked the beginning of a long and convoluted process that was only resolved through the sheer will and effort Astrid exerted on her efforts.

Astrid: "Um, I got referred to a neurologist first, who ruled out that it, you know, that it was likely to be any other neurological disorder, um, and that what I was saying was broadly consistent with, um, knowledge of autism at the time. Um, (laughs) and then, well, I, I almost, I almost died of irony from this whole entire experience. So then she was gonna look for, uh, like a neuropsychologist or a, or a neuropsychiatrist that I could see. And, weeks and weeks later, I get a call back from the head of neurology at Bellevue claiming that Bellevue Hospital does not have any person qualified to look at this. And I'm like, that both can't be true, but that, like,

that's, that's so bizarre that I don't know how not to believe you. Um, so they're like, well you could call this person at NYU. He's running a study. And so, um, I'm trying to get ahold of this NYU professor, who is running a study about autistic people and yet has no particularly easy way for people to get in touch with him. Like, doesn't have an email address dedicated to the study, does not seem to have office voicemail.”

This unfortunate set of circumstances led Astrid to pursue a line of action that was decidedly difficult for her as an Autistic individual.

Astrid: “And so, um, I don't, I don't know if you're familiar with, with ways that using the phone can be especially difficult for, for people on the spectrum. Um, for both, like, anxiety reasons and for auditory processing reasons. Um, and so, like, I'm struck trying to call this guy back again and again and again to get in touch with him, um, and finally do, and decide that, like, that, that study he's running isn't, you know, the right thing for me to do. And he finally refers me to somebody else, to a private, uh, psychiatrist. So I get in touch with that guy, and it turns out that that guy does in fact have office hours at Bellevue. (laughs) And it was just that the head of neurology could not pick up the phone and call the head of psychiatry to find that out.” (laughs)

Ultimately, Astrid received the help she needed not because of the medical industry, but in spite of it.

Harley had a very similar experience in his search for mental health support. After taking the initiative to find as many potential resources as possible, he quickly found himself stymied due to a lack of appropriate help.

Harley: “Uh, uh, I, I do inquiry emails and phone calls and I'd find out like, "No, this is a women's only like sexual assault PTSD group or this is a ex-military only PTSD group." Uh, like man, there's not much like male non-military PTSD support. Uh, and that was, that was a disappointment in the system, was finding like one-on-one was really my only way to, to make these breakthroughs. There was really no group option for me.”

*Researcher's Note: Luckily, Harley was able to successfully connect with a supportive individual therapist, but others in his position might not be so fortunate.*

Faith's encounters with the mental health industry echoed the stories told by Kitten, Harley and Astrid, however, her story is unique in that her conflicts with the system were potentially fatal. Faith spoke the following to me when recounting her interactions with helping professionals as a working actor in Los Angeles.

Faith: “Um, the next time I had, uh, encounters with mental health professionals was wildly unpleasant, because I was in Los Angeles. I was very unhappy for a lot of reasons. So I went to ... The guy that I was dating, saw this counselor that he really liked. So I went to her. And she was the devil. (laughs) Like she- she said, um ... Like I went in one day and I just sat and I just cried for like a half an hour. And I thought, you know, this is a safe place, I should be allowed to do this. Um, and she was like, "I'm going to refer you to a psychiatrist." Right? Those are the ones that write prescriptions?”

Clay: “Yes.”

Faith: “Okay. So she said, "I'm gonna refer you to a psychiatrist, but honestly, I think you're unhappy because you're in Los Angeles, so you should probably leave." And I was like, "That's not... first, that's not what I want to hear, but also, like, that- that's not encouraging. That's saying, hey you're unhappy, not let's find things here that will make you happy" or, you know, "get happy where you are or whatever," It was leave. And that- that still strikes me as not an appropriate response. But, whatever. So this went to the psychiatrist, who, rather than like ... Now I understand that you can take like one kind of antidepressant, and it might not work, so you can take a different kind. You don't just take one kind and then add Klonopin and then add Abilify, and then add this and that. But you don't, you don't just start taking nine million pills at once. Just try a different antidepressant.”

Faith: “But this guy instead, uh, he prescribed, um, Zoloft, which apparently I had- I don't remember what it was called, but it's like you're supposed to chill out some when you take it. Um, and I did the opposite. Um, so then he kept prescribing things on top of it, and it got to the point where like, um, I had cut like a couple of times like as a senior in college, um, I think it was right after college, anyway, but so I amped it up again. And I was doing it a lot. And he was like, "So I'm going to write you a prescription for Seroquel", and I was like, "Okay, fine, whatever." And I would take a Seroquel, and all that would do was like chill me out enough to just feel like draw a relaxing bath, pour a glass of wine, and go to the bathtub. That didn't help. And he just ... That just left such a bad taste in my mouth about why were we not looking at other options.”

Faith's encounters with the mental health industry weren't just unhelpful, they were potentially life-threatening.



Faith: "I told one of my friends who was a- a pharmacist at the time, and she was like, "No, no." She goes, "I don't care what he told you. You have to stop taking these." I think it was Abilify, but, um, whatever it was, she was like, "Don't take that." She was like, "Your heart is going to explode. Stop. You can't- you can't take those together, like at the levels you are taking them, and, no, no."

Faith tapered herself off the medications and rapidly found her life returning to a manageable state. It would be years later that she finally got the help she needed from a Counselor who asked her to take a screening exam for ADHD.

*Researcher's Note: I recently had a job interview for a faculty position that required a research demonstration. I did a PowerPoint presentation on where I was at the time with this dissertation. The search committee came to see it, and most of them loved it. The head of the School Counseling program actually cried during the "Harley and Me" section. The stats guy on the committee, however, was decidedly less impressed. About five minutes into the presentation, he pushed himself away from the table and folded his arms. During the Q & A, he asked me the following question-*

*"What's new about this?"*

*You see, his contention was that all I could produce from this research were things that have long been known to the helping professions. Show unconditional positive regard, be nonjudgmental, keep negative responses to client revelations on the inside, advocate for your*

*clients, let them take the lead in case conceptualization. What he meant was that I couldn't tell him- or the profession- anything new that could possibly benefit Counseling clients.*

*Aside from this reaction, he was actually a good guy, and I liked him. But if I ever get another chance to talk to him, I'll ask him one thing. If the notions of unconditional positive regard, a nonjudgmental stance, and client advocacy are such Goddamned old news to the helping professions, why did the Seven have such a hard time finding them?*

### **Harley and Me, A Deadtime Story**

*"So, Let's Make a Short Story Long" - Harley*

*Researcher's Note: What the hell happened here? Therapy? Scholarship? Performance Art? Maybe it's all three, maybe it's a revise-and-resubmit. You tell me. Prior to recruiting Harley for this project, I knew that he had moved back to his native state of California approximately five years ago. We had worked together and socialized together fairly frequently through the Atlanta theatre circuit, and I presumed his motive for relocating was to pursue opportunities in the lush cultural and theatrical climate of the Bay Area.*

*I was wrong.*

Clay: "Now as far as you are comfortable telling or as much as you want to say or as much as important to say, what was the event or the trauma that lead to where you are today?"

Harley: "So uh, now let's make a short story long. Um, so--"

Clay: (laughs)

Harley: "My father's cancer diagnosis uh, he had bladder cancer, which spread pretty um, terrible. Um, so he had a first round of surgery. Uh, was clear, then it came back, spread. You know, he had this massive lump in his groin uh, you know. Uh, so he went onto hospice care at home and uh, he made the decision to uh, end his own life uh, shortly after the state of California voted to allow that to be legal. But it was going to take months before the actual wheels of that working, started to move. Uh, so my mother and my father spent a couple of months trying to figure out if my dad could relocate to Portland and choose Oregon's options. Uh, that was going to be a massive hassle. So in the end, what my parents ended up doing was, consulting with an end to life counselor in Oregon and then using the dark web to order medication from Asia and uh, so I sat with my father in the days leading up to his decision to end his own life and talk to him about his choices. And my brother flew down to Portland to be there and uh, on the day that my dad decided to do it, I got a phone call from my mom and she said, "You know, if you want to, if you want to come up and be here for this uh, you know, it, it shouldn't it shouldn't take long but if you want to be here, I'd appreciate it." So I left my home in Oakland. I drove up to Roseville, which is near Sacramento. And uh, what unfolded was uh, over 36 hours of my dad having seizures uh, because something went wrong with how he tried to kill himself. Uh, it was supposed to take 12 hours according to the nurses that we consulted in Oregon. After 24 hours, we had nurses on the phone trying to talk us through something. Uh, after 36 hours, it was grand mal seizures. He had bitten his tongue uh, so I convinced my mom to take a sleeping pill. Uh, take a nap and then I uh, I smothered my father. And uh, then called the hospice nurse and said, "He passed away." And uh, and then I kept that a secret. I didn't tell my mom. I told her that he passed away peacefully and uh, so ... Yeah, so. My father tried to kill himself. He wasn't able to do it and so, I had to do it instead and uh, and then that just snowballed into the worst year of my

life. Uh, my girlfriend who lived with me at the time, walked out on me. The theater company that I'd worked for two and a half years, fired me.”

*Holy. Shit.*

*I had no idea. I really, really did not have the faintest clue.*

*I had no idea what I was getting into here with Harley. So many thoughts and emotions flooded me at once that my brain almost blew a fuse trying to process them all. I felt horror and overwhelming concern for Harley, I felt guilty for not going out of my way to check on him more following his move, I felt exhilarated because I knew I had a blue-ribbon story on my hands, and I felt really guilty for having the previous thought, which made me wonder what it meant that my thoughts had flown so quickly to commoditizing my friend's terror and anguish. It was overwhelming.*

*But more intense than any of that was the feeling of being uprooted. I had no idea how to respond in the space, I had been taken off center. I didn't know how to respond as a researcher. I didn't know how to respond as a friend. I wasn't even sure of who I was in that moment. After 10+ years working with emotionally disturbed adolescents and severe alcoholics and addicts, I thought I had heard it all and couldn't be shaken. But as I sat a nation's width away from Harley as we Skyped, I had no idea which Clay should respond, or what any of the Clays could possibly say. So I decided to go with my gut and say the first thing that felt right to me:*

Clay: Okay. Um, wow. This is just um, a layer and level of honesty and uh, generosity on your part, that um, I've been doing this for a long time and I really wasn't prepared for something of such emotional weight and I really want to express my gratitude, um, my thanks for your

willingness to share that with us today. Is this, uh ... What was it like? Did you hold onto that secret for a while? Was there anyone that knew what you had to do, in order to seal this gate?

