

**Murdoch University**

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THE DISCURSIVE CONSTRUCTION OF SCHIZOPHRENIA AS A  
PROBLEM OF SELF IN RELATIONSHIP

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## DECLARATION

I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary educational institution.

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## ABSTRACT

People with a diagnosis of schizophrenia are thought to experience a ‘loss’ of self, theoretically assumed to be the direct result of their ‘disease’ or mental illness. This investigation proposes that constructions and reconstructions of self-identity and the relationships surrounding these sense-making activities are an ongoing process and result in a multitude of alternate versions of self. Using discursive and conversational analyses, this study examined detailed responses to questions of self from nine people with a diagnosis of schizophrenia and the four support workers who assisted them at a local social support service centre. Diagnosed participants tended to rationalise and ‘normalise’ their behaviours and experiences in order to present a socially acceptable self-identity. Support staff accounts of people with a diagnosis of schizophrenia were interwoven with medically discursive diagnostic criteria and behavioural characteristics. Once a label had been attached to the person, the process of reconstructing the self had to incorporate the pervasive, disabling associations attached to their diagnosis, where the only acceptable version of self was discursively medical. People receiving a diagnosis of schizophrenia experience a compromised sense of self-identity and thus, their diagnosis becomes the defining characteristics of their self – an identity classification.

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I would like to dedicate this work to my mother, who was unfortunately not able to see its completion.

## OVERVIEW

*“The self is something which has a development; it is not initially there, at birth, but arises in the process of social experience and activity, that is, develops in the given individual as a result of his [sic] relations to that process as a whole and to other individuals within that process”*

*(George Herbert Mead, 1934, p. 135).*

Notions of self, selfhood, and identity have long been posited to be a product of the social world in which people live. Mead (1913) argued that the self emerges from social interaction/communication between the person and others, where the person first learns to see themselves as an object, as others see them. The person takes on the perspectives of others, and through language and social interaction, or ‘social acts’, the person learns the roles, words, gestures and rituals etc. that come to define them.

Yet, not all descriptions of self are agreed upon. For example, contention arises when a person is deemed by others to be mentally ill, and shared ideas of self and identity are brought into question. The person’s notions of themselves may conflict with others’ versions of them e.g. ‘you’re mentally ill’ – ‘no, I’m not’. In mental health, the power and primacy given to particular versions of self influences and in many cases determines the consequences of accepting or rejecting a specific account. In particular, the accounts given by mental health professionals will wield more power than those of mental health consumers, based upon the expert status accorded to them in society. These ‘discursive complexes’, or patterns of discourse that specify our understandings of emotional distress

and behaviour (Parker 1996, 1998), are indicative of the powerful regimes of knowledge and governance in current Western culture.

The aim of this thesis is to examine notions of schizophrenia as a problem of self-identity and a problem of relationship. Traditional theorists of schizophrenia posit that people who receive a diagnosis of schizophrenia have lost their sense of who they are; their self-identity (Bleuler, 1950; Hemsley, 1998; Mahler, 1952, 1968). This reflects the taken-for-granted theorising dating back as early as Bleuler (1950), outlining schizophrenia as a ‘loss of self’ (Hemsley, 1998; Mahler, 1952, 1968). This theme continues to hold currency with notions of ‘self-disturbance’ put forward in a recently published, discursive account of self in people with a diagnosis of schizophrenia (see Keane, 2009). Indeed, Sass (2007, p401) goes so far as to declare that schizophrenia “...seems to involve some kind of disorder of the entire personality...”. But beyond whatever conflicting issues within the psyche that may (or may not) be involved in a diagnosis of schizophrenia, there is also a massive social realignment that is occasioned by such an apparently consequential diagnosis. That is, once a person is medically identified as ‘schizophrenic’, the resulting diagnosis introduces a new identity that the person is expected to adopt or adhere to as a person who is ‘mentally ill’ (Boyle, 2002). This reconstruction or renegotiation of a new identity is often contentious. Through the renegotiation of self, accounts of how the person incorporates (or doesn’t incorporate) others’ versions of themselves into their own accounts can be explored.

The psychoanalytic ‘loss of self’ approach is contrary to contemporary understandings of schizophrenia. Current orthodoxy in psychiatry doesn’t allow for competing theories, or alternatives to the

biomedical ‘disease’ model and the neurochemical imbalance models promoted to the general public (Ingleby, 1981; Turner, Mathews, Linardatos, Tell & Rosenthal, 2008). The critical psychiatry movement is one area that questions the validity of psychiatric diagnosis, and at the forefront is Mary Boyle’s (2002, 2004) compelling critique of schizophrenia as a problematic scientific concept. This thesis is both motivated and informed by the critique of this movement, yet it takes a somewhat different emphasis; rather than challenging the validity of schizophrenia as a diagnostic category, it examines the impact on self-understanding, social relationships and the reciprocal interaction between them and a diagnosis of schizophrenia.

In this thesis, an ethnomethodological approach is taken in the investigation of many different versions of self and identity that can be constructed by and for a person who has been given a diagnosis of schizophrenia. The setting for the research is a local mental health service centre that assists consumers<sup>1</sup> with day-to-day living skills: 13 people involved with this centre participated in the study (nine consumers and four support workers). The thesis begins with a brief discussion of current theoretical constructions of ‘schizophrenia’ (Chapter One, Part One), along with an alternative approach to interpreting and assisting people with a lived experience of schizophrenia (Chapter One, Part Two). The study’s focus, procedure and analytic orientation (Chapter Two) are detailed to give foundation to the following analyses. Chapter Three presents biographical sketches of each of the primary participants in the study, giving voice to each person talking about their experiences of change in their self-

1 The term consumer will be used throughout to refer to people with a diagnosis of mental illness / schizophrenia.

understandings and their relationships with others associated with their diagnosis. At this point I shift from presenting each person's story as an individual narrative to look at the common issues and challenges experienced and the ways in which these were managed by participants. Chapter Four then examines the localised construction or reconstruction of different versions of self given by each of the primary participants. Chapter Five concerns the participants' accounts of the ways in which they believe they are seen by others, and introduces the argument that the diagnosis of schizophrenia powerfully influences the nature and quality of the relationships participants have with their family and friends, particularly by undermining their claims to autonomy and responsible self-management. Chapter Six examines an alternative perspective through accounts given by the four staff members of each of the nine primary participants, offering a window into how the participants' diagnosed with schizophrenia are seen by the mental health workers who provide services to them, allowing the examination of possible contention or divergence in self-identity. Finally, Chapter Seven revisits notions of self in people with a diagnosis of schizophrenia, bringing together constructions and reconstructions of self-identity and the relationships surrounding the sense making activities of the self. Above all else, this thesis hopes to deepen understanding and assist in giving meaning to the lived experiences of people diagnosed with schizophrenia.

## CHAPTER 1 – Renegotiating a Sense of Self

*“The things patients talk about and the way they talk do not seem to reflect our concepts, or at the very least, our concepts seem to reflect only such a very narrow range of what is going on in these people”*

*(Strauss, 1994, p.103).*

A diagnosis of schizophrenia can have a profound impact upon a person's sense of self. Research and literature on schizophrenia frequently refer to a diagnosed person's self or identity as 'lost' (Bleuler, 1950; Hemsley, 1998; Mahler, 1952, 1968), and over time one's prior identity is replaced by an identity and life which revolve around notions of 'being a psychiatric patient' (McCay et al., 2006). A person's sense of self, the self known to the person and others though, does not come from within but through negotiation with others, through the complex processes of social interaction and social validation (Baumeister, 1998; Gergen, 1989, 2008). The thoughts, feelings, behaviours, actions and reactions that might be said to be typical of a particular person are fundamentally social, being both generated and witnessed in relationships.

The challenges to one's self-identity presented by a diagnosis of schizophrenia are clearly apparent. People entering the mental health system receive a diagnostic label based upon their behaviours/reactions to severe emotional problems (American Psychiatric Association – APA, 2000). Sadler (2003, 2007) suggests that the diagnostic process promotes a 'self-illness ambiguity', where there is a blurring between the personal self and mental illness. The APA states that the various classifications and

syndromes within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) are indicative of behaviours rather than persons (APA, 2000). Yet diagnosis provides not only the basis for a disordered self, but results in others viewing the person as “...*being* mentally ill rather than having a mental illness” (Sadler, 2007, p.115). Thus, the diagnosis of schizophrenia and its pervasive, disabling associations (Lefley, 1989; Penn, Kommana, Mansfield & Link, 1999; Switaj, Wciorka, Smolarska-Switaj & Grygiel, 2009) become defining characteristics of the person – an identity classification – which can be seen through the common use of the term ‘schizophrenic’.

This thesis is not suggesting that the lived experience of emotional distress does not occur or is not real in some way for a person diagnosed with schizophrenia. Rather, it examines the construction and sense-making of that emotional distress (and the resulting behaviours) which lead to a diagnosis of schizophrenia, and the impact this has on understandings of self-identity and relationships. Since the pioneering work of Mead (1934) it has become uncontroversial to suggest that self-identity is derived from the social world, where social interaction and communication work to construct mutually negotiated and socially flexible repertoires of ‘self’ and ‘identity’ that makes each of us recognisable in our social worlds. That is, the language and terms that people use to describe themselves and others are formulated and agreed upon in relationship. I argue that the transformation of a lived experience of emotional distress into a diagnostic label ‘fixes’ an aspect of the self in such a way that it becomes a major ‘fact’ that must be negotiated and incorporated, in some way, into the diagnosed person’s social selves.

This chapter is divided into two parts: Part 1 will first outline notions of self and examine research on schizophrenia (e.g. deficits / biases / family studies), where the medical concept of schizophrenia informs common sense understandings of extreme emotional distress, providing an account that locates the source of this distress as residing in stable psychological and biological deficits within the distressed person. The constructions and presentations of scientific notions colour the way a person views themselves and the way that others view them, sometimes resulting in stigma and discrimination via a social discrediting of the person (Goffman, 1962). Part 2 adopts an alternative, transformative approach to current medical orthodoxy addressing the fundamental issues of language, knowledge and meaning surrounding extreme emotional distress (Seikkula, 2008; Seikkula, Aaltonen & Alakare, 2000). Here, a transformative dialogue can be built enabling new understandings and meanings of emotional distress and lived experiences to emerge. This thesis posits that once a diagnosis of schizophrenia is received, a renegotiation of self occurs where the person (in relationship with others) redefines who they are. The diagnosis/label can be contested, negotiated, rejected, and/or accepted, as their former identity must now incorporate some or all of the associations aligned with their diagnosis.