Harley: "My girlfriend. Uh, it took me a couple of days but, uh, she finally was able to just like confront me about my mood and was just like, "I, I don't know what's going on with you," and I just turned to her in the kitchen. We were cooking dinner together and I just, "I killed, I killed my father." Uh, and uh, that was the beginning of the end for our relationship..."

*Following this point, the interview continued to flow and move as it always had. This was a great relief to me, as I was deeply worried that I would say or do something that was incomprehensible, exploitative, jarring, or otherwise disastrous to wreck the whole thing. But no, I survived and so did the interview. But look what happened later on, when he was talking about how much his therapist helped him-*

Harley: "Uh, I had to feel her out and uh, and I talked around it and when I finally said it, she- like you- you know, thanked me..."

*Whoa.*

Harley: "...and it was just like, "Cool. All right. We've got this," 'cause I'd done phone introductions to two other therapists and I'd like jumped right to the truth and I could gauge their reaction on the phone. Just like, "Uh, wow. Uh, uh, this is going to be expensive and involved." I was just like, "No, not the right ... Not, not the right answer, therapist. Don't uh, yeah."

*She-like you- thanked me. Wow. I mean, I don't think I was able to do that because I'm Super-Counselor or Super-Interviewer or anything of the sort. But I was thunderstruck that somehow, in the delirium of emotionality and cluelessness, I had managed to speak the same words that made Harley feel like it was okay to keep going with his counselor. And this strikes to the heart of my whole idea- I've always known that no matter how shocking, upsetting, or jarring a client's narrative might seem to us, we will always do better by honoring and attempting to understand their positions instead of treating them like something that's broken and in need of extensive reconstruction. This moment made me feel more vindicated than anything else in the study, and that's saying a lot.*

### **Patricia vs. Institutional Power**

"I wasn't disabled until I had a bunch of medical professionals jumping into my life." - Patricia

*Researcher's Note: The following section contains the most difficult things I heard during this study as well as the most difficult things I had to write.*

Each member of the Magnificent Seven were stymied and limited through their interactions with societal institutions. Of all the Sevens' narratives, however, nowhere were these limitations more pronounced, repetitive, and damaging than in Patricia's story. Remarkably, Patricia never presented herself as a victim, and her narrative is full of hope and enthusiasm about her future. The stories from her past, however, paint a radically different picture. The following passages describe her initial break with reality, as she called it, and the shocking aftermath.

Patricia: "Okay. At 32, I had a full blown break with reality- hearing, seeing, smelling things that were not there. Completely sure the CIA was after me. And, um, yeah. It was a true break, and I was committed."

Clay: "Okay, and how long did that episode last?"

Patricia: "I was in the hospital for two weeks, but I was confused for a lot longer, and I think that has to do with the fucking police department because when they came to, my mother called them...my mother came to my house and called them and said, you know, "She's talking weird. I don't know what's," you know, she didn't, my mother didn't understand what was going on. So the police came and they decided they were gonna take me. Instead of taking me to the hospital, they drove me around telling me, "Yeah, we were on your roof. Yeah, we're gonna kill you. We're taking you somewhere they can't find the body," blah blah blah blah blah. So by the time I got to the hospital, I was sure what I was saying was true. So it took two weeks before I could fake myself out of the hospital, which I did by just not saying what I was thinking. I figured that out real quick, and the other patients told me that, 'cause I said, "The cops are after me." They said, "Don't say that. Don't ever say that."

Clay: (laughs)

*Researcher's Note: I didn't know what else to do.*

Patricia: "You know?" (laughs)

Clay: "Yeah."

*Researcher's note: I didn't know.*

Patricia: "I got myself out of there in two weeks, but it took months before I truly figured out what was going on."

Clay: "Okay, yeah. And the, that's a pretty breathtaking act on the part of the police. I mean I know that stuff happens. I'm well aware that it does. But the fact that they would say that to a young woman experiencing a psychotic break is just sort of, what was that about?"

Patricia: "They really had nothing better to do, you know. I was the, uh, I was like ... The three of them came for me, and I was completely docile. I would never have been violent. Confused, scared out of my mind, but violent, never. So you know, it wasn't like I was being a jerk. But it took months for me to figure that out. And when I got home- And I did figure it out, and I was telling people what happened, they didn't believe me. You were sick. You don't know what you were hearing. When, to this day, I know the difference between ... I was completely out of my head. There's no doubt in my mind. I thought the CIA was coming and they were gonna kill me and... You know, but I can look back now and say, you know, what was real and what wasn't, and riding around on that car all the way to Phillipsburg, telling me that they were gonna kill me, I remember clear as day."

Patricia's account is fortified by the story that followed.

Patricia: "My younger sister is a, she's a spitfire, that one. And I told her and she believed me and she went after them and, and gave them the, you know, ran them up and down, and they apologized to her for doing it. Not to me, to her. Once they apologized to her, she came home and told my mother, you know, "Patricia was telling the truth the whole time. They even admitted it."

Somehow, Patricia rebounded from this episode without any long-lasing emotional or mental damage. The institution of Law Enforcement, which was ostensibly designed to protect



people, only compounded her distress at the worst possible juncture in time. It is also worth noting that once inside the psychiatric hospital, Patricia received words of wisdom from her fellow inmates on how to quickly get out of her predicament- “don’t say that, don’t ever say that.” In the midst of her delusions and hallucinations, Patricia was able to connect with a community of equally delusional people who shared secret knowledge of the machinations of madness with her. If she wanted to get out, she had to know what to say and what not to say. She took the knowledge to heart, and was soon thereafter released from the hospital by selectively filtering the account of her situation to the hospital staff. Patricia’s unfortunate encounters with societal institutions, however, were only beginning. This episode ushered in a long series of damaging and unhelpful encounters with helping professionals. As the help she was offered was ineffective and oppressive, Patricia turned to her strong work ethic to cope. She largely weathered her breaks with reality and was able to work and live on her own terms for years, but after a particularly troublesome break, the defenses she had crafted collapsed around her.

Patricia: “You know, I did, I ran a cleaning company, before my last episode. I ran a cleaning company. And I had been through many an episode in the years that I worked at that cleaning company. What happened was my last episode is I pretty much got caught, is what happened, and they threw me in the hospital and once that happened, my life went to hell in a hand basket for a long time. Because everybody said, first they didn't care when they threw me into a mental institution that I needed to call customers because I was going to lose it, lose my business. They didn't care that I lost my business, they didn't care that I lost my place to live, I walked out of that mental institution with nothing. I lived at my old room at my mom's house and here I sit. So they took everything from me, as far as I'm concerned, because they wouldn't allow me to get my

stuff together. Nope, nope, don't worry about your business. It took me 20 years to build up the business, I was working, 3 houses a day, I was pulling in 150 dollars a day, and you want me to forget about my business? I lost it all. By the time I got out a month and a half later, customers had other people or were pissed, or, you know at my apartment, my boyfriend got a new girlfriend by the time I got back. So I ended up with me and my dog at my mother's house.”

(laughs)

Clay: “How did you find a way out of that?”

Patricia: “So if I wouldn't have gotten caught, with that episode, I'd still be cleaning. I'd still be running that company. But I wasn't disabled until somebody told me I was. And then, that's when I lost it, that's when I lost faith, but you know Clay, when you have a medical professional, a doctor tell you that you're not capable, you believe it. Especially at the time, I wasn't educated, I had high school diploma and a couple of years of junior college, but other than that, I didn't know. He was God to me. You know he said, doctor said, you can't work. Doctor said you got to go on disability.”

Though Patricia's narrative is largely optimistic and brimming with hope, it is also understandably tinged with bitterness when she discusses the treatment she received from most Psychiatric professionals. The anger is especially palpable in her voice when she discusses the power differential inherent to her relationships with the medical profession.

Patricia: “I have mental health professionals telling me, don't worry Patricia, you don't have to work, and I want to say to them, thanks, but I don't want to live in poverty the rest of my life. I don't want this to be it for my life. Because that's what you're sitting here telling me. You're looking me in the face and saying you can do nothing else but sit home and live on you 525 dollars a month, and we'll pay for your medicine, have a nice day, you know. You tell somebody

that, and you can make a person who wasn't depressed, depressed, you know. Because I wasn't disabled until I had a bunch of medical professionals jumping in my life.”

With family support and sheer determination, Patricia was eventually able to stabilize herself and start over. In our follow up interview, she spoke about the unique help she received from Dr. Groves, and how even his influence was colored by institutional narratives of mental illness.

Patricia: “Doctors don't really talk, they just prescribe medication, but Dr. Groves really talked, he would ask me, you know how you doing? And I kind of trusted him because I was feeling better, I wasn't up and down anymore, the medications were working. So I kind of liked him, because he was prescribing the meds that were actually making it so that people didn't look at me like I was weird, you know, I wasn't talking to myself, constantly. I was trying to interact with people really well, where before that I felt kind of on the other side of the glass, you know? I kind of started feeling like hey, I'm thinking like everybody else, and then I started popping out of bed a little bit easier and I started going to school, and you know life got better with Dr. Groves. So that's what made me trust him, but I got lucky with Dr. Groves because Dr. Groves was a good doctor but however, Dr. Groves was the first one who told me, don't worry ma'am you don't have to work, you know? And it's that, that I don't think he even realized what he's doing, you know I don't think the medical professionals, I think they're trying to say, don't worry about it, don't stress her out about it, but what it comes out as is you're not capable. I wish they would change the language. And I wish that SSI would let me work for a time, if SSI would say,

yeah you go work 20 hours a week, we won't send you any money, and we'll pay your med bill, I'd be good to go.”