## **PART 1: Schizophrenia: The Self and Diagnosis**

In contemporary western psychology, the self is generally described through mentalistic processes. An example of the mainstream theoretical knowledge and ideas about the self and its functions can be seen through the theorising of Baumeister (1998; Baumeister & Bushman, 2010). Baumeister suggests that when people speak of the self they are not referring to a physical but a psychological identity. This self plays many roles in multiple social relationships incorporating thoughts, feelings, and attitudes, of not only the individual, but others with whom the individual is socially involved. Baumeister posits that the self is formed from three major human experiences: reflexive consciousness, interpersonal being, and executive function. Reflexive consciousness deals with the notion of self-awareness, where the self is observed or inferred from social interaction or events rather than observed directly. This knowledge about the self can then be obtained, stored, altered, and used. The social world is extremely important in the formation of the self as humans are interpersonal beings. They are members of groups and form relationships with others. The self is not constructed in social isolation but through the connections it has to others. Finally, the self has an executive function which allows choices to be made, actions to be executed, and control to be gained over the self and others. In this way, the self is an agent acting on the world. For example, this is seen when a person weighs up options and makes a decision.

Many theories have also been offered that place the self in context. For example, Ulric Neisser (1993; Neisser & Jopling, 1997) emphasises the cultural significance of self, whereas the work of Hazel Markus and

colleagues view the self as a dynamic and changing concept that reflects and mediates the negotiation of a variety of social circumstances (Markus & Kunda, 1986; Markus & Nurius, 1986). They take into account environmental factors and interactions with others that may alter or influence the self that is presented to the world, or the person's sense of self. In these explanations of self, the person weighs up all of the information they obtain about themselves through their social contexts and interactions with others, yet ultimately formulate their own self-identity, thus reducing self-identity back to the mentalistic processes of the individual. Hormuth (1990) provides a view of self that is not socially isolated, yet still retains the core concept of the individual. He explains how the self remains stable, linking cognitive processing and the understanding of self to interaction with others, objects, and environments. Thus, the self in context is a perspective that sees an individual interacting with the world. This is also true of the strength of the 'social cognition' model (Baumeister, 1998, 1999), yet differs in the degree of centrality given to 'others' in the formation and continual reproduction of self. Ecological approaches also add to current understandings of self by including the possible impact that the person's physical environment has upon their conceptions of self (Hormuth, 1990; Neisser, 1993).

In context, the self can be conceptualised as a part of an ecological system involving both change and continuity within shifting person-environment relationships (Hormuth, 1990). "The self-concept constitutes the cognitive representation of a person's social experiences, and, in turn, it influences that person's perceptions of and acts toward his or her environment" (Hormuth, 1990, p.210). Hormuth explains that firstly, direct

social experience incorporates others. Secondly, objects are used to represent or symbolise these many social experiences. Thirdly, the setting for social experience is the environment. Collectively, these three aspects of the ecological self represent a person's cognitions of self. This model incorporates an individualistic self structure, and possible responses of self to change within the ecology of the person (Hormuth, 1990), and allows for a change in self over time. That is, as relationships and environments change, so does the self.

Social constructionists argue that concepts such as psychological traits and selves are social and historical creations, rather than naturally occurring phenomena (Cromby & Nightingale, 1999; Gergen, 1985, 1989, 2009; Harre, 1993; Harre & Gillett, 1994; Hruby, 2001). The individual is a reflection of the prevailing social order, a social order that determines the meanings that are attached to various behaviours, and that determines which behaviours are acceptable and which are not. Individuals must share in the rules of meaning of the societies of which they are part or become morally suspect. But this is more than just the consequences of choices; the shared social meanings of behaviour and shared understandings of the nature of self are what render us intelligible to each other, and allow our participation in society. Failure to share in these rules may result in the questioning of one's identity. Thus, "...the individual is at social risk until he or she can either jettison the socially unacceptable practice of negotiating reality or convince others to accept an alternative view of 'the way things are' " (Gergen, 1981, p.69).

## **Schizophrenia and the Self**

A person's sense of self can be profoundly influenced by a diagnosis of schizophrenia. For example, diagnoses of abnormality and the resulting labels placed upon the person can result in the view of a damaged self, and not only influence the way that others view the person, but the way that the person views themselves (Goffman, 1959, 1962, 1974). The subsequent renegotiating and a sense of self in relationship with others requires the navigation of both professional and public opinion of these problems and behaviours that are widely understood as schizophrenia. Social understandings of schizophrenia, informed as they are by scientific research and the opinions of experts, provide the new and challenging 'reality' against which a person diagnosed with schizophrenia must construct a socially recognisable and acceptable self.

Research on schizophrenia typically focuses upon symptomology (i.e. the two main criteria of delusions and hallucinations (APA, 2000)) and the cause of schizophrenia. Delusions are described as persecutory where a person believes that others are out to harm them, grandiose where the person tends to greatly inflate their importance, power, or self-worth, and Capgras syndrome where the person believes that people such as close friends or family members are not who they say they are and have been replaced by imposters. Hallucinations can occur in any sensory modality, but are typically reported as auditory. This is where a person hears voices, people speaking to them that others cannot hear; the person believes the voices either emanate from within or are external to themselves (APA, 2000).

Scientific understandings of schizophrenia and the self tend to follow one of three major approaches: deficit models, biases, and familial approaches. Deficit models align themselves to physiological causality, distinguishing between ‘normal’ and ‘abnormal’ (Corcoran, Cahill, & Frith, 1997; Hoffman et al., 2003). Biases, on the other hand, incorporate context and view ‘abnormal’ behaviours as occurring on a continuum with ‘normal’ behaviour (Garety & Freeman, 1999; Kinderman & Bentall, 2000). Finally, a familial approach investigates the inter-relations of people within their immediate environment, and the effects that this may have on the person (Laing & Esterson, 1964; Rothbaum, Rosen, Ujiiie, & Uchida, 2002).

### **Deficits**

Expert opinions on what schizophrenia ‘is’ (i.e. its presentation in terms of symptoms and prognosis) and where it comes from (i.e. epidemiology) provide the materials that people draw on in forming their understandings of what a diagnosis of schizophrenia means, both for the person receiving the diagnosis themselves and for the friends and family of the diagnosed person. Deficit models of mental health stem from biomedical reductionism, positing neurological dysfunction to be responsible for emotional distress (Bracken & Thomas, 2001). Cognitive processes that underlie or maintain these deficits are investigated in the individual (Penn, 2000). From this perspective, the symptoms of schizophrenia are manifestations of an underlying psychological disorder, and it is the individual that is dysfunctional, abnormal, and in need of correction. Deficit models then link the person’s lived experience of emotional distress to deep psychological dysfunction. Self-identity

becomes enmeshed with the stigma associated with abnormality (Scheff, 1966). The deficit view of emotional distress as a product or symptom of underlying neurological dysfunction has become so widespread that the questioning of this paradigm is now almost heretical (Bracken & Thomas, 2001; Keen, 1999; Read, Mosher & Bentall, 2004).

Research from a deficit perspective typically utilises general perception and emotion tests to compare the cognitive performance of people with a diagnosis of schizophrenia to control groups (Penn, 2000). If impairments are found in particular areas relative to the control group, a deficit is assumed in the person with the diagnosis. One of the most frequently researched areas of delusional thinking is that of persecution, which indicates a person believing that others are trying to harm them (APA, 2000). Frith (1992) proposed that delusions of persecution arise from a deficit in Theory of Mind; that is, persons said to have schizophrenia are unable to accurately infer the thoughts, beliefs, and intentions of others as compared to a control group. Studies conducted by Frith and colleagues (Corcoran, Cahill, & Frith, 1997; Corcoran, Mercer, & Frith, 1995; Frith & Corcoran, 1996) found that only negative symptoms of schizophrenia (e.g. *alogia*, *anhedonia*) correlated with Theory of Mind deficits, whereas delusions of persecution are put forward as positive symptoms of schizophrenia (APA, 2000). Furthermore, these findings were only relevant in those people currently in a symptomatic state; those in remission showed no deficit compared to controls. This point is often overlooked, as much research and treatment for the schizophrenias does not appear to differentiate between an acute psychotic state and remission (Ciudad et al., 2009; Herold, Tenyi, Lenard & Trixler, 2002; van Os et al., 2006). This

suggests that the versions of self and others held by a person with a diagnosis of schizophrenia are not necessarily 'inaccurate' or 'delusional' much of the time, but are heavily influenced during periods of extreme emotional distress. Thus, the assumption of experts that there is an overall deficit in Theory of Mind for people diagnosed with schizophrenia works to dismiss the diagnosed person's perceptions of themselves and supports expert opinion of that person.

Deficits in cognitive functioning are also proposed when examining auditory hallucinations, such as disrupted speech perception (Hoffman et al., 2003; Hoffman, Rapaport, Mazure, & Quinlan, 1999), and integration difficulties between memory systems and current sensory input (Hemsley, 1993, 1998, 2005). One of the most popular theories proposes that these symptoms result from a deficit in the internal monitoring of one's own thoughts (Johns & McGuire, 1999; McGuire et al., 1995). This occurs when the person does not recognise their own thoughts and believes them to belong to someone else. Support for this theory came from a Single Photon Emission Computed Tomography (SPECT) study, which found that when people heard voices, there was greater blood flow in the Broca's area of the brain (Broca's area has been linked to internal thought processes) (McGuire, Shah, & Murray, 1993). Although this theory was challenged when later, more detailed technology could not replicate the study, it remains a common explanation of auditory hallucinations (Hoffman et al., 1999).

Insight deficits are described as a person's lack of understanding and recognition of their mental illness (Baier & Murray, 1999) or, alternatively, their 'unawareness of illness' and, consequently, a failure to properly understand and appropriately regulate their own behaviours (Lysaker, Bell,

Milstein, Bryson, & Beam-Goulet, 1994). Neurological models explain this deficit in terms of brain malfunction (Baier & Murray, 1999), typically in the frontal and parietal lobes (Smith, Hull, Israel & Willson, 2000). A qualitative study conducted by Baier and Murray (1999) used open-ended questions to assess insight in 26 people with a diagnosis of schizophrenia. Their responses were categorised and coded, and placed into a matrix to show differences and similarities between participants. People said to be lacking in insight "did not view the unusual things that were happening to them as symptoms of schizophrenia", "did not attempt to explain", and "did not attribute any reduction in these unusual perceptions, thoughts, behaviours, or events to the medication" (Baier & Murray, 1999, p.17). Here, the only acceptable answer for a diagnosed person to be said to show insight was a discursively medical response; that they had "correctly attributed the symptoms to the disease" (Baier & Murray, 1999, p.18). By adhering to current biomedical accounts of severe emotional distress, the individual can only view themselves as 'diseased', as abnormal. Competing accounts are given no credence, and indeed may be taken as evidence of a 'lack of insight' that is itself attributable to the disease. Insight is also frequently associated with treatment and medication compliance. In this way, non-compliance can be understood as a manifestation of cognitive deficits (see Lysaker et al., 1994), illustrating the extreme difficulties confronting a person diagnosed with schizophrenia who wishes to challenge or resist that diagnosis.

Studies of generalised cognitive deficits in performance on neuropsychological tests serve to show that emotionally distressed people do not perform as well as people who are not emotionally distressed



(Mathews et al., 2002; Mathews & MacLeod, 2004). Many practitioners believe in the legitimacy of schizophrenia as a disorder of neurocognition (Foster-Green & Nuechterlein, 1999), despite the failure of cross-sectional research to find an association between measures of neurocognition (e.g. attention, cognition, and perception) and positive psychotic symptoms that can explain more than 10% of the variance (Foster-Green & Nuechterlein, 1999; Kurtz, 2006; Roncone et al., 2002). With this in mind, Foster-Green and Neuchterlein (1999) propose that deficits found in neurocognition relate to functional outcome (e.g. social problem solving and community functioning) rather than actual symptomology. That is, contrary to the view of deficits in basic neurocognition, this claim highlights deficits in social cognition or social functioning. Here, the broader realm of social interaction and relationship is introduced; where a person's social functioning is not an individual endeavour but an interactive event which necessarily includes input from others.

### **Biases**

A bias approach to understanding schizophrenia views potentially 'symptomatic' behaviour on a continuum and takes context into account when explaining this behaviour (Penn, 2000). Penn gives the example of the self-serving attributional bias, where the individual ascribes positive outcomes to the self and negative outcomes to external factors in order to preserve their self-esteem. Delusional conviction, distress, and preoccupation in people with schizophrenia fluctuate over time (Brett-Jones, Garety & Hemsley, 1987). Garety and Freeman's (1999) review of the literature on reasoning biases concluded that people experiencing delusions

show a tendency to jump to conclusions, using less information to reach a decision than people not experiencing delusions. In most tasks where people received all of the information before making a decision, people experiencing delusions came to similar conclusions to those of control groups. The area where they tended to show more of an extreme bias than the non-delusional person was with emotionally salient information. Highly emotive tasks affect the reasoning abilities of all people, yet people experiencing emotional distress show more extremely biased responses (Beck & Rector, 2005; Dudley, John, Young, & Over, 1997; Mujica-Parodi, Greenberg, Bilder & Malaspina, 2001).

Bentall and colleagues (Bentall, Kaney, & Dewey, 1991; Bentall, Kinderman, & Kaney, 1994; Blackwood, Howard, Bentall, & Murray, 2001; Kinderman & Bentall, 1997; Kinderman & Bentall, 2000) have argued that there is also evidence of an attributional bias in people experiencing persecutory delusions. Kinderman and Bentall (2000) proposed that the relationship between attributions and self-representations is circular. They suggested that particular attributions influenced the accessibility of certain representations of self, yet salient self-representations also influenced attributions. Based on Higgins' (1987) Self Discrepancy Theory, Kinderman, Prince, Waller, and Peters (2003) assessed self-discrepancies before and after participants had processed threat-related information. The authors measured the self-perceptions of non-psychiatric, depressed, and paranoid individuals on the Self-Concept Checklist developed in an earlier study (SCC - Kinderman & Bentall, 2000). The checklist comprised both positive and negative self-descriptors, and required participants to complete three sections. They had to indicate which words described them as they

actually are (self-actual), how they would ideally like to be (self-ideal), and how they thought that others (parents) actually saw them (other-actual). This task was completed twice, before and after the administration of a Stroop task which manipulated anxiety/threat. The authors found no significant differences for any of the groups on the self-actual:other-actual or self-actual:self-ideal comparisons prior to the Stroop task. After the Stroop task, self-actual:self-ideal discrepancies for people with depression opened, whereas discrepancies closed for individuals diagnosed as paranoid. That is, for depressed people the gap between how they saw themselves and how they would ideally like to be increased, whereas any discrepancies for people labelled as delusional narrowed. For this latter group they also found that self-actual:other-actual discrepancies widened after priming with threat-related material. This suggests that threat-related material impacts upon the sense of self of a person diagnosed as paranoid by bringing closer together their actual and ideal selves while at the same time widening the gap between their self-perception and their beliefs about how they were seen by others.

Current research suggests that people diagnosed with schizophrenia (with an emphasis on paranoid delusions) have a tendency to jump to conclusions (Dudley et al., 1997; Garety & Freeman, 1999) or require less evidence to accept options (a Liberal Acceptance bias) (Moritz, & Woodward, 2007), attribute the cause of negative events to other people (Bentall et al., 1991; Bentall et al., 1994; Blackwood et al., 2001; Kinderman & Bentall, 1997; Kinderman & Bentall, 2000), and are basically happy with their current view of self (Kinderman et al., 2003). When the self is threatened through priming effects, they tend to believe that others

see them differently than they believe they actually are. This, according to Kinderman et al. (2003) is evidence of a defensive bias related to the self-concept, where the person is fundamentally protecting themselves from feelings of low self-esteem. Freeman, Garety, Kuipers, Fowler, and Bebbington (2002) acknowledged the evidence of an attributional bias toward others, yet they believed that the evidence for notions of self-concept defence was weak. They argued that persecutory delusions directly reflected the person's emotions, and were consistent with their beliefs of self, others, and the world. If this is the case, then these existing ideas, as Kinderman et al. (2003) suggest, are highly sensitive to priming effects.

Together, this research suggests that emotionally distressed people diagnosed with schizophrenia will respond defensively when the self is under threat. They tend to view others as not understanding them and seeing them differently to the way that they believe they are. Also, rather than reflecting decontextualised cognitive processes, these biases may be a reflection of the experiences of people diagnosed with schizophrenia. None of these studies are prospective, leaving open the real possibility that a diagnosis of schizophrenia may itself have a part to play in the development of defensive, self-protective biases.

### **The Family Environment**

Family is an important source of social and economic support for many people diagnosed with schizophrenia (Laing, 1969), and cultural differences in responses of families to people with a diagnosis of schizophrenia exist (Jenkins & Karno, 1992; Lopez et al., 2009). Family relationships are thus likely to be crucial in the negotiation of a sense of self

for a person diagnosed with schizophrenia. Also, in some theories of the aetiology of schizophrenia, family processes are strongly implicated; this can shape part of the social understandings of schizophrenia that form a backdrop to the renegotiation of self, and create issues of blame and responsibility that may need to be managed. In the original work in this area by Laing, the family was defined as "..., networks of people who live together over periods of time, who have ties of marriage and kinship to one another" (Laing, 1969, p.3). Definitions of family today, however, have challenged traditional perspectives and often include extended family members and people who have no legal or biological ties to each other (Weeks & Quinn, 2000). Each member of the family's identity rests on collective notions residing within all members of the family (Laing, 1969). Family in this sense can also transcend space and time through the internalised relations and operations of repeated patterns of behaviour across generations, a kind of environmental heredity. For a person diagnosed with schizophrenia, others' understandings of their lived experience are diminished if the family is not taken into account, and the relational processes forming a current self-identity are lost.

The investigation of families of people diagnosed with schizophrenia allowed Laing and Esterson (1964) to view experiences and behaviours taken to be symptoms of schizophrenia as more socially intelligible than is generally assumed. Familial interaction is often characterised by enduring and intensive face-to-face reciprocal influence on each other's experience and behaviour (Laing & Esterson, 1964). An important component of this intensive influence is emotion, where patterns

of communication between parents and diagnosed offspring have been investigated in relation to affect.

A major area of investigation dealing with emotion and the schizophrenias within the family is the concept of Expressed Emotion (EE), representing overt familial affect (Gottschalk & Keatinge, 1993). Initial measurements of EE were based on the idea that the development of psychopathology or the recurrence of disorder, particularly schizophrenia, was influenced by negative familial communication patterns. The comparison of high and low levels of critical comment, hostility, and over involvement from relatives (usually parents) of the troubled person suggested that high EE levels were a precursor to relapse (Breitborde, Lopez & Nuechterlein, 2009; Butzlaff & Hooley, 1998; Leff, 1992). A meta-analysis of EE research conducted over a period of 15 years by Butzlaff and Hooley (1998) came to two general conclusions. First, the EE construct is a reliable predictor of relapse in a variety of conditions such as mood disorders and eating disorders, as well as the schizophrenias. The second finding suggested that there was a reduction in rates of relapse through family-based treatment. The studies suggest that emotional intensity and expression within families is a major factor in the course of the schizophrenias. Families high in EE represent an environmental stressor (Jenkins & Karno, 1992; Lopez et al., 2009).

Additional concepts such as communication deviance (Miklowitz et al., 1991) and negative affective style (Diamond & Doane, 1994) are investigated in patterns of parental interaction with diagnosed offspring. Communication deviance is a measure said to detect unstructured or fragmented, unfocused or distracted communication patterns (Docherty,

Cutting & Bers, 1998). In these studies, high levels of communication deviance were indicative of people who had difficulty in their interactions with others. That is, they had trouble in establishing and maintaining an attentive focus with others, a characteristic posited to be quite often found in people with diagnoses of schizophrenia. Grant and Beck (2009) proposed that communication deviance/disturbances in people with a diagnosis of schizophrenia emanate from both cognitive impairment and evaluation sensitivity (people who are overly sensitive to rejection) (see also Rosenfarb, Nuechterlein, Goldstein & Subotnik, 2000). Docherty et al.'s (1998) earlier research though, placed communication deviance into context by investigating both parents and the person with a diagnosis of schizophrenia, specifically excluding parents who had a history of mental problems. They matched parents of people diagnosed with schizophrenia with a control group, comparable in age, sex, education levels, socio-economic status, and race. The study found that the speech acts of parents of people diagnosed with schizophrenia contained significantly more unclear references than speech acts of controls' parents. The parents' mean score on this measure was almost identical to the mean score obtained for their diagnosed offspring. Three possibilities arose from these results. Unclear and fragmented speech may be an indication of the stress involved in dealing with an emotionally disturbed child, it may indicate some kind of genetic marker or biological vulnerability, or it may reflect a parental communication style that has an adverse affect upon developing children (Docherty et al., 1998).