As intensely difficult as the medical institution and its barriers have made life for Patricia, her greatest obstacles to self-realization may lie in the cultural and social stigma surrounding psychotic disorders that she encounters in her everyday life. In the following passage, Patricia explains what she wished more people could understand about Schizoaffective Disorder.

Patricia: “You know, I'll tell you, they say, you know, everybody's different. Everybody's different. All, everybody who has depression is different. You know, except if you have a severe mental illness. Say you're schizo-something, and they lump you into one category-And you're all alike, you know? (laughs) You know what's funny, um, it's the stigma-That, that gets in your way more than the disease. Like yesterday, we're watching TV and somebody pushed somebody in the subway, and I'm sitting next to my mother and she's just going, "Please don't be mentally ill, please don't be mentally ill." (laughs).

Patricia also explained how the stigma surrounding her disorder had affected her ability to make new friends.

Patricia: “I can have, I have had people in my life who have gotten to know me. You know, you meet them, "Hey, I'm Michelle," we get along great, calling each other on the phone, bu-bu-bu, "I have schizoaffective disorder." Never hear from them again. People are scared of the disorder. That's the problem I have, is they're scared of me. They think I'm gonna hurt their kids.”

Patricia explained that cultural stigmas cut the deepest when she found them among members of the medical institution.

Patricia: "I had a doctor assistant, um, this girl took my blood pressure for over a year. And then the yearly thing came where they make sure they got your meds up to date and blah blah blah, you know. So she's looking at my meds, and she goes, "What's that for?" I said, "I've got Schizoaffective Disorder." She opened the door, sticks her foot in, and goes, "Okay, calm down." I was like, "What?" And she left, and the doctor came in. But that's, and now this girl is supposed to be a medical professional, and you hear Schizoaffective, so you open the door and stick your foot in it like I'm gonna attack you any minute and tell me to calm down when all I said was what it was. So all that girl needed to go out and do is say, "She's agitated." All she had to do was walk out that door, go to the doctor, and go, "That girl was in there, agitated." And then it would've been me defending myself, or as I have learned, don't defend yourself, and when they tell you that you're going to the hospital, volunteer, or you're not getting out."

Despite her many setbacks and unfortunate encounters with societal institutions, Patricia has indeed proven herself capable. She is currently a student in a reputable online Masters' program Counseling, has a 4.0 grade average, and is in the Practicum phase of her training.

### **Summary**

Each member of the Magnificent Seven had negative encounters with institutions, policies, and cultural stigma that made it difficult to learn about and claim their disorders. Some of these negative encounters took the form of byzantine organizations with procedures that led to nowhere, other encounters involved prejudiced and detached helping professionals, other

encounters found participants caught in the crossfire of pervasive symptomology and the commoditization of mental health, and some encounters included life threatening situations with prescribers, authority figures, and bureaucratic dismissal. Additionally, contemporary gender roles played a part in shaping male and female narratives. One participant in particular endured negative and destructive encounters with numerous institutions of power including law enforcement, social services, helping professionals, and cultural prejudice.

**Epilogue: Part One**

“Fuck off to anybody who tells you to calm the fuck down” – Kitten

“Don’t give up. Don’t give up.” - Faith

*Researcher’s Note: As I conducted this study for the purpose of helping individuals with pervasive psychiatric symptomology, I asked each participant two questions that were geared towards consumers and potential beneficiaries of this research. The answers did not disappoint.*

Clay: “What would you want to say to people who share your condition and haven’t been diagnosed, who might believe in the stigma, or not have good support from professionals? If you could send them a message, what would you want to say?”

Patricia: “Go get on medication, do that first, because you can't fix anything else, if you can't think straight. So the first thing you have to be is medication compliant and the second thing you have to be is drug free. My cross to bear, use d to love my beer, my cross to bear, just can't do it, that's what you have to do. And you'll live a better life.”

Harley: (laughs) “It gets better. That's the last thing you want to hear right now and I understand that. Uh, shit. You, you know, you're not alone. It might not feel like it's getting better and it might get worse but you're not alone. Uh, you know, if I had to, if I had to you know, reach to the comic books uh, and then unfortunately, it's bouncing from the comic books to a comic book movie but you know, we're, we're at the bottom of that terrible pit and uh, we've got to climb out and uh You know, we can, we can be Bruce Wayne climbing out of the pit or we can be uh, you know, Talia Al-Ghul climbing out of the pit or we can be Bane and stay at the bottom of the pit.”

Astrid: “Um ... oh God. The, the, I think the comforting one is, I think there is a place where everybody belongs in the world. I think there is something that everybody is meant to be doing. Um, um, there, there are ways to, there are avenues to gain the capabilities that you need to do what you're supposed to be doing. Um, the less comforting one is that, uh, if you don't prioritize your own autonomy, nobody else is going to.”

George: “Just because there are people much worse off than you, your illness is still probably worse than you think it is for the people close to you.”

Faith: “Don't give up. Don't give up. Like you're gonna find the resources, you're gonna find the people, you're gonna find the tribe. Just don't give up, because there were a lot of times I just wanted to give up. And there were times that I essentially did give up.”

Amanda: “This is really hard and you feel wrong, like you are taking up some sort of space you are not supposed to be taking up and that you're being in the world in a way that is not supposed to be but that is wrong. You are in the world exactly as the world needs you to be and you have so much to offer and it's such a shame that the world has told you that's not the case. And I want you to know that you can find a way of being exactly who you are and using your talents and abilities and it is so much easier if you find something to lean on and don't be afraid to lean on those things and don't be afraid to use those things. I think we have been told that people are an island and that we are supposed to have all of our shit figured out by ourselves. But that's just not true and that's not true to the wisdom of women everywhere. We are a community and you are



standing on the shoulders of thousands of years of strong, empathic, sensitive, anxiety ridden, women and that wisdom won't fail you if you allow it to come to life.”

*Researcher's Note: Once you've picked your jaw up off the floor, notice how in this passage, Amanda's speech patterns sharply contrast with all the previous passages. Not a stammer or a backchannel in the entire message.*

Kitten: (long pause) Listen to your gut, accept your emotions, and fuck off to anybody who tells you to calm the fuck down.

### **Epilogue, Part Two**

“Thank you for bringing me to this place because I wouldn't be here without you” – Amanda

“This seems like a good place to end it.” - Harley

Clay: “If your disorder was standing next to you right now, and you had the chance to say one thing to it before it disappeared, what would you say?”

Faith: “Oh my gosh. Hmm. I'd want to ask it why. Um, and I don't, I don't know how, how much I would even specify, I would just want to know why everything. Like why do I think the way I do? Why is it hard for me to do certain things? Why do I feel isolated from ... Just why everything. And I'd probably also say thank you. Just because I, like I was just saying, I, I wouldn't change it, like certain aspects of it are super hard, but I mean everybody's life is hard in some way. And I at least get to put a name on mine.”

Amanda: “I think, I'd want to say "as much as I want you to chill the fuck out sometimes, thank you for what you've taught me, thank you for bringing me to this place because I wouldn't be here without you, and you know we have a rocky relationship sometimes but I am doing my best to be in a good relationship with you. And my only request would be that you would try to be as good to me as I try to be to you." Yeah.”

Harley: “Now this is interesting. So one of the things that I discovered wasn't going to work in Kendall's therapy with me was role playing or, um, improvisational dialogue with imaginary things, um, just because that's kind of how my brain works already. I, I am often in dialogue with characters of my own creation based on other people, um, which I've been told is a terrible thing and I shouldn't do it when I get into fights with significant others and they say, um, I hate that you've played this out already, or you know, I hate that you think you know what I'm going to say and frequently, frequently I'm right but no, it's so hard for people to truly surprise each other sometimes, um, but conceptually if I could put my PTSD into a chair, I'm less interested in the dialogue and I'm more interested in observing. I want to, I want to, I want to read the body language of my PTSD. I want to see what kind of a presence it is. Is it, is it a tiny little thing that has a personality that tries to make it seem bigger than it actually is or is it a giant hulking monster that might just you know have a gentle spirit inside?... I want to engage with my PTSD, like...can I wrestle you? Can I, can I kill you and aah can I deal with you. I don't know if I want to talk. Yeah, hey, want to fight? Um, yeah, yeah I challenge my PTSD to a fight. It's something I want to do. Um, planning to stay, long night, got PTSD sat down and it looks just like a mirror image, that would be the perfect answer. I am my PTSD. My PTSD is mean. We can integrate and move on. That sounds like a good place to end it.”

Patricia: “Oh wow, what would I say to it? I'd say, work with me. You know what, Clay, if somebody said to me tomorrow I could take that mental illness away from you, I'm not trying to give it away. I don't like the episodes, the manic depression and the duh, duh, duh, duh, but on medication, I like the way I think. I like the way that I can read and remember it, and I know that

I'm intelligent, because other people tell me I'm intelligent, you know what I mean. So I don't think that I would give it away but if I was looking at it I think, please work with me, please don't pop up when I can't do you.”

Kitten: “No one invited you. You have overstayed your welcome. And, although I do appreciate your influence in making me prepared for the worst, I am ok being a little unprepared.”

George: (long pause)...Just stay over there.

Clay: (laughs)

George: (laughs)

## **Chapter Five**

The purpose of this study was to illustrate the personal narratives of individuals who live with a psychiatric diagnosis and consider it to be a positive or integral component of their identities. The current chapter is divided into four sections. In the first section, I briefly review the need for this study and review the research process. In the second section, I review and forward conclusions from the research findings. In the third section, I enumerate and describe the limitations of this study. In the fourth section, I suggest potential directions for further research on the matter.