The findings from this research suggest that emotional interaction within families is much more complex than any of the individual family

communication constructs imply. There is a need for caution though when pointing the finger of blame at the family, as heightened emotions will occur during times of stress (Leff, 1992; Norman & Malla, 1993). Long-term problematic interactions surrounding the emotional and communicative styles of families direct the ways in which the diagnosed person and their family manage self-identity and relationships.

In sum, there are a range of different approaches to understanding the aetiology of schizophrenia that implicate aspects of the self in different ways. A deficit approach views disorder as occurring within the individual organism as a result of faulty neurocognition. These understandings of the emotions and behaviour of people given a diagnosis of schizophrenia challenge the very identity of the diagnosed person by promoting a view of the person as having a disordered, abnormal, or dysfunctional self. The person is then required to renegotiate their self-identity based on others' attributions of their behaviour, thoughts and emotions, and can only be said to show insight if they agree with the predominant biomedical explanations. Bias models retain these biomedical explanations, but place unusual behaviour within a context, introducing the social world of the person. Disorder is still within the individual, although leaning more toward varying degrees of difference and influenced by the surrounding environment. Here, contention between the diagnosed person and others over self-identity is acknowledged, yet the person is still required to adhere to others' descriptors of them. Familial relationships and the learnt emotional and communicative styles within those relationships directly impact upon the diagnosed person's sense of self. Collective notions of self that form a current identity cannot be separated from the family or others in which they



developed (Laing, 1969). Thus, self-identity is distinctly relational, and directly associated with the social world and the labels that are placed upon us.

## **Stigma and Discrimination**

Labels placed upon a person can impact not only upon the way that others view the person, but upon the way that the person views themselves. Negative attitudes surrounding people diagnosed as mentally ill can result in stigma and discrimination, thus influencing mental health and well being. Stigma socially discredits the person and their identity (Goffman, 1959, 1963, 1974). Through social interaction, society's normative expectations produce negative attitudes and beliefs about attributes that are considered deviant. This results in a devaluing of the person said to hold those attributes; the person's social identity is spoiled (Goffman, 1963). Experiences of social rejection, discrimination, and social isolation may accumulate over time and damage the person's sense of self. Although this is not inevitable, stigma presents another challenge to a person diagnosed with schizophrenia in the development of a coherent and positive identity for themselves.

Stigma and discrimination have been strongly linked to the label of 'mentally ill' in western cultures (Corrigan, 2007; Link, Cullen, Struening, Shroud & Dohrenwend, 1989; Link, Struening, Rahav, Phelan & Nuttbrock, 1997; Martin, Pescosolido & Tuch, 2000; Read & Law, 1999; Rusch, Angermeyer & Corrigan, 2005). This is particularly true of labels for severe emotional problems such as schizophrenia (Lefley, 1989; Penn et al., 1999). Scheff's seminal work on the labelling theory of mental disorder (1966)

explains that all members of a society, people who may become psychiatric patients and people who may not, will form ideas about what it means to be mentally ill. Representations of the mentally ill derived from the media, from personal experience, and from the reported experiences of others, are organised around the ascribed psychiatric label. The social stereotypes arising are often negative and derogatory, and create expectations of and attributions for behaviour. Social categorisation and social groups play an important part in a person's sense of who they are and how they are directed by others; their self-identity (Tajfel & Turner, 1979; Turner, 1982). Moscovici (1981, 1984) explains that stereotypes are more than individual or group processes though; they are social representations, a 'community of meanings' about social groups that emerge during particular social, political, and/or historical contexts (Augostinos & Walker, 1998). The application (or not) of stereotypes to the person by others and by the person themselves (Rosenfield, 1997) sets the tone for many of the social experiences of people with schizophrenia.

This stigma attached to mental illness can affect people both psychologically and socially (Link et al., 1997). The person may become depressed, feeling unwanted and lonely, and may be rejected (or anticipate rejection) by friends and family members, employers and neighbours. The most common reactions of people with schizophrenia to stigma tend to be isolation and avoidance (Gonzalez-Torrez, Oraa, Aristegui, Fernandez-Rivas & Guimon, 2007). Negative attitudes and opinions of mental health professionals can also produce unhelpful identities and views of the self (Murray & Steffen, 1999). Rao et al. (2009) assessed the attitudes of health professionals from acute and general mental health settings towards forensic

hospital patients, people with schizophrenia, and people with substance use disorders. They found that there appeared to be greater stigmatisation by health professionals towards enduring illnesses such as schizophrenia as compared to brief psychotic episodes, or people with substance use disorders who were in remission. This suggests that from a professional perspective, schizophrenia is not viewed as an illness that people recover from.

As a result of the stigmatising stereotypes of schizophrenia, expectations of rejection and a lack of perceived control over their lives are two main sources of negative self-beliefs (Scheff, 1966; Vauth et al., 2007; Watson, Corrigan, Larson & Sells, 2007) among people with schizophrenia. Due to societal stigma, the person's experience of devaluation and discrimination often attached to their psychiatric label hinders their social interaction (Link et al., 1989). Many people then keep knowledge of their diagnosis to themselves, attempt to educate others in regard to mental health concerns, or withdraw from others that they might usually interact with. These kinds of behaviours alleviate much of the possible rejection that they believe they may encounter. This is supported by Vauth, Kleim, Wirtz, and Corrigan (2007) who found that people with schizophrenia who displayed an avoidant coping style tended to anticipate stigma at higher levels, thus leading to the erosion of personal empowerment and self-efficacy. It is useful to keep in mind that unless withdrawal from others is total, people will still have some social interaction with others. Leading on from avoidant coping styles, this interaction is likely to be affected by the person with schizophrenia's expectations of rejection and discrimination, potentially taking on a form similar to a self-fulfilling prophecy.

Public education developed to reduce the stigma surrounding mental illness is often aimed at convincing the general public that psychological problems are similar to physical problems (Read & Law, 1999). Public education is typically based on biomedical and genetic explanations of severe emotional distress (Read, Haslam, Sayce & Davies, 2006), where the core assumption to address stigma and discrimination is for people to be taught that emotional problems are ‘diseases’, illnesses, and/or disorders. Although this can appear to direct fault or blame away from the person, it can also create a belief that the person with the diagnosis has no control over their problems, that they must be controlled by others (mental health professionals) as their behaviour is unpredictable and possibly dangerous. In addition, this absence of control approach tends to absolve a diagnosed person of any responsibility for their behaviour. Earlier research conducted by Birchwood, Mason, Macmillan and Healy (1993) found that people who were accepting of the diagnosis given to them by their doctor reported lower perceived control over their emotional problems. For people who had experienced psychoses, they found links between low perceived control and depression, and negative cultural stereotypes of mental illness and depression. They concluded that by taking control away from the person and viewing them negatively, the person becomes depressed (often regarded as a secondary symptom with many psychological disorders (APA, 2000)).

Mechanic (1996) investigated the attitudes of mental health professionals towards people with mental illness. He found that mental health professionals generally expected and preferred consumers of mental health services to take on dependency roles and conform to dictated treatment regimes. In addition, most staff preferred to work with people

who had less severe emotional problems who they believed were more likely to improve over time. The attitudes and behaviour towards clients also seemed to vary with the theoretical perspective taken by the professional; biologically oriented professionals tended to be less likely to involve consumers of mental health services in the planning and management of those services as compared to professionals with a psychosocial orientation (Kent & Read, 1998).

Stereotypical beliefs concerning emotional control issues are also central to widespread misconceptions and community fear, in which people with mental health concerns are assumed to be violent (Bentall, 2009; Langan, 2010; Mouzos, 2000). In Australia between 1989 and 1998, only 4.4 per cent of homicide offenders had been diagnosed with a mental illness (Mouzos, 1999). Mouzos found that people with mental health concerns were no more likely to perpetrate violent criminal behaviour than non-diagnosed citizens. Perceptions of the dangerousness of people with a diagnosis of schizophrenia (and mental illness in general) tend to diminish the more a person has had contact with mental health consumers, and the more a person has information regarding contextual factors surrounding the person's behaviour (Penn et al., 1999). Yet, public fear of violence tends to evoke a desire for limited contact with people experiencing emotional distress (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999).

Finally, in a longitudinal study on men with mental illness and substance abuse problems, Link et al. (1997) found that, despite an improvement in their mental health, the effects of stigma remained with the men. That is, perceived devaluation and discrimination, and reported

discriminatory experiences continued to affect the men in a negative fashion, even though their symptoms had generally improved.

The pervasive effects of stigma toward people with mental health concerns can be extremely detrimental to a person's sense of self. Unhelpful views of the self can result in social isolation, a perceived loss of control, and depression. Sceptical views from others toward the person can evoke fear and discrimination, resulting in others taking control of the person and not allowing self determination. Very little research has been conducted on the stigma generated towards people with a diagnosis of schizophrenia within the family, and Moses (2010) suggests that this may be due to difficulties in separating stigma from other negative family interactions such as hostility and rejection. In his qualitative study of stigma experienced by adolescents with mental health disorders, Moses found that almost half of the 56 adolescents reported stigma from immediate or extended family members, where teasing, low expectations, avoidance, distrust, unfair blame and exclusion were commonplace. Other authors have found that stigma from family members can also appear as exaggerated worry, belittlement, and paternalism, working to undermine the diagnosed person's sense of accomplishment and maturity (Gonzalez-Torres et al, 2007). However, contact with people who have emotional problems and knowledge of contextual factors surrounding behaviour may help to alleviate fear and misconception (Penn et al., 1999). Therefore, some family members may be more understanding of their son, daughter or sibling diagnosed with schizophrenia as they tend to have better knowledge of the person's life experiences. The emotional distress of the diagnosed family member may evoke a multitude of reactions, emotions, and

behaviours from other family members, and this may impact heavily upon the diagnosed person's sense of self and their relationships with those family members.