### **Review of Research Process**

All contemporary helping professions utilize psychiatric diagnosis as a fundamental element of case conceptualization and treatment planning (American Counseling Association, 2014). Psychiatric diagnoses fall under the umbrella of a medical model which stipulates that the thoughts, feelings and behaviors that clients present to the counseling process are demonstrate

the presence of disease in the brain (Joyce, 1980; Surís et al., 2016). While the medical model of psychiatric diagnosis benefits the helping professions in certain ways, the one-sided, deficit oriented conceptualization of human experiences as symptoms of disease occludes alternate perceptions that acknowledge strengths and benefits inherent to clients' presenting conditions (Hansen, 2007; Zalaquett et al., 2008).

Research has emerged on mood disorders, in the field of neuroscience, and in the field of education that question the fit of a deficit, disease oriented model of mental health that fails to account for the positive aspects inherent to Psychiatric Diagnosis. (e.g; Carson, 2014; Martin, Marsh, & Debus, 2003; Peterson & Carson, 2000; Stearns, 2015). Though my investigation of the literature uncovered multiple studies that spoke to potential benefits inherent to Psychiatric Diagnoses, I was unable to uncover research on how individuals who have Psychiatric Diagnoses might experience and develop a strengths-inclusive concept of their conditions. Therefore, the present study was designed to examine the life narratives of individuals who live with a Psychiatric Diagnosis and consider it to be, at least in part, a beneficial component of their identities.

I recruited seven participants for the present study; two were found through postings on the CESNET listserv, and five were recruited through postings on my personal Facebook page. Each participant engaged in an approximately on-hour-long interview over Skype or telephone. Following my review of each transcribed interview, each participant was sent and answered a personalized set of follow-up questions. After the Narrative Analysis was completed, I sent the finished manuscript out for Peer Review and Member Checks. Feedback from members was minimal and largely supportive; all suggested edits involved either a) adding additional content to clarify demographic and personal information such as religious denominations, sequence of

analyzed events and job histories, or b) making changes to the names of people, places, and programs in order to preserve the confidentiality of participants and their support figures.

Feedback from Peer Review addressed the structure and sequences of the analysis rather than making substantive shifts in content or approach.

### **Conclusions**

The following research questions guided this investigation:

- How do individuals who live with a Psychiatric diagnosis that they consider to be a strength manage the negative aspects of Psychiatric symptomology while capitalizing on its positive properties?
- What supports and environments are necessary in maximizing the positive aspects of Psychiatric diagnosis?
- To what extent are such individuals capable of consciously harnessing these traits, and how do sociocultural influences impact their experiences of succeeding with a Psychiatric diagnosis?
- How do they consciously incorporate the diagnosis into their self-concepts, if they do so at all?

The responses to these research questions will be extrapolated from the data analysis presented in chapter four. Table 1 (p. 197) presents a summary of plotline analysis by category, Table 2 (p. 198) presents a summary of thematic development by category, and Table 3 (p. 198) summarizes institutional/participant barriers and interactions by category.

Table 1				
Plotline Analysis by Category				
Emerging Awareness of Difference	Early Struggles with the Problem	Epiphany of Identity	Duality of the Problem	Development of Empathy
Salient Characteristics				
Sense of being different from an early age or shortly after genesis of disorder	Participant continues to internalize frustration caused by sense of difference	Participant has an experience that leads to positive development of self-concept	Participant continues to reconceptualize their relationship to the disorder	Participant seeks out community of people who share his/her disorder for mutual support
Participant reaches out for assistance from primary supports	Participant receives some sort of intervention which is partially/largely ineffective	Epiphanies can spring from positive events or from reflection on negative events	Participant realizes how aspects of the disorder have led to personal growth and the development of strengths	Participant experiences a deepened sense of empathy attributable to having the disorder
Primary support system rebuffs plea for assistance	Participant learns to cope with sense of difference through maladaptive means (substance abuse, cutting behavior, binge eating, people pleasing)	Participant begins to conceptualize their sense of difference in a more positive manner	Client begins to utilize humor when dealing with/communicating about the effects of their disorder	Participant acknowledges that greater empathy enhances them as a person or in their profession or endeavors
Participant internalizes negative emotions that result from failure to connect with support	Participant is labeled by members of support system who do not understand the participant's subjective experiences ("You're just sick/You're just being sensitive.")	Participant begins to privilege the self, engages in self-care and pursues self-made goals and desires	Participant benefits from receiving psychoeducation on coping skills and symptomology related to his/her disorder	Participant is spurred to advocacy for those who have not experienced the sort of self-realization he/she has achieved

Table 2	
Thematic Analysis by Category	
Activities of Difference	Persons of Difference
Participant engages in an endeavor/hobby pastime that enhances his/her ability to cope with symptomology	Supportive persons are proactive in supporting and assisting participants in a nonjudgmental manner
The activity of difference is engaging and exciting for the participant, helps them to focus attention and build skills	Supportive persons often share the participant's disorder, engage participant in mutually beneficial loop of support and processing
The activity can be ritualistic, or can help the participant connect with/commemorate an important person or event	Supportive persons see symptoms as logical responses to environmental stressors rather than marks or signs of defectiveness
The activity promotes creativity or helps the participant to express and process emotion	Supportive persons help the participant to set and reach their own goals and standards rather than promoting restrictive or reductive goal setting
Participants connect to the work and life stories of prominent artists and creative individuals	Persons of difference help the participant celebrate and enjoy the positive aspects of his/her disorder

Table 3		
Institutional Barriers Reported by Participants		
Gender Roles	Mental Health Industry	Other Institutional Barriers
Male participants are told to "toughen up," met with verbal or physical violence	Participants are stymied by byzantine organizational procedures and poor or negligible cross-organization communication	Encounters with unconcerned/unfit law enforcement officials lead to participant harm
Female participants are accused of attention seeking/overtly sexualized behavior	Participants are opposed by mental health professionals who attempt to restrict or discourage participant goals/wishes in conformity with medical model	Participants are stymied by a social service system that offers all-or nothing assistance and restrict participant desires for self-actualization
	Mental Health professionals dismiss or ignore client concerns and experiences	
	Mental health professionals describe participants as sick or in profound need of repair	

**Maximizing the Positives, Minimizing the Negatives – Research Question 1**

“Why wouldn’t I use it?” - Amanda

The investigation of research question one produced some of the most unexpected and varied findings of the entire study, especially as they pertain to Psychiatric diagnosis. Findings from all three dimensions of the research- plotline analysis, thematic analysis, and the investigation of institutional barriers- contributed to a nascent understanding of the first question. However, the bulk of the relevant conclusions can be drawn from the first dimension. An examination of participant plotlines reveals that participants benefitted from the Epiphanies of Identity, understanding the Duality of the Problem, and the Development of Empathy. Further analysis of this process yields comparisons to previous literature and points towards possible means to clarify and advance long-established concepts.

During the Epiphany of Identity, the participants experienced an event or realized a new perspective that led to dramatic differences in self-awareness. These experiences began to untangle the entrenched, negative self-concepts the participants developed during their Early Struggles with the Problem. Working through these epiphanies helped the Seven gain better understandings of the Duality of the Problem, which furthered the cascades of positive development. As the Magnificent Seven grasped this duality, they also began to use humor to cope with negative symptomology, tie aspects of their diagnoses to specific character strengths and benefits, and prioritize positive, self-made goals and self-care. Participants also reported that struggling with their disorders had led to a deeper sense of empathy; furthermore, they gained appreciation for how this expanded empathy had enhanced their capacities as both professionals and human beings. Through this process, the participants learned to capitalize on the strengths of their disorder while minimizing the negative aspects.



While the participants had assistance along the way from Persons of Difference, a crucial key to these developments lies in the fact that they were largely self-made or self-taught. In this manner, a comparison of the plotline analysis to existing literature yields comparisons to *client factors* as described in previous research (Asay & Lambert, 1999; Duncan & Miller, 2000; Miller & Duncan, 2000). This results of this study point to a potentially invigorating framework for how client factors might be understood and developed- counselors might employ questions such as, “Has there ever been a time when you thought that the world was crazy or wrong, instead of you?” and “What gifts has your disorder given you, even if just through learning how to cope with it?” that could potentially help clients understand and advance their place on this developmental continuum.

Participants were also empowered to reframe their relationships with their disorders through Activities of Difference. These activities include endeavors and hobbies that participants found personally engaging, relaxing, and purposeful. While Activities of Difference are enjoyable for participants, they also promote skill-building and self-discipline that aid the participants in coping with their disorders. Activities of Difference tend to involve physical activity and creative expression; additionally, participation in theatrical endeavors was exceedingly common and was reported by six of the Magnificent Seven. This finding might be diminished due to the previously discussed snowball sample, but a comparison with existing literature yields further support that creative endeavors- including theatre- might be particularly beneficial in helping individuals reframe their relationship to Psychiatric Diagnoses.

As revealed through the Emerging Awareness of Difference and Early Struggles with the Problem, the Magnificent Seven began their narratives by expressing an inability to understand their sense of difference or find support for working through their notions of difference. This

impediment led to an increasing tendency to internalize frustrations, confusion, and anger brought about by their stymied self-awareness and social support. As this internalization intensified, members of the Seven adopted maladaptive behaviors such as cutting, substance abuse, and eating disorders in order to cope. However, there is reason to believe that the correlation between the progression away from these harmful habits and the implementation of healthier coping among the Seven might not be a coincidence.