Social understandings of schizophrenia form the context within which a person diagnosed with schizophrenia engages in renegotiating a sense of self that incorporates this diagnosis. The findings of scientific studies and the opinions of experts are highly influential in creating shared social beliefs: what schizophrenia is, how it occurs, how it can be treated/managed, and what can be expected of a person diagnosed with schizophrenia. As a sense of self cannot be developed or sustained in a social vacuum, the particular nature of the social understandings of schizophrenia are crucial, as they are likely to form the basis of the expectations that others have about the person diagnosed with schizophrenia and thus, the nature of many of the social experiences within which a sense of self is negotiated and sustained.

In the next section, I consider in detail an approach known as 'Open Dialogue' that has been developed in response to concerns that responses of mental health professionals to people presenting with severe emotional distress can often accentuate such distress. The theoretical approach of Open Dialogue is evidence that taking the self in relationship seriously can have a profound impact on the success of therapy. This indicates that the self in relationship is often a problem for people with a diagnosis of schizophrenia, and is worth exploring more deeply in non-acute settings.

## **PART 2: A Transformative Approach**

*“... the person who has schizophrenia feels that his or her self, his or her sense of identity, is fundamentally and significantly lessened relative to how he or she had experienced himself or herself in the past”.*

*(Lysaker & Hermans, 2007,p.130)*

Social constructionism proposes that knowledge is constructed by, for, and between constituents of a discursively mediated society (Hruby, 2001). That is, the knowledge held about the self and world is based upon the language used to give meaning to objects and events in the world. These meanings are agreed upon by members of a given community as reality, fact, or common sense. Knowledge, here, refers to the certainty that the phenomena we know of contain particular characteristics that are real (Berger & Luckmann, 1966). Reality, then, relates to qualities of this phenomena that are "... independent of our own volition (we cannot 'wish them away')..." (Berger & Luckmann, 1966, p,13). For knowledge and reality to have meaning for a person or for a given society, it must embody the representations, goals and intentions, interpretations, and significations of common or shared responses to given phenomena (Maines, 2000). Although it cannot be willed away, these phenomena are not independent of the person (Botella, 2000). The knowledge that is held and the meaning that is given to that knowledge is produced through the contrast between experiences and constructions of reality. These experiences and constructions are conveyed primarily through language (Hruby, 2001).



Consensus in meaning, though, is difficult when a person is severely emotionally distressed. As noted earlier, this thesis does not aim to challenge the lived experience of emotional distress, but rather, to explore the complexities of understandings and constructions of that distress. Scher (1994) suggests that a person diagnosed with schizophrenia does not act and interact, perceive or conceive as others in their society expect. Language deficits are commonly noted in popular literature surrounding schizophrenia (Condray, Steinhauer, van Kammen, & Kasparek, 2002; DeLisi, 2001; Melinder & Barch, 2003), with widespread deficits suggested in cerebral lateralisation, attention, comprehension, and production of language (DeLisi, 2001). Traditional perspectives build upon beliefs that the utterances of people diagnosed with schizophrenia are highly individualised, pathological, arise from thought disturbances, and are incomprehensible and senseless (Wrobel, 1989). Investigators aim to describe and classify such language, with the idea of error prominent.

Wrobel (1989) emphasises that people diagnosed with schizophrenia are indeed in distress, but cites Anna Gruszecka's 1923 and 1924 work in that fault lies not with the person, but with others' inability to understand them. Gruszecka proposed that, in times of severe emotional distress, sensory-pictorial thinking replaces symbolic thinking. This primitive form of thought reflects the distressed person's inability to find words to describe how they are feeling, resulting in a mixing of concepts or what is sometimes described as metaphorical speech. Wrobel puts forward that people with schizophrenia are not confined by discursive conventions and perceive the world differently to the average person (1989). Common language is inadequate in describing this different perspective. Atypical notions of time

and space and dialectical peculiarities result in differential story construction (Wroble, 1989). How then, can the doors of communication be opened to people speaking, experiencing, and feeling a different ‘reality’?

## **Open Dialogue**

Open Dialogue is a language-based, social-network approach to psychiatric care (Seikkula, 2008; Seikkula, Aaltonen & Alakare, 2000; Seikkula et. al., 2006; Seikkula, Arnkil, & Eriksson, 2003; Seikkula & Olson, 2003 – also see Alanen, 1997 for psychotherapeutic treatment). Initiated in Finland in 1988 for acute psychosis, the approach espouses an established set of practices which utilise social construction theories to generate dialogue within families. This enables the construction of words for a person’s experiences when psychotic symptoms exist. Three main principles underlie the approach – tolerance of uncertainty, dialogism, and polyphony – and all three largely overlap.

Tolerance of uncertainty deals with building relationships where all parties can feel secure (Seikkula, 2008; Seikkula et al., 2003; Seikkula et. al., 2006; Seikkula & Olson, 2003). Based on Batesonian (1962) tradition, Seikkula et al. (1995) focused on the larger systems of relating that generate the paradox of double bind communication. Rather than focusing on the speaker and receiver of contradictory information, Bateson (1992) broadened the scope by examining people caught in an ongoing system of conflicting definitions of relationship, and the resulting subjective distress.

Calling upon Bakhtin’s (1984) notions of dialogism, Seikkula et al., (1995) attempt to reduce isolation by encouraging communication between the person in distress, the person's significant others (their social network),

and the treating team (Seikkula et al., 2000; Seikkula et al., 2003; Seikkula & Olson, 2003). This discourse brings together a multiplicity of voices into one unified framework, building a communicative relationship between the distressed person and the people involved with them.

These ideas extend to the third principle of polyphony, which encourages a multitude of people to interact with and give voice and understanding to the person's distress during a psychiatric crisis (Seikkula, 2008; Seikkula et al., 2000; Seikkula et al., 2003; Seikkula & Olson, 2003). The crisis that the person finds themselves in then becomes opportunistic; they are able to form and reform identities, relationships, and stories, or new constructs of self and the world (Gergen, 1999; Seikkula et al., 2003).

The key to the Open Dialogue approach is to capture a person's interest long enough (tolerance of uncertainty) for them to be able to express what they feel and are experiencing (dialogism) through the assistance of significant others within their network (polyphony) (Seikkula et al., 2003). Outcomes regarding this method of treatment have been very promising. Participants in Open Dialogue were compared with people receiving traditional treatment (medication and hospitalisation) from four different research centres in Finland. The authors found that Open Dialogue participants required less hospitalisation and less neuroleptic medication (35%) as compared to traditionally treated patients (100%). After a two-year follow up 82% of Open Dialogue patients displayed no or mild psychotic symptoms as compared with 50% of traditionally treated patients, there were fewer people living on a disability allowance (23% of Open Dialogue patients as compared to 57% of traditionally treated patients), and

relapse rates were much lower (24% of Open Dialogue patients as compared to 71% of traditionally treated patients).

The suggestion here is that people experiencing severe emotional distress or people in the midst of a psychotic episode utilise a language and form of thought that is different to others within the same social network. As the Open Dialogue approach has shown, in a safe and accepting environment, it is possible to find a common language to bridge this gap. Self-identity and life experiences can be made and remade through dialogue by constructing shared narratives in order to aid the recovery process.

### **Self Narratives**

Narrative theories provide the tools, concepts and methodologies for discerning meaning in people's lives (McAdams, 2006). McAdams (1985, 2006) theorises that stories of self come from within the individual, where a person construes their life as 'evolving stories', reconstructing the past and their imagined future to provide their lives with purpose and unity. Gergen (1994, 1997, 2008, 2009) takes a slightly different approach, suggesting that the self in narrative form is a collection of stories, each embedded within the other, and always in the context of relationship. From infancy and through relationships with significant others, narrative skills are acquired enabling the telling of stories. Through convention, all stories have a predetermined structure; the beginning, middle, and an end. In addition, there must be a point to the story, stability of characters over time must be ensured (Gergen, 1994; Ricoeur, 1984), and there must be an explanation for what occurs within the story. Narratives are formulated, systematically relating events in a sequential manner, to render the self intelligible.

Stories of self follow three basic narrative forms: the stability narrative, the progressive narrative, and the regressive narrative (Gergen, 1994). The stability narrative sees events as essentially unchanged, where goals or outcomes remain stable over time. An example of this would be the statement 'I'm still having problems with my memory', indicating that the person's memory is no better or worse than it was before. The progressive narrative links events together, showing improvement over time. A person might say 'I'm getting better at remembering information'. The regressive narrative is the opposite, showing a decline over time, such as 'I just can't seem to remember much anymore'. A more complex self-narrative may have many high points, low points, and plateau, and the account's purpose determines the telling.

When people with a diagnosis of schizophrenia convey stories of emotionally laden events to others, the meaning and clarity of those narratives are clouded as compared with stories told by people without a diagnosis of schizophrenia (Gruber & Kring, 2008). This may be due to an observed disruption in the temporal coherence of their narratives, often viewed as a marker of pathology (Lysaker, Wickett, Campbell & Buck, 2003). However, the content was generally similar to undiagnosed people in that emotional life events told by people with schizophrenia were personable, socially embedded, and emotionally-laden (Gruber & Kring, 2008). Difficulties with linearity were also found by Gruber and Kring (2008), who found that schizophrenia patients had difficulties in recounting their life stories in a way that determined a clear sequence of events. This includes details of what occurred before and after that particular event.

The self, though, is a multiplicity of narratives nested within each other (Gergen, 1994, 1997, 2008, 2009). That is, stories of self may cover vast periods of time (the macronarrative) or, alternatively, a person may talk of what they did last night (the micronarrative). Both the varied relationships in which the person finds themselves and the differing contextual demands encountered favour multiplicity. For example, a person may be described as a sibling, a parent, and a friend. To be successful in the telling, the self needs to be established as an enduring, coherent, and integrated identity. Lysaker and Hermans (2007) propose that people with a diagnosis of schizophrenia experience a ‘lessened’ sense of self (or self-identity) as compared to their experience of their sense of self in the past. The authors argue that dialogue with others, notably a therapist, leads to a ‘regrowth’ of self, or a richer sense of self.

The self, in this sense, needs the validating support of others, and this support comes not only from shared meanings within a culture, but from others’ acceptance of their narratives, and from the ways in which a person is told stories of themselves as a character in other people’s narratives (Gergen, 1994). Others must agree with the person’s stories about themselves. In addition, others must also agree with their place in these stories, and in doing so, the other person’s identity is affirmed. Therefore, agreement is determined through others’ willingness to perform certain roles and histories in relationship to the person. A degeneration of identity results when others do not support either the role the person has proposed for them or the person’s own role in the narratives. In this important sense, then, identity is not possessed by an individual; it does not come from within the individual, but is situated within relationships

(Gergen, 1991, 1994, 1997, 2008, 2009). Continuous participation in the relational process not only provides people with the potential for a multiplicity of selves, but supports certain kinds of selves which are dependent upon the very relationships we engage in.

## **Conclusion**

Research on self-identity associated with a diagnosis of schizophrenia often describes the person's sense of self as 'lost' through the experience of severe emotional distress (Bleuler, 1950; Hemsley, 1998; Mahler, 1952, 1968). That is, through a focus on the content of extreme beliefs and behaviours, theorists propose that the person loses the idea of who they are.

This thesis argues that the self or self-identity is not grounded within the individual, but continually renegotiated in relationship with others. The person's knowledge of themselves and the meaning it holds for them emerges through social interaction (Baumeister, 1998; Gergen, 1994; Goffman, 1959, 1974; Hormuth, 1990). Social interaction and communication, therefore, influences not only the person's view of themselves, but others' views of that person (Meade, 1934). When a person is diagnosed with schizophrenia, a challenge to self-identity occurs through the expert-endorsed views of the deficits and the incapacities associated with schizophrenia, as well as the stigma of negative characteristics associated with that label/diagnosis (see Gonzalez-Torrez, 2007; Link et al., 1997; Martin et al., 2000). Representations of what it means to be mentally ill (Scheff, 1966), social stereotypes and social categorisations (Tajfel & Turner, 1979; Turner, 1982), and particular social,

political, and/or historical contexts (Moscovici, 1981, 1984) create expectations of and alternate views of the diagnosed person's behaviour. Once diagnosed, a renegotiation process ensues, where the person tries to rework a self-identity that is not harmful or derogatory to themselves.

The self is made, agreed upon, and remade through a collection of stories, and always within the context of relationships (Gergen, 1994). Giving voice to people with a diagnosis of schizophrenia allows for the person's perspective to be heard and, through collaboration with others, meaning and clarity can be achieved to assist with understanding. Yet, language for a person in extreme emotional distress can be difficult – "...unbearable experience has no words" (Seikkula et al., 2003, p.409). Restoring or assisting with communication between the person experiencing emotional distress and others is fundamental to providing a more helpful version of self. The lived experience of emotional distress and the resulting diagnosis underlies the complexity and interdependence of negotiating and renegotiating self-identity.



## CHAPTER 2 – The Present Study

A sense of self can be determined through relationships with others (Gergen, 1994; Hormuth, 1990), particularly as people influence each other's behaviours and experiences (Laing & Esterson, 1964). Stable patterns of interaction with others (see Docherty, 1995), and the emotional climate such as feelings of hostility, criticality, and over involvement with these people (see Butzlaff & Hooley, 1998) may influence not only how a person sees the self, but also how they believe that other people would see them.

For the schizophrenias, although symptomology is the focus of treatment, psychosocial issues affect quality of life to a much greater extent than symptomology (Ritsner, et al., 2000), particularly as events occurring after the person has been diagnosed, even within the mental health system, can have a large impact on a person's feelings of competency (Williams & Collins, 2002, p.305). For a person diagnosed with schizophrenia, feelings of incompetency and the shaping of a sense of self emerge through contact with friends and family members, professionals, other consumers of mental health services and society in general. In effect, others' views of the person will influence the subsequent behaviours and experiences of that person (Laing & Esterson, 1964). Negative responses to the person by others may diminish, erode, alienate, or alter the person's social identity and sense of self (Estroff, 1989; Williams & Collins, 2002). Yet, people are not passive recipients of suggestions from others. Resistance to others' descriptors of one's self may reveal a desire for independence, and the rejection of stigma, stereotypes and negative perceptions of self.

The present study was a response to the pervasive notion that schizophrenia involves, in some form or other, a loss of self (see Bleuler, 1950; Mahler, 1952, 1968). The prevailing clinical view of people diagnosed with schizophrenia centres upon expert interpretations of behaviour with a focus on symptoms rather than the way in which behaviour and symptoms are incorporated into a person's understanding of themselves (Roe & Davidson, 2005). To address this, in this study, mental health consumers given a diagnosis of schizophrenia were asked about themselves; about their views of their personal qualities, their relationships with others, the way that they believed they were perceived by others, and about the way in which their diagnosis has impacted on them. This would enable people with a diagnosis of schizophrenia to provide their own accounts of themselves and the way in which they saw themselves reflected in others' eyes. To explore the different accounts of self (see Gergen, 1994), and to enhance understanding of the person (see Seikkula et al., 2003), staff members at the service centre were also asked to give accounts of how they viewed each of the people with the diagnosis of schizophrenia with whom they worked.

Discourse and conversation analyses were drawn upon to examine these accounts, using the person's own language and incorporating others' perspectives. Emphasis was placed upon the content of participants' talk, and the way in which accounts were oriented towards the particular interactional requirements surrounding this production. This allowed for an understanding of the lived experience of people with a diagnosis of schizophrenia, giving voice to people often unheard in the mental health literature (Estroff, 1989).

## **The Study**

In Australia, the Federal Government subsidises mental health-related services for the general population such as hospitalisation and residential care, outpatient and community care services, specialist and general practitioner consultations, and many prescription medications. State and territory governments also fund and deliver services, assisting with broader needs such as accommodation support and community based mental health support services.

For this study, I took an ethnomethodological perspective, approaching a local mental health service centre that focused upon enhancing the living skills of people with mental health diagnoses. I spoke to them about my research, and we agreed that I would start with voluntary work for a couple of hours, once a week, in order to become familiar with the centre and with the people who used it. This would give consumers the chance to get to know me, and perhaps engender trust so that they might speak to me about their self and lives. The volunteer work enabled me to talk to consumers about their everyday lives in a casual setting. Through this, I had hoped to allow for familiarity during the interview process, in turn increasing the chance of openness in our discussions.

After approximately one year, the manager of the mental health service was approached formally using the Manager Approach Protocol (see Appendices A & B). A meeting was arranged with the manager to once again outline the study, and ask permission to involve both consumers who had been given a diagnosis of any of the schizophrenias (primary participants) and staff members from the centre in my research. The manager was asked to approach people on my behalf, as it was not

necessary for me to know specific personal details such as psychiatric history and exact medication dosage. General Handouts (see Appendix C) were given to all participants through the manager, with the manager explaining the study to them and asking for volunteers. All prospective participants were advised that they were free to change their mind at any time, and that their treatment at the centre would not be affected due to refusal or dropping out of the study. Only information given by participants during the formal interviews is analysed in the study.

So as not to interrupt the daily routine of the service, the manager organised the times and days for the recorded semi-structured interviews to take place. This ensured that an office on the service provider's premises would be available allowing for privacy and for participants to feel at ease in a known environment. As one primary participant was not able to make her appointment with me at the service centre, her interview took place in a car outside of the main mental health services centre. In all, the recorded conversations took place over a three month period.

Thirteen people, seven men and six women, volunteered to participate in this study. Five men and four women aged between 28yrs and 57yrs had a primary diagnosis of one of the schizophrenias for at least two years. Primary participants (mental health consumers given a diagnosis of schizophrenia) were all of Anglo-Australian ethnicity, and were currently living in the community with the support of local mental health services. All were able to give informed consent as no person was currently receiving heavy doses of medication that may have greatly interfered with their cognitive abilities. In addition, no primary participant had been hospitalised in the two months prior to the interviews.

Two male and two female support workers also participated in this study. One male and one female were in the 18yrs to 37yrs age bracket, and both of these people had university degrees. The second male and female were in the 48yrs and over age range and neither had university qualifications.

All participants signed a consent form (see Appendix D) with a general information letter about the study attached. People retained a copy of this form and handout so that they had a written record of what they had signed. Consent included the understanding of ensured confidentiality and the recording of the conversation. A mini-disc recorder and a separate self-standing microphone were used to record all conversations.

Participants completed a brief demographic form (see Appendix E), which asked basic questions such as age, gender, ethnicity, marital status and whether the person had any children. A question regarding the person's general health was included, as this may have affected their responses on the day.

Primary participants indicated the types of services from which they currently received assistance, such as recreation or employment services. This gave an indication as to the amount of assistance the person obtained. Questions regarding present living arrangements and employment status were indicative of the person's independence. Another area of importance was comorbid diagnoses, as this gave a clearer picture of the problems that the person faced.

Support workers indicated the type of service they were working for, whether they were employed on a full-time basis, and the number of years they had been working in the mental health area. This gave an idea as to the

practical experience the person had in the field, whereas education level was indicative of exposure to dominant theories surrounding mental health.

### **Interview Focus**

Initial questions for interviews were drawn up with the purpose of gathering information on how people constructed accounts of themselves, the emotional problems that they had, and their relationships with others. Four people who were not associated with this study and currently working in the fields of mental health and disability appraised the questions for ease of understanding, logical flow, and relevance to the area of investigation. The final groups of questions for all participants incorporated feedback from this review (see Appendix F). Open-ended questions and lay language were used in an attempt to prevent the leading of participants toward the current, dominant theories of mental health, and to allow for their own understandings and discourses to emerge. For example, in my dialogue, the word ‘problems’ replaced the terms ‘mental illness’ and ‘schizophrenia’. People were free to determine the meaning of the word problems for themselves (e.g. physical, psychological).

All participants were asked the same sorts of question to minimise any possible discrepancies with the topics covered. Questions were divided into the three major categories of accounts of self, accounts of other's beliefs about the person, and accounts of others. Each of the three sections dealt with self-descriptors, well-being, and personal experiences, and were structured to incorporate past, present, and future versions of self.

In the first section, primary participants were asked about the language used to describe people with mental health concerns and which

terms they preferred. This question primarily dealt with categorisation and the attachment of labels to self and/or others. For example, currently, the word consumer is used to describe people with mental health problems. Next, primary participants were asked to describe themselves as a person. This terminology was broad enough to allow for many different types of self descriptors, such as trait theory characteristics (Costa & McRae, 1985), social roles (Goffman, 1959), and/or self narratives (Gergen, 1991).