Existing literature suggests that therapies which utilize creative and expressive arts are especially well-suited for helping individuals externalize and express repressed, internalized emotions. For instance, Keeling and Bermudez (2006) researched the effects of a therapeutic program that incorporated sculpture and creative writing. Results revealed that the intervention assisted participants in expressing emotions, gaining greater awareness of personal strengths and abilities, and generated a sense of personal empowerment (Keeling & Bermudez, 2006). Additionally, therapeutic modalities that incorporate theatrical practices and conventions- including Psychodrama and Drama Therapy- have been utilized to help individuals connect with repressed feelings that may be difficult to access in conventional talk therapy (Jones, 2008a; Konopik & Cheung, 2013; Snow, D'Amico, & Tanguay, 2003). Mackay (1989) successfully utilized Drama Therapy in assisting survivors of sexual violence to uncover and work through repressed emotions. Furthermore, the survivors credited Drama Therapy with helping them gain the necessary confidence to overcome fears about reengaging in social activities and behaviors (Mackay, 1989). Konopik and Cheung (2013) examined the effects of a Psychodrama program and concluded that it was essential in helping participants link suppressed or frightening feelings to desired outcomes or expectations. While a comprehensive examination of creative therapies and their utility for externalizing suppressed emotions and improving communication is beyond

the scope of this dissertation, it is reasonable to conclude that creative activities such as theatrical endeavors might be beneficial in helping individuals with Psychiatric Diagnoses improve communication skills, connect with healthy supports, and improve their outlook on their disorders.

Finally, I will relate the effects of Diagnosis itself on the participants' ability to manage and control their Psychiatric conditions. Overwhelmingly, the members of the Magnificent Seven professed that receiving their diagnoses and appropriate psychoeducation on their conditions helped them to understand and cope with negative symptomology. In fact, all seven participants explicitly stated that learning about their diagnoses had helped them to cope with and manage their disorders. Despite this uniform positivity towards identification with and understanding of diagnosis, however, six members of the Seven went on to recount considerable hardships wrought by the way diagnosis was conceptualized by helping professionals.

### **What Helps, What Hurts – Research Question 2**

“Don't turn my problems into cha-chings.” - Harley

Six of the Magnificent Seven stated that the manner in which these diagnoses were conceptualized by helping professionals (or at least one helping professional) they had worked with) had been unhelpful or explicitly harmful. Findings drawn from the third dimension of this study- specifically, the Institutional Barriers produced by helping professionals- speak directly to this conclusion. These obstructive behaviors demonstrated by helping professionals include the following: restricting or discouraging the pursuit of participant goals, ignoring or dismissing accounts of participant experience with the problem, byzantine practitioner policies and negligible cross-organizational communication, and asserting that the participant is “damaged” or in need of extensive repair.

The Magnificent Seven were also highly congruent in identifying behaviors and attitudes in helping professionals that they found beneficial and nurturing. These behaviors included the establishment of a trusting and secure environment for the expression of feelings and secrets, a specific willingness to let participants work through feelings of suspicion, anger, and resentment towards the counselor/counseling process, and a tendency to affirm, honor, and congratulate the participants for expressing painful or shameful experiences rather than reacting in a restrictive and pathologizing manner. In many ways, these behaviors are simply the “flip side” of the Institutional Barriers identified in other helping professionals.

Furthermore, the Magnificent Seven were able to identify common behaviors in all types of individuals who supported and nurtured them in their quest to own their diagnoses. These behaviors include both an understanding of symptomology as a logical response to environmental stressors and a willingness to encourage participants to achieve and succeed in spite of symptomology. For instance, both Faith and Amanda explicitly identified supports who were willing to see their symptomologies as unique and necessary reactions to pressure rather than markers of defect or disease. On the other hand, Patricia and George both identified Persons of Difference who helped hold them to high standards- Patricia’s father would flip her mattress if she didn’t get up for school, and Jessica Williams both coached CB to improve and allowed him to “sweat it out” when he bit off more than he could chew. Taken together, these types of behaviors serve as two sides to the same supportive coins.

The characteristics of helpful and supportive individuals identified across the seven narratives- be they spouses, counselors, parents or friends- are highly congruent with foundations of the Person-Centered Care Model of Psychiatry (Borg et al., 2009; Clayton, 2013; Davidson & Roe, 2007; Mezzich et al., 2010). Specifically, the findings speak to three characteristics of

Person-Centered Care as identified by Borg et al. (2009): clients being the primary drivers of treatment planning, treatment planning that focuses on strengths and abilities rather than symptom reduction, and focused efforts to integrate clients into integrated settings rather than restrictive environments. Other findings such as the tendency amongst the seven to test and adhere to self-realized personal boundaries reflect the Person-Centered idea of *recovery-in* mental illness, in which clients with enduring symptomology focus on maximizing enjoyment and abilities while being mindful of personal limitations (Borg et al., 2009; Davidson & Roe, 2007). However, not all of the environments and supports identified by the Magnificent Seven were fully compatible with either the Person-Centered Model or the Counseling Model- as previously discussed, some of these factors were more congruent with the Medical Model.

By considering these multifaceted conclusions along with conclusions related to the first research question, I was able to conceive of a prototypical, theoretical “middle ground” between the Counseling and Medical Models that best describes supportive environments and practices that allowed the Magnificent Seven to flourish. While this model is by no means exhaustive, well-defined or even complete, I am proposing it as a starting point for identifying a “middle path” between two paradigms that at times seem contradictory and exclusive. In effect, this model utilizes a “both/and” outlook on counseling paradigms over an “either/or” outlook; this notion has been forwarded in previous scholarship (Jeffrey Guterman et al., 2012; Martin et al., 2012) Building on both the Counseling and Medical Models as they are described in on p. 11, I propose the following model as a springboard for future investigations into evolutionary avenues for the Counseling Profession

- An outlook on symptomology as both a logical, unique response to environmental stressors and a personal challenge that can be managed and mitigated

- A focus on both developing client strengths and ameliorating symptomology
- An acknowledgement of both client and counselor owning an expert position- the counselor being an expert on theory, education and process, and the client being the expert of their own experience and conceptualizing appropriate goals for counseling
- An understanding that both parties should be active and engaged in the counseling process- the counselor focuses on education and process while the client focuses on goal-setting and setting the pace of the process
- An acknowledgement that Psychiatric Disorders have both general and unique ways of manifesting themselves in the client's experience, and a focus on dealing with them from both angles.

It is my hope that future scholarship might refine and investigate this model while further exploring points of convergence between the Counseling and Medical Models.

While the refinement and combination of helping paradigms might lead to exciting new approaches to psychopathology in Counseling, data from this research suggests that the Counseling profession could be facing a deficit in its ability to help individuals like the Magnificent Seven. As six out of the Seven experienced an Emerging Awareness of Difference in childhood and/or adolescence, it stands to reason that counselors should be ready and available to meet the specialized developmental needs of this crucial demographic. A quick scan of websites that represent the accrediting bodies of major helping professions, however, reveals a glaring anomaly. Though specialized degrees and training in child and adolescent service are accredited in Social Work (U.S. Department of Health and Human Services, 2018), Psychology (American Psychological Association, 2018), and Psychiatry (American Academy of Child &

Adolescent Psychiatry, 2008), investigation of the Council for the Accreditation of Counseling and Related Programs (CACREP) website reveals that no equivalent specialization is accredited in the Counseling profession. Therefore, it stands to reason that voices within Counseling may choose to advocate for an accredited degree program that can assist professional Counselors in their efforts to meet the mental health needs of children and adolescents.

### **How Far Can They Take it, and What are They Facing? – Research Question 3**

“You know Clay, when you have a medical professional, a doctor tell you that you're not capable, you believe it.” – Patricia

The third research question inquired as to how much control participants gained over their Psychiatric conditions, and how various sociocultural influences and institutions of power might have impacted the process. The degree to which participants were able to “control” their Psychiatric conditions was not investigated as thoroughly as the previous two questions; I consider this to be a byproduct of the procedures inherent to Narrative Analysis. As my responsibilities as a researcher included privileging participant voices and following their narrative lead throughout all discussions, my queries quickly began to coalesce around research questions one and two- these seemed to be the issues most germane to participant experiences and also the ones that most greatly inflamed participant passions.

The Magnificent Seven, however, had much to say about how sociocultural and institutional power had hindered and impacted their experiences. In describing unhelpful and damaging encounters with helping professionals, members of the Seven explicitly and repeatedly referenced meeting with helping professionals who discouraged the pursuit of or cast doubt on the participant’s ability to achieve self-made goals. Instead, these helping professionals truly treated the participants as if they were diseased, disabled, and incapable of setting and meeting their own goals- regardless of how capable or motivated the participants actually were. As Patricia lamented in chapter four, “I wasn’t disabled until I had a bunch of medical professionals

jumping into my life.” This testimony and others like it speaks to the fact that the Medical Model is only partially compatible with the Counseling Model; furthermore, it illustrates the dangers and limitations of describing clients conditions and experiences as diseases.

Other sociocultural barriers to the Magnificent Seven’s development include damaging encounters with uncaring and unfit law enforcement officials, the presence of stigma in both the Medical community and everyday life, and the Byzantine and poorly organized functions of major medical establishments. The negative impact of the criminal justice system on the outcomes of individuals with mental health needs is not a new subject in the realm of mental health; Parsons and Bergin (2010) asserted that victims of criminals sometimes experience a phenomenon known as *secondary victimization* after enduring harmful encounters with law enforcement figures, Norris and Cooke (2000) discussed the negligible training many law enforcement officers receive in regards to individuals with mental health needs, and Borum (2000) highlighted the high rate of encounters between law enforcement officials and individuals with mental health needs and the equally high risk of such encounters leading to negative outcomes. The solution to this problem might lie in increased partnerships between professional counselors and law enforcement agencies; for instance, Young, Fuller and Riley (2008) examined the effects of a partnership program between counselors and law enforcement officials and determined that it yielded positive results for counselors, police officers, and individuals who interact with law enforcement alike.

The effects of stigma on the well-being of individuals with mental health needs are likewise common in existing literature. Corrigan (2004) asserted that stigma produces two main effects on consumers of mental health- specifically, it reduces self-esteem and decreases access to crucial avenues for social connection. Both of these assertions were reflected in the Seven’s



narratives. Marques, Figueiras, and Queiros (2012) echoed these assertions while also identifying stigma as a serious barrier between individuals with mental health needs and fair access to housing and employment. This additional stipulation was well represented in Patricia's narrative. Finally, Soghoian and Gasparyan (2017) identified the stigma against mental illness as the number one barrier to improvements upon mental health problems on a global scale. In order to address the lingering and intense impact of stigma on individuals with mental health needs, new individual and systemic interventions for addressing stigma must be designed and implemented. Henderson et al. (2014) asserted that the most effective interventions for reducing stigma involved increased contact between mental health professionals, their clients, and the friends, families, and primary supports of clients. These findings echo the foundations of the Person-Centered Care Model, which privileges the presence of family and social supports in the therapeutic process along with increased interaction between individuals with mental health needs and the wider community (Borg et al., 2009).

The issue of poor practices and negligible communication between facets of the mental health industry is also addressed in the literature, although not nearly as thoroughly as the previous two barriers. Bramesfeld et al. (2012) conducted a focus group on the subject that included representatives from multiple disciplines of mental health treatment and concluded that methods of interdisciplinary communication should be mandatory in the curricula of all medical disciplines. Adair et al. (2005) examined communication between sectors of the mental health industry and determined that higher degrees of communication (referred to as Continuity of Care by the researchers) was associated with improved health outcomes for individuals with severe mental illnesses. Mitton, Adair, McDougall and Marcoux (2005) examined the relationship between improved continuity care and health care expenses and determined that improved

communication was associated with lower costs. In light of these results, the importance of improved and regular communication between disparate realms of mental health care becomes increasingly more vital- improved communication leads to benefits for mental health professionals, individuals with mental health needs, and the prices and costs of service. It is hoped that professional counselors will advocate for the creation of interdisciplinary committees that can work together to improve the state of communication between components of greater health care institutions.

#### **How do They See Themselves? – Research Question 4**

“People thought I might be deaf, or that I was Autistic (whoops, I was).” – Astrid

“You have high blood pressure, we don't walk around calling you high blood pressure” - Patricia

The fourth research question sought to illuminate how participants consciously incorporated Psychiatric diagnosis into their self-concepts. Of all the research questions, question 4 yielded the most varied results. For Patricia, Schizoaffective Disorder wasn't something she was, it was something she had- it was no more defining of her identity than varicose veins or overgrown cuticles might have been. For Astrid, however, the experience of being Autistic was decidedly different- it began as a vague and unwanted sense of being different, but grew to become an integral and indispensable component of her identity. Most of the Magnificent Seven fell somewhere between these positions- George appreciated all that his disorder had done for him, but was none too disturbed that his current medication regimen largely prevented the possibility of future clown raids. Faith sometimes lamented the struggles and obstacles generated by her ADHD, but she was also grateful for its impact on her life and referred her enhanced empathy with great pride. After reflecting on these varying attitudes towards the incorporation of diagnosis into self-concept, I determined that the only commonality between the seven narratives was the fact that each participant had drawn the distinction for themselves rather than deferring

to the expert opinions of health care providers. In this way, the narratives of the Seven lend further support to the empowering and autonomy-privileging aspects of the Person-Centered Care Model (Borg et al., 2009). This conclusion also lends support to a Social Constructionist perspective on Counseling, which promotes the notion of working within client worldviews and utilizing clients' own unique metaphors and language in the therapeutic process (J. T. Guterman & Rudes, 2008; Jeffrey Guterman & Leite, 2006; Rudes & Guterman, 2007).

### **Summary**

The preceding section interpreted the study findings through the lens of the research questions. In regards to the first question, members of the Magnificent Seven found multiple ways to maximize the positive aspects of psychiatric diagnosis while minimizing the negative factors. In one of the more surprising findings, each member of the Magnificent Seven identified receiving an accurate diagnosis and zetic education on their diagnoses as integral to their ability to manage negative symptomology while maximizing positive aspects of diagnosis. Less surprising, perhaps, was the discovery that all seven participants preferred mental health interventions reflective of the Counseling Model and Person-Centered Care (e.g.; Borg et al., 2009; Zalaquett et al., 2008) than the Medical Model of Care (Joyce, 1980; Zalaquett et al., 2008). Six of the Magnificent Seven identified involvement with artistic expression (either as a creator or consumer) as critical to their ability to manage the Duality of the Problem. Furthermore, all six of these participants specifically identified involvement with theatrical endeavors as a key component in learning to maximize the positive aspects of their conditions. Participants also identified physical activity as an important tool for enhancing self-concept; lastly, they identified involvement with a number of Activities and Persons of Difference as vital resources in managing the Duality of the Problem.

With regards to environments and supports, it was determined that the participants endorsed interventions and attitudes that reflected the Person-Centered Model of Care, the Counseling Model, and the Medical Model. Specific elements of Person-Centered Care identified by the research include a focus on expanding possibilities and abilities rather than focusing on deficits and environments that are collaborative and integrative rather than restrictive (Borg et al., 2009). Specific aspects of the Counseling Model endorsed by the Seven include an understanding of symptomology as a logical response to environmental stressors and a focus on strengths and resources. Components of the Medical Model endorsed by the Seven include the utilization of diagnosis to inform treatment planning and case conceptualization (Craddock & Mynors-Wallis, 2014; Frances, 2014; Surís et al., 2016). I then forwarded the idea of a blended model as a jumping-off point for beginning debate and discussion on how a combined, improved paradigm that features the best facets of each model might be produced in the future.

In regards to the first component of the research question, little was uncovered as its relevance to the project was siphoned away as other research questions took on greater importance. Several relevant factors were identified in regards to the second half of the question, however. Specifically, the Magnificent Seven were able to identify multiple sociocultural barriers to the development of their unique viewpoints- these barriers include mental health treatment that utilized restrictive and disempowering interventions and conceptualizations, cruel and incompetent treatment from law enforcement officials, and draconian policies coupled with ineffective communication amongst various institutions of mental health treatment. Several solutions to resolving these barriers were proposed.

Lastly, research revealed that members of the Magnificent Seven had varied manners of incorporating their diagnosis into self-concept. Some members saw it as a medical condition that

was peripheral to their identity, some saw it as an integral, indispensable aspect of their identity, and some participants experienced a variable incorporation of diagnostic identity as a result of negative encounters with restrictive sociocultural institutions. This finding offered further support for the Person-Centered Model of Care (Borg et al., 2009) and a Social Constructionist perspective on Counseling. (J. T. Guterman, 1996; Rudes & Guterman, 2007).

### **Informed Critique of the Research Design**

Several limitations of the research design must be addressed. First of all, the inclusion requirements for potential participants was invented somewhat *ad hoc* by the researcher due to a scarcity of applicable recommendations in the extant literature. While deliberation and care went into the conceptualization of the inclusion criteria, certain weaknesses are apparent. First and foremost, the authenticity of participant accounts could be called into question without a rigorous method for verifying the satisfaction of inclusion criteria. It was decided, however, that formal requirements for verifying participant congruence with inclusion criteria could prove damaging and alienating to individuals who do not know the researcher (e.g: letters from mental health professionals verifying a Psychiatric diagnosis, confirmatory statements from participants' primary support figures, etc.). Therefore, the researcher utilized his clinical experience in positioning and assessing participant trustworthiness. While this solution was admittedly imperfect, it was more congruent with the social justice foundations of Narrative Analysis and its doctrine of liberating participant narratives as opposed to policing them (Fraser, 2004; Fraser & MacDougall, 2017).

Additionally, the guiding assumptions and research questions are largely grounded in research adjacent to the subject matter due to the lack of empirical studies on the subject of analysis. Again, care and caution were applied to the literature review in order to support the

research endeavor as rigorously as possible. While themes and guidelines that inform the proposed study have been defended as well as possible, there is slight empirically-grounded research to support the study's tenets of inquiry.

Due to my decision to open the sample up to individuals with a broad spectrum of disorders, data analysis proved complicated and difficult. Though consistent themes and plot points were identified, these points of interest manifested themselves in manifold ways from participant to participant. Additionally, participants experienced these points of interest at variable junctures of their growth and development. Despite this potential limitation, the identification of sub-group comparisons and organizing themes inherent to Narrative Analysis positioned me to draw the most meaningful conclusions possible. My decision to utilize Narrative Analysis as a theoretical perspective was largely influenced by these unique characteristics.

Flowing from the previous limitation, data analysis was further compounded by the high degree of correlation between identified themes and plotlines. For instance, Activities of Difference were often largely intertwined with Persons of Difference, and the sociocultural barriers to participant development were visible and impactful across multiple dimensions of participant narratives. This interdependence amongst data points provided obstacles to the clear and straight forward explication of analyses, hopefully any lack of clarity can be directly met in future studies on the subject.

Also, the study may have been limited by my limited experience with both Qualitative Research and Narrative Analysis. In all stages of the interview process, I placed a premium on privileging participant voices; this decision led me to take a passive role in the interviewing process. I do not believe that this decision was a poor one, however, the benefit of hindsight

allowed me to identify moments when I could have non-obtrusively asked focused follow-up questions at various junctures in each interview. This adjustment might have promote sharper data collection that focused more tightly on the research questions. It is my hope that practice makes perfect, and that my abilities as an interviewer and a Narrative analyst will progress throughout my research career.

Finally, it could be argued that the themes and plot points identified in this study lack a crisp and well-defined conceptual clarity. Members of the Magnificent Seven seemed to operate within a synergy created by the overlap of Activities of Difference, Persons of Difference, and developmental processes like the Emerging Awareness of Difference. Furthermore, these plot points and themes often overlapped and influenced each other, which presented definite challenges during the coding process.