Primary participants relayed any change in themselves that may have occurred over time (see Hormuth, 1990). That is, they were asked to give an account of themselves before their problems began. This question allowed for the possibility for a person to talk about the extent to which they had experienced changes in themselves and the nature of any such changes. Questions on well-being for primary participants continued to investigate accounts of self over time, asking the person how they felt about their life before their problems began. All primary participants then gave accounts of future selves. How a person sees themselves today may influence their accounts as expectancies about oneself may have bearing on the retention of self-related information (Wegner & Vallacher, 1980). That is, if a person believes that their mental health will not improve, this may influence how they see themselves in the past, at present and in the future. This section concluded with a question on personal experiences. For primary participants, talk then moved on to behaviours and activities that they do now as compared to before their problems began. This question was designed to allow for talk about any change in themselves due to factors such as altered personal circumstances, symptomology, and an increase in knowledge gained through general life experiences.

The next section, for primary participants, dealt with accounts of how the person thought that others saw them, focusing on friends, family, and support staff. They were also asked if their friends and family members saw them differently now as compared to before their problems began. It is possible that people who saw no change in themselves would nonetheless believe that others saw them differently after their diagnosis. Primary participants then gave accounts of any major experiences they have had since their problems began. The structure of this question allowed primary participants to speak about either negative or positive events, and did not confine these events to a particular setting or situation.

The third section of questions dealt with accounts of how people saw others in their immediate environment. Questions for primary participants focused on how they saw close friends, family members, and support staff (with the distinction between professional and non-professional staff being made here). Primary participants also responded to how others might influence the way that they saw themselves. This question raised issues of awareness of others' behaviour and opinions of them, and how this may affect the person's sense of self, along with the amount of control and self-determination a person thought that they had over their own beliefs, opinions, and perhaps behaviours. This reciprocal process was also touched on in the next question, which asked about any changes in the behaviour of significant others since the person's problems began. Questions on well-being covered accounts of how the person felt about their friends, family members, and the support staff assisting them, attempting to associate behaviours with emotions and feelings about others. An additional question concerning any possible changes in behaviour of others toward the person



since their problems began narrowed the earlier question of change in others by associating this change with the primary participant.

Questions for staff members followed a similar course to those for primary participants. In the first section of the questionnaire, staff members were asked which term they preferred to use when talking about primary participants. They were then asked to describe themselves, and whether they would see themselves differently had they chosen another occupation. They were asked how they felt about themselves on that day of the interview and how they felt about their future. For the 'experiences' section, staff members were asked to recount things that they currently do that they did not do before they started working in the area of mental health.

Like primary participants, staff members were also asked to give an account of how others (fellow staff members) saw them. In addition to this, a question on personal experiences invited information about major incidents that had occurred since they started working in the mental health field. This too allowed for versions of both positive and negative experiences to be given.

The third section for support staff assessed versions of how each of the staff participants saw each of the primary participants. Once the staff member had spoken in detail about one primary participant, conversation proceeded to the next primary participant. First, the staff member related their description of the primary participant as a person. This gave an idea of the language and orientation of staff members in their descriptors of people with mental health issues. Next, the staff participant conveyed how they thought that the person would describe themselves. Staff members were also asked about each primary participant's friends and family members,

along with how they believed that other staff members saw the person, giving accounts of another perspective of the immediate others in the person's life. To examine how mental health workers perceive their clients as understanding themselves, staff members described how they believed each primary participant saw his or her own life. Finally, experiences such as the behaviour of the primary participant toward friends and family members and the staff member in question gave an indication of the closeness of these emotional relationships from the staff member's perspective. All interviews concluded by inquiring how participants felt about the questions posed. This gave people the opportunity to voice their opinions and comfort levels during the interview process, and to comment on the goals and methods of the study itself.

### **Interview Procedure**

Before any recording took place, participants responded to a request for their consent, and a specific protocol followed (see Appendix G). This incorporated an outline of the study, explaining the kinds of issues to be discussed. Participants were assured that if a topic came up that they did not want to discuss, this would be respected and no pressure would be exerted. In addition, primary participants gave their permission for their friends and family members to be involved in the study. Each person was given a number of general handouts to give to those people that they felt comfortable for me to talk to. That is, I did not directly approach friends and family members of participants. Unfortunately, no friends or family members were willing to participate in this study. Next, demographic and consent forms were completed by participants, and a brief explanation of

recording equipment was given with all people being advised that the mini-disc recorder would make a slight whirring noise confirming that it was working.

The interviews were semi-structured, allowing participants to explain, in their own way, their responses to my questions. This meant that, at times, the conversations went off track and concentrated on areas that participants wanted to talk about. This also meant that not all questions were asked of all participants. Once the conversations had concluded, I thanked people for their time. All participants were advised that, if they liked, they would be provided with an information sheet of general findings at the end of the study.

I transcribed all interviews using an adaptation of Jeffersonian format (Antaki, Billig, Edwards & Potter, 2002, p.16; Jefferson, 1985; Potter, 1996, p.233-234) (see Appendix H), yielding 240 pages of dialogue. This allowed for both discourse and conversational analytic procedures as it included the notation of such things as pauses and vocal intonations. Through the utilisation of a discursive approach, this study hoped to allow for the diagnosed person to give their point of view of themselves and their experiences, a perspective rarely heard in mental health (Goodwin & Happell, 2006; Human Rights & Equal Opportunity Commission, 1993).

### **Analytical Orientation**

In keeping with constructionist perspectives of many different selves (Gergen, 2008, 2009; Harre, 1993), this study aims to explore the discursive construction of self by people diagnosed with schizophrenia and the mental health staff who provide them with support services. It aims to fill a

knowledge gap in the literature on schizophrenia by listening to representations and stories of self told by people with a diagnosis of schizophrenia. "We lack rigorous inquiries into how individuals with schizophrenia represent themselves in ...text and speech..." (Estroff, 1989, p.194). Drawing upon discourse and conversation analysis, this study investigates the accounts given of a number of people diagnosed with schizophrenia by both themselves and by others.

To investigate these accounts, a discursive approach will be taken. Discourse though, is not a neutral, objective phenomena utilised for the sole aim of communication (Edwards & Potter, 1992; Potter, 1996; Potter & Wetherell, 1987). Nor is it merely a tool that is descriptive in nature. Discourse is situated and occasioned, action-oriented, and both constructed and constructive (Edwards & Potter, 2001). That is, talk occurs within a sequence of interaction, it invokes or orients to particular perspectives or versions of self and world, and is designed to counter alternative perspectives or versions whilst maintaining its own integrity (see Billig, 1987). Talk, then, is action-oriented in that it is designed to 'do' something (Edwards & Potter, 2001). It is constructed in the sense that people choose their discourse, they choose which words to use on which occasions. Discourse is also constructive as it acts to convey a particular version or impression; it performs a particular activity, such as a justification, a blaming, or a complaining. Most importantly for the purpose of this study, discourse is also the primary medium through which people attempt to construct and convey their self.

The focus of discourse analysis then is upon the social practice of talking and writing, examining the many different devices and resources

that enable those practices (Edwards & Potter, 2001; Fairclough, 2001; Pomerantz, 1984; Potter, 1996; Potter & Wetherell, 1987; Wooffitt, 1992). Emergent themes and discourses can be further analysed through the process of talk-in-interaction (Antaki, 1994; Drew & Heritage, 1992; Mazeland & ten Have, 1996; Sacks, 1992; Schegloff & Sacks, 1973; ten Have, 1990, 1999). That is, features of conversation such as sighs, vocal intonations and pauses are social actions managed for a specific purpose – they give a particular impression, and convey meaning or the intention of the speaker – and they can be investigated further for the interactional work that they perform. In essence, both of these approaches argue that analytical claims can only find solid ground within discourse (Verkuyten, 2001).

An eclectic approach is taken with this study, drawing firstly upon a thematic analysis. The primary purpose here is to identify patterns emerging from accounts of the lives of people with a diagnosis of schizophrenia. This works to empower consumers of mental health services, as authority over their own life experience is often diminished due to problems of credibility. For example, the phrase ‘lack of insight’ is regularly used in mental health for ‘problematic’ versions of events produced by consumers (see Baier & Murray, 1999). Wrobel (1989) goes further to theorise a separate language for people diagnosed with schizophrenia. This language is often rendered senseless and incomprehensible, pathological, and is said to result in differential story construction.

The study also takes a rhetorical approach to identify devices used to manage accounts. Edwards suggests that the “...experiential grounding of descriptors serves as a warrant, or alternatively as a basis for refutation, and

establishes the speaker's credibility and accountability for a report, while also opening up possibilities for counter claims" (1991, p.525). In this sense then, the experiential grounding of a descriptor is rhetorically organised. Edwards furthers that this is particularly evident when a person's credibility is at issue, such as giving an account of a disputed or unusual event.

A common device drawn upon when 'doing' a description is that of Membership Categorisation (Sacks, 1992), a process of classifying people into groups or categories. In everyday conversation people construct and use these markers as a form of expression to denote who they and others are, but they are also used to accomplish social and interpersonal goals. For a person to have an identity they must be given (or give themselves) certain features or characteristics that are aligned to the category in question (Category-Bound Activities). These activities give the impression of commonality, typical things that one could expect from a person belonging to such a category (e.g. behaviours, beliefs, and feelings). Thus, categorisation can prompt, allow, or alternatively, discourage what comes next in conversation, highlighting the consequentiality of this device.

Many techniques can be employed to strengthen knowledge claims. One example is that of a show concession. Antaki and Wetherell (1999) explain that the three-part structure of a show concession – proposition, concession and reassertion – works to strengthen the speaker's initial assertion. To begin, a proposition is made that is open to challenge. Acknowledgement of challenge comes through a concession made by the speaker, which is then followed by a reprise where a version of the original proposition is restated. This management of counter-argument moves to

fortify the initial claim. A second device working to promote the legitimacy of a claim is known as active voicing (Wooffitt, 1992; Hutchby & Wooffitt, 1998). This is where the speaker reports someone else's speech within their own account of events. In this way, it can be used to show that the reported events really did happen, and to distance the speaker from the claim that they are making as they did not actually say it, someone else did. Therefore, the claim is strengthened through the implication that it is not merely one person's opinion.

To strengthen or lend validity to descriptive accounts, conversational techniques are also explored. Jefferson (1990) outlines a device regularly applied in everyday speech, where the speaker lists three characteristics or behaviours in order to summarise a common or general way of being (three-part listing). A generalised end-list completor to finish off this list then acts to minimise or downplay any extremity in the claims, but also works to reinforce the claims of the account by inferring the generality of the descriptors.

Many discursive and conversational devices emerge in this study. In my interpretation of accounts, I focus on the themes and rhetoric that I propose to be sense-making resources for participants as they work to describe themselves and their experiences. These identities are locally and interactionally defined, negotiated between myself and participants during the interviews, and manage richer social accounts of themselves and their problems.

The following analyses explore the multiplicity of identity construction surrounding people with a diagnosis of schizophrenia. Chapter Three allows for familiarity by presenting an overview of the primary

participants in this study. Each person's story is told from their perspective, outlining their life experiences and interactions with significant others in their lives. In this chapter, I also give my version of the person that I saw. As the agent through which their self narratives are told, my perception of each person is presented here; their stories are filtered through my eyes. Chapter Four then investigates the construction of self identity and how this identity is managed through the descriptors of self that are given by primary participants in this study. Chapter Five explores others' perspectives of self in an investigation of how primary participants thought that friends, family members and staff at the service centre might see them. Here, the relational nature of self is attended to through emerging issues of importance for primary participants, and is guided by the notion that self identity is influenced by others. In keeping with this theme, Chapter Six focuses upon descriptors of how primary participants see their friends, family and staff members. This allows for a broader understanding of the relationships that primary participants have with their significant others, and how this might influence how they see themselves. Finally, to incorporate another perspective of primary participants, descriptors of each of the nine primary participants given by four support workers at the service centre are included in the study in Chapter Seven.



### CHAPTER 3 – Biographical Sketches

I had known the participants in this study for over a year before the interviews took place, usually dropping by the centre on a Monday morning for a coffee and a chat, and attending the occasional barbecue. I wouldn't say that we were well acquainted, but knew enough of each other to be able to do away with the initial reservations that you would have with a stranger, lending an informal, friendly atmosphere to the interviews. Primary participants, people who had been given a diagnosis of one of the schizophrenias, were in the process of reintegration back into the community. Many were caught in the oscillating cycle of institutionalisation and community life through episodes of relapse.

In conducting interviews with people at the service centre, my agenda was to conduct my research. Yet, in choosing to be involved in this study, primary participants may have had an agenda of their own, to tell their story. This chapter's aim is to give voice to consumers who invited me into their confidence, their world, and told me of their lives. Some people became quite emotional when touching on topics sensitive to them, and I did not push for them to elaborate. Their narratives represent the accounts that they chose to give me on the day: their perspectives on themselves, their relationships and the events in their lives, which were then told through my eyes. They also allow for familiarity with each participant before any analysis is conducted.

The tellings were not necessarily chronological, and accounts were given as adjuncts or further explanations of their responses to my questions. The first narrative was ordered in a linear format ranging from childhood

through to adulthood, as the account appeared to align to a life story. For the rest of the narratives, tellings were grouped according to major issues or themes that were introduced in conversations. As only one service centre was approached, I did not ask for exact ages, not wanting to identify participants. However, some people gave their exact ages voluntarily. I had known all participants for approximately one year before the interviews commenced, and at the beginning of each narrative I also give my perspective on the person that I saw.

The purpose of these accounts is to provide some context for the specific issues covered in later chapters, and to present an overview of each person's story before comparing and contrasting the various experiences of participants in relation to particular challenges involved in living with schizophrenia. As social constructionism suggests that versions of self and life experiences are continuously deconstructed and reconstructed within relationships (Gergen, 1991, 2008), the biographical sketches are given here with as little interpretation as possible. Thus, they provide not only the opportunity to hear a version of self from the person, but a basis from which further analysis can then be conducted.

## **Ken**

The first case study depicts Ken, who indicated that he was a single Anglo-Australian man, aged between 28 and 37 years. He had no children, lived alone, was unemployed and, in addition to a primary diagnosis of schizophrenia, had been diagnosed with a secondary mood disorder. Ken is a tall man with a solid build, quietly spoken, watchful yet friendly. He didn't give specific details regarding past events in his life, and I didn't

push for this. His story emerged throughout the interview revealing a pattern of abuse, anger, violence, and reparation. In his account the abuse had occurred in childhood and his teenage years. Talk of anger emerged through statements such as being at 'loggerheads' with his father, and violence said to be related to his nervous breakdowns. Reparation came through Ken's current efforts in recycling to earn money for charitable organisations.

In the 12 months that I had known him, I gained the impression that Ken had great difficulty with relationships and didn't know how to form and maintain relationships with others. A quiet man, I noticed that when sitting with others at the service centre, Ken did not readily contribute to conversations. In talking to staff members, I was informed that at times, Ken's behaviour toward others was inappropriate. The manner in which he related to other people was sometimes offensive, such as crudeness when talking to an attractive woman. In his interactions with me I found him to be genuine and trying very hard to be accepted as a regular guy.

Early in the interview Ken had emphasised that emotionally, life hadn't been good for him, and I asked him whether he thought that he had changed over time. He said; "ahhh, I think I've matured a lot more. Before I was ahh sick, mentally sick, I wasn't very good. It was like uhh I had a lot of i-issues with anger and stuff like that. I used to get beaten up when I was at high school, and uhhh that's kind of released it; cleared my mind a bit, but I was still put in the hospital, oh, about three or four times? And umm, yeah, I think it's been quite good (mumbled). I know that it sounds quite strange, but it's good that I had the nervous breakdown cause it kind of cleared my mind (mumbled)" (CS1/L85-99).

An expansion on life-long emotional issues came in Ken's account of major life experiences, starting with his childhood and progressing through to his current activities. "When I was a kid at a place called Mofflyn, which has all been knocked down now, but when I was a kid it was there, and uhh I went through a lot of physical abuse. I don't know if I went through sexual abuse but physical abuse was (mumbled). I tried to commit suicide when I was a little kid, and then uhh high school was really bad cause I used to work on the farm a lot. I didn't look that good (mumbled) (laughs). Five hours a day on the farm, you know" (CS1/L296-312). I commented that most kids would not have had to do that, and Ken replied, "No, so I, because I was different they, the kids, used to pick on me, and it took a long time for me to get that out of my system. Then afterwards, it didn't worry me (mumbled), but then the Army was like that as well. I don't mean to be rude, but it's called bastardisation and it's really bad. I'm lucky cause I seem to have grown out of that as well" (CS1/L314-324).

Talk of the Army had emerged earlier when I asked Ken if he thought that others might have seen him differently now as compared to the past. Ken said, "umm, well, when I came out of the Army I was (mumbled) or something. I, you know, I wouldn't recognise people and they [family] thought I was on drugs or something and very dreamy. I've never taken any illicit drugs, and uhh yeah well, when I came out of the Army I wasn't that good" (CS1/L196-201).

Ken's relationship with his father was highlighted when I asked how his family might influence the way that he saw himself. He said, "umm, when my dad was alive he was always putting me down and stuff, and I

used to put myself down pretty badly. I was just pretty miserable, and then uhh, he passed away, and then, I don't mean to be mean, but I was like, I was always at loggerheads with him" (CS1/L221-227). I asked if some of that tension had gone now, and he said "yeah, and after my dad died I had uh, another nervous breakdown and uh, I don't mean to be mean, but I got a bit on the violent side, but I-I paid it all back " (CS1/L231-235). Ken continued, "...and I've done as much volunteer work and stuff as I could. I crammed it in to my day. Got a lot of money for a good cause. I started selling stamps. Went so I could put it back into the community. It took a lot to get anything" (CS1/L237-243). Ken also mentioned recycling activities; "Yeah, I like recycling things I think, so I get things like aluminium cans (mumbled). I'm hoping to get 100 bags of aluminium cans so I can give it to the June O'Conner Centre" (CS1/L71-77).

Talk of change gave a general view of Ken's current relationships. I asked Ken if he thought that his friends and family had changed since his problems began. He said, "Yeah, like all my friends from the Army, they'd just never understand it, so, oh I think my two sisters are pretty understanding (mumbled)" (CS1/L266-271). I commented that he had lost some people along the way, yet kept others, and Ken said "yep. I think I've gotten along better with my oldest sister because I was pretty uh mean to her when she was feeling sick, and now I know what it feels like to be mentally ill. Now I understand her problems. There's definitely a lot of ignorance out there in the community, specially with uh what's happening to me and uh my mates. It would definitely help things out a lot more" (CS1/L274-285).

## **Brenda**

Brenda's account covered the past four years of her life. She identified herself as a single, Anglo-Australian woman, aged between 38 and 47 years old. She has a teenage son, was unemployed and lived alone, and in addition to schizophrenia had been diagnosed as having a secondary mood disorder. Brenda's narrative concerned her interactions with her mother and her son. At times she avoided talk about herself in the individualised terms that are so prevalent in clinical descriptors of people with schizophrenia. Brenda's accounts of changes in herself were grounded in the physical and social circumstances of her life, such as living with her mother and her pride in her son.

Over time, I found Brenda to be a fairly reserved yet friendly woman who became quite animated when talking of her son. There also appeared to be a quiet determination about her. At the service centre, Brenda would agree with others in what looked like an attempt to keep the peace, yet her body language conveyed that she didn't agree at all. I came to believe that Brenda had learnt to stay silent, to keep her thoughts to herself, and to outwardly do as others told her, others with more power than she.

Brenda spoke little of her individual self. I had asked Brenda to describe herself, and she said "well I'm a bit hah, I'm a bit shy sometimes when I first meet people, and I'm a bit, you know, sort of standoffish until I get to know them" (CS2/L20-22). Later in the interview, when talking of how support staff might see her, she offered a little more of her self, still dealing with her interactions with others. "I'm always happy. I never complain about anything, but then, no one would listen if I complained

anyway (laughing), so, heh, that's what I've been told 110 times. Ohh, get on with it" (CS2/L224-230).

A question on whether she thought that she had changed over time evoked talk of her mother. "YEAH, I'm not as (sigh) I'm not, not, not, don't lose my temper as quick as I used to. Not as stressed. I've found I've mellowed out in the last four years. I lived with my mum for four years before I got my own place, so she's sort of mellowed me out and I ver-very rarely lose my cool. I haven't hardly lost my cool in over four years" (CS2/L45-52). Later in the interview she explained how this mellowing had come about. We had been talking about change in herself over time, and Brenda