### **Suggestions and Implications for Future Research**

As this study is (as far as I was able to ascertain) the first of its kind, multiple follow-up studies could be performed to test the conceptual fidelity of the developmental processes, ideas and procedures identified in this research. Multiple approaches could be utilized in future studies; further Narrative Analyses could be conducted, or more homogeneous groups of individuals (Autistic Women, Women with Schizoaffective Disorder) could be studied from a Phenomenological framework. Goals of future follow-up studies could include a) addressing aspects of the current study's research questions that were not fully answered, b) an attempt to further organize, probe, and test the developmental processes proposed in the current study, c) an attempt to investigate chronological factors that might influence the developmental processes proposed in this study, d) attempts to establish greater conceptual clarity of the current study's identified findings, e) a deeper examination of the relationship between individuals who benefit

from traits associated with psychiatric diagnosis and overarching institutions of mental health, f) further investigation of and debates on the blended Counseling model proposed by this study, and g) an investigation of potential solutions to the sociocultural barriers identified in the current study.

Perhaps the most disturbing findings identified by the current study pertain to the negative and sometimes destructive relationships between the Magnificent Seven and institutional entities including law enforcement, psychiatric hospitals, and other mental health providers. Perhaps future studies on Public Health policy could focus exclusively on the phenomenon of institution-as-barrier in order to shed light on alternatives and potential solutions.

One of the most interesting and consistent findings of this research pertains to the presence and development of empathy. Each member of the Magnificent Seven explicitly stated that struggling with negative symptomology made them more empathetic towards the suffering of others. Furthermore, six of the Seven explicitly stated that their increased sense of empathy made them better people. While the benefits of increased empathy may seem obvious, research on empathy and altruism has yielded a host of benefits related to the concept. Empathy has been associated with increases in cooperative behavior (Batson, 2011; Rumble, Van Lange, & Parks, 2010), it has been demonstrated to be a mediating variable between self-esteem and mental well-being (Simsek & Bozanoglu, 2011), and it has also been linked to an increase in positive relationships and improved mental and physical health (Batson, 2011). Perhaps future studies could examine empathy development more closely in order to determine if the current findings can be replicated. If the link between psychopathology and increased empathy can be further validated, perhaps other studies can examine how individuals who live with a psychiatric diagnosis can reap the positive benefits associated with increased empathy.



Lastly, future studies could further examine the relationships between individuals who capitalize on aspects of psychiatric diagnosis and the support figures in their family of origin. Each member of the Magnificent Seven was able to identify harmful or unhelpful behaviors exhibited by family support figures; however, none of the Seven reported a strained relationship with their parents in the present, and six out of Seven explicitly reported a presently warm and beneficial relationship with their parents. If this complex, compassionate, and grateful way of relating to important support figures can be further studied, perhaps family therapy and research into anger and resentment can benefit from the results.

In the immortal words of my friend Harley, this seems like a good place to end it.

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## CURRICULUM VITA

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### **Clayton V. Martin, LPC, MS, NCC**

1400 Middle Street, Apartment 415, Williamsburg, VA 23185  
(404) 449-3028  
cvmartin@email.wm.edu

## I. EDUCATION

Doctor of Philosophy (Ph.D), CACREP Accredited  
Counselor Education and Supervision  
The College of William & Mary, Williamsburg, VA  
Anticipated Graduation Date: June, 2018

Title of Dissertation: *The Magnificent Seven: A Narrative Analysis of Suppressed Discourses in Psychiatric Diagnoses.*

Master of Science (M.S.), CACREP Accredited  
Mental Health Counseling and Marriage and Family Counseling/Therapy  
Barry University, Miami Shores, FL, Conferred 2011

Bachelor of Arts (B.A.)  
Drama Studies  
University of Georgia, Athens, GA, Conferred 2003

## II. PROFESSIONAL EXPERIENCE

### **Licensed Professional Counselor**

Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists  
(License Number LPC009574)

### ***February 2018 to Present***

#### **Adult Outpatient Services Counselor**

Colonial Behavioral Health, Williamsburg, VA

Provide individual and group counseling to persons with substance abuse concerns. Coordinate service requirements with referral providers, facilitate the collection and analysis of drug and alcohol screenings, provide psychoeducation on Cognitive-Behavioral techniques for reducing harmful behaviors associated with substance abuse.

### ***May 2017 to Present***

#### **Family Counselor**

New Directions, The College of William & Mary, Williamsburg, VA

Provide group counseling services to both children and parents in a community based, eight-week therapeutic program. Implement a strengths-based curriculum for children and young adults. Provide supervision to junior program clinicians.

***May 2016 to Present***

**Student Co-Director**

New Leaf Clinic, The College of William & Mary, Williamsburg, VA

Training of Master's level clinicians in an on-campus, Motivational Interviewing-based substance use counseling program. Provide weekly individual and group supervision for Master's Level clinicians. Conduct individual therapy sessions, group therapy sessions, and provide substance-use related psychoeducation to the student community at The College of William & Mary. Maintain compliance with university policy, client legal obligations, and administrative procedures.

***September 2015 to May 2016***

**Program Supervisor**

Project Empower, Williamsburg, VA

Conducted individual therapy sessions with local high school students who have been referred to counseling for substance abuse concerns. Provided supervision to Masters' level clinicians who worked for Project Empower, provided training and education for Masters' level clinicians who worked for Project Empower. Coordinated referrals with local guidance counselors, coordinated Masters' level supervision with Project Director.

***September 2015 to Present***

**Research Assistant**

Dean of Students, The College of William and Mary, Williamsburg, VA

Assist the Dean of Students in conceptualizing, organizing, and executing Quantitative research endeavors. Conduct literature reviews germane to courses being taught by the Dean, assist the Dean in analyzing student feedback; assist with placing teaching assistants in courses being taught by the Dean.

***April 2014 to August 2015***

**Case Manager, Young Adult Program**

Talbott Recovery Campus, College Park, GA

Conducted individual and group therapy sessions with young adults in a partial hospitalization substance abuse treatment program. Provided psychoeducation on the subject of addiction to patients, and present educational lectures on addictive and psychological matters in seminar series. Assisted patients in progressing through treatment level system in order to assure timely program completion. Implemented strengths-based treatment planning to help young adults cultivate resilience, motivation, and improved self-concept. Provided on-call services on a rotating basis in order to meet the continuing needs of recovery residents.

***November 2013 to April 2014*****Intake Clinician**

Ridgeview Institute, Smyrna, GA

Conducted intake assessments for substance dependent and psychiatric patients to determine the appropriate level of patient care. Facilitated patient referrals to inpatient, partial hospitalization, intensive outpatient program, and outpatient providers. Facilitated the acquisition of inpatient admission authorizations from patient insurance companies. Educated patients in regards to treatment options and treatment alternatives.

***June 2013 to September 2013*****Level 1 ASAM Group Therapist**

A Growth Place, Stockbridge, GA

Provided weekly Level 1 ASAM group therapy sessions for court-mandated DUI and Possession clients. Provided psychoeducation based on the Transtheoretical Model's stages of change, facilitated and processed group discussion regarding psychoeducational topics. Position terminated upon dissolution of practice.

***February 2012 to April 2013*****Youth and Family Therapist**

Henderson Behavioral Health, Fort Lauderdale, FL

Provided intensive in-home individual and family therapy services to severely emotionally disturbed young adults as an alternative to residential treatment. Completed intake assessments and psycho-social assessments, and developed treatment plans. Implemented strengths-based treatment planning to develop resilience, motivation, and improved self-concept in young adults. Managed crisis response and developed safety plans.

***May 2011 to December 2011*****Counselor Intern**

Honeyshine Mentoring Program, Miami, FL

Provided individual and group counseling services to young females transitioning out of the foster care system.

**Counselor Intern**

College Reach Out Program, Barry University, Miami, FL

Provided individual and group counseling services to middle and high school students in the Miami-Dade County public school system.

**Counselor Intern**

Maureen Duffy Family Enrichment Center, Barry University, Miami, FL



Provided individual counseling, couples counseling, and family therapy services in a community mental health setting.

***January 2011 to December 2011***

**Intake Coordinator**

Success

University, Barry University College Reach Out Program, Miami Shores, FL

Provided intake services for inclusion in a solution-focused youth counseling program.

**Youth Mentor**

Barry University College Reach Out Program

Provided psychoeducational and mentorship services to Miami-Dade County public school students.

**Research Assistant**

Department of Counseling, Barry University, Miami Shores, FL

Conducted research with faculty in the Mental Health Counseling and Marriage and Family Counseling/Therapy program. Topics included: postmodern approaches to the treatment of sexual disorders, postmodern approaches to the treatment of eating disorders, and philosophical issues in counseling.

***September 2009 to December 2011***

**Research Assistant**

Department of Education, Barry University, Miami Shores, FL

Collected and analyzed data regarding student teacher internship evaluations. Determined general strengths and weaknesses of student teacher cohorts and reported back to head of internship. Facilitated communication between student evaluators and department administration.

***January 2011 to May 2011***

**Graduate Assistant**

Department of Counseling, Barry University, Miami Shores, FL

Provided clerical and administrative support to Counseling Department faculty.

### III. TEACHING EXPERIENCE

***Spring 2018***

**Co-Instructor, Career Counseling and Development, EDUC C31**

Department of Counseling, The College of William & Mary, Williamsburg, VA

Co-developed philosophy, pedagogy, and evaluative procedures for Career Counseling course. Delivered lectures and facilitated experiential learning exercises for students.

Coordinated with instructor of record to determine sequence of lectures, course objectives, student learner outcomes, and assessment procedures. Implemented a strengths-based curriculum to assist students in developing their own approaches to career counseling. Conducted live assessment of oral examinations at midterm and end of semester.

***Spring 2017***

**Teaching Assistant, Career Counseling and Development, EDUC C31**

Department of Counseling, The College of William & Mary, Williamsburg, VA

Co-developed philosophy, pedagogy, and evaluative procedures for Career Counseling course. Coordinated with instructor of record to determine sequence of lectures, course objectives, student learner outcomes, and assessment procedures. Conducted live assessment of oral examinations at midterm and end of semester.

***Summer 2016***

**Teaching Assistant, The Counselor and Psychopathology, EDUC 645**

Department of Counseling, The College of William & Mary, Williamsburg, VA

Assisted instructor of record in developing and implementing course content. Presented lectures on the subject of Personality Disorders, assisted instructor of record in evaluating student assessments.

***Spring 2016***

**Teaching Assistant, Career Counseling and Development, EDUC C31**

Department of Counseling, The College of William & Mary, Williamsburg, VA

Co-developed philosophy, pedagogy, and evaluative procedures for Career Counseling course. Coordinated with instructor of record to determine sequence of lectures, course objectives, student learner outcomes, and assessment procedures. Conducted live assessment of oral examinations at midterm and end of semester.

***Spring 2011***

**Campus Educator**

Avon Foundation for Women Domestic Violence Awareness Trainer, Miami, FL

Provided seminar training for college students on how to recognize the patterns of interpersonal violence and advocated for the protection of battered partners.

#### IV. SCHOLARSHIP AND CREATIVE ACTIVITIES

##### **Refereed Publications**

Honderich, E.M., Grunhaus, C.M., & Martin, C.V. (in press). Counselors' experiences of workplace aggression and organizational values: A descriptive analysis. *Counseling and Values*.

Kim, K. H., & Martin, C. V. (in press). ADHD, creativity, or both? In E.G. Carayannis, Encyclopedia of Creativity, Invention, Innovation, and Entrepreneurship. New York: Springer Science & Business Media.

Kim, K. H., & Martin, C. V. (in press). Creative, or a behavior problem? In E.G. Carayannis, Encyclopedia of Creativity, Invention, Innovation, and Entrepreneurship. New York: Springer Science & Business Media.

Kim, K. H., & Martin, C. V. (in press). Creativity and age. In E.G. Carayannis, Encyclopedia of Creativity, Invention, Innovation, and Entrepreneurship. New York: Springer Science & Business Media.

Kim, K. H., & Martin, C. V. (2017). Creative attitudes: The 4S (soil, sun, storm, and space) attitudes. In E.G. Carayannis, Encyclopedia of Creativity, Invention, Innovation, and Entrepreneurship. New York: Springer Science & Business Media.

Martin, C.V., Kooyman, B., Branch, K., & Sheffield, R. (2016). Addressing ethical dilemmas in doctoral-level counselor education/supervision programs. *Vistas*. Retrieved from: [https://www.counseling.org/docs/default-source/vistas/article\\_38a2ce2bf16116603abcacff0000bee5e7.pdf?sfvrsn=3cd84b2c\\_4](https://www.counseling.org/docs/default-source/vistas/article_38a2ce2bf16116603abcacff0000bee5e7.pdf?sfvrsn=3cd84b2c_4)

Guterman, J. T., & Martin, C.V. (2016). Using puppets with aggressive children to externalize the problem in narrative therapy. In (A.A. Drewes and C. Schaefer, Eds.). *School age play therapy*. Washington, DC: American Psychological Association.

Martin, C.V., Guterman, J. T., & Kopp, D.M. (2012). Extending the dialogue about science and humanities: a reply to Hansen. *Journal of Humanistic Counseling*, 51, 161-163.

Guterman, J. T., Martin, C.V., & Kopp, D.M. (2012). Science and humanities: A necessary unity for the counseling profession. *Journal of Humanistic Counseling*, 51, 145-154.

Guterman, J. T., Martin, C.V., & Rudes, J. (2011). A solution-focused approach to Frotteurism. *Journal of Systemic Therapies*, 30, 59-72.

Martin, C.V., Guterman, J.T., and Shatz, K. (2011). Solution-focused counseling for eating disorders. *Vistas*. 1-11. Retrieved from [http://www.counseling.org/docs/vistas/vistas\\_2012\\_article\\_88.pdf?sfvrsn#sthash.d591dIu0.dpuf](http://www.counseling.org/docs/vistas/vistas_2012_article_88.pdf?sfvrsn#sthash.d591dIu0.dpuf)

### **Refereed National Presentations**

- Guthrie, K., Martin, C., Williams, N., Paek, S. H., Lee, H. E., & Kim, K. H. (2017). *How to develop Inbox, Outbox, and Newbox creative thinking skills*. Workshop Presented at the National Association for Gifted Children annual conference, Charlotte, NC.
- Martin, C.V., and Niles, S. (2017). *Reframing strain: A re-examination of contemporary work stress*. Workshop Presented at the Association for Counselor Education and Supervision biennial conference, Chicago, IL.
- Martin, C.V. (2016). *Educating the Twice Exceptional Student: A Strengths-Based Approach*. Workshop Presented at the National Association for Gifted Children annual conference, Orlando, FL.
- Wagner, N., & Martin, C.V. (2016). *New Approaches for Strengths-Based Counseling and Supervision*. Workshop Presented at the Southern Association for Counselor Education and Supervision biennial conference, New Orleans, LA.
- Martin, C.V., Wagner, N., Tuazon, V., Gonzalez, E., & Grunhaus, C. (2016). *Fathers Experiencing Grief Due to Miscarriage, Stillbirth, and Neonatal Death: A Strengths-Based Approach*. Workshop presented at the International Association of Marriage and Family Counselors annual conference, New Orleans, LA.
- Martin, C.V., & Guterman, J.T. (2015). *Solution focused counseling: Advanced techniques and applications*. Workshop presented at the American Counseling Association annual conference, Orlando, FL.
- Guterman, J.T., & Martin, C.V. (2015). *The DSM V: A postmodern re-vision for counseling*. Workshop presented at the American Counseling Association annual conference, Orlando, FL.
- Martin, C.V., & Guterman, J.T. (2014). *Enhancing the therapeutic alliance with youth clients*. Workshop presented at the American Counseling Association annual conference, Honolulu, HI.
- Guterman, J.T., & Martin, C.V. (2014). *Solution-focused counseling for depression*. Workshop presented at the American Counseling Association annual conference, Honolulu, HI.
- Guterman, J.T., & Martin, C.V. (2012). *Solution focused counseling for eating disorders*. Workshop presented at the American Counseling Association annual conference, San Francisco, CA
- Roseman, F., & Martin, C.V. (2011). *Using data for enhancing effective internships*, Workshop presented at the National Student Teacher and Supervision Conference, Slippery Rock, PA.
- Fernandez, M., & Martin, C.V. (2011). *Humanizing GLBT disabilities: A multicultural perspective of GLBT issues*, ARCA Conference Workshop at ACA, New Orleans, LA.

**Refereed State Presentations**

Honderich, E.M., Martin, C.V., & Grunhaus, C. (2016). *Workplace aggression in the counseling profession*, Virginia Counseling Association annual conference, Williamsburg, VA.

**Invited Presentations**

Guterman, J.T., & Martin, C.V. (2014). *New developments for solution-focused counseling*. Pre-Convention Learning Institute (6 hours) presented at the American Counseling Association annual conference, Honolulu, HI.

**Media**

Cited in article, "Reconsidering ADHD" by Laurie Meyers, *Counseling Today*, retrieved July 20, 2016: <http://ct.counseling.org/2016/07/reconsidering-adhd>

Cited in article, "Connecting with Clients" by Laurie Meyers, *Counseling Today*, retrieved August 19, 2014: <http://ct.counseling.org/2014/08/connecting-with-clients>

**Professional Memberships**

American Counseling Association  
Since 2010

American Mental Health Counselors Association  
Since 2017

Chi Sigma Iota, Omega Mu Chapter  
2016-Present

Chi Sigma Iota, Beta Upsilon Chapter  
2010-2016

National Career Development Association  
Since 2017

**Professional Training**

2016 SACES Conference and Exhibition  
Southern Association for Counselor Education and Supervision  
New Orleans, LA

2016 IAMFC World Conference  
International Association of Marriage and Family Counselors

New Orleans, LA

2015 ACA Conference and Exposition  
American Counseling Association  
Orlando, FL

2014 ACA Conference and Exposition  
American Counseling Association  
Honolulu, HI

2012 ACA Conference and Exposition  
American Counseling Association  
San Francisco, CA

2010 ACA Conference and Exposition  
Military Counseling Certificate  
American Counseling Association  
New Orleans, LA

2010 FCA Conference  
Florida Counseling Association  
Miami, FL

Eating Disorders, Recovery, and the Therapeutic Process  
Miami-Dade NEDAW Steering Committee  
Miami Shores, FL

Narrative Practice for Girls in Foster Care  
Presentation for Barry University College Reach Out Program  
Miami Shores, FL

Sexual Abuse Prevention Training  
Avon Foundation for Women Domestic Violence Awareness Program  
Miami Shores, FL

Solution-Focused Practices in the Classroom  
Presentation by Dr. Lee Shilts, Barry University  
Miami Shores, FL

### **Awards and Honors**

First Prize: American Counseling Association Annual Ethics Competition, Doctoral-Level  
Awarded 2016

Avon Foundation for Women Domestic Violence Training Grant  
Awarded 2011

Barry University Goizueta Foundation Scholarship  
Awarded 2011

Barry University College Reach Out Program Scholarship  
Awarded 2011

Franklin College of Arts and Sciences Scholarship  
Awarded 2003

## V. PROFESSIONAL AND COMMUNITY SERVICE

November 2017-Present  
Board Member, Creativity Network, National Association for Gifted Children

August 2017- Present  
Program Development Co-Director for Campus Recovery Community, The College of William  
& Mary

April 2017- Present  
Inaugural Member, Social Justice & Diversity Fellowship at The College of William & Mary

January 2016- Present  
Initial Program Reviewer, Council for Accreditation of Counseling and Related Educational  
Programs (CACREP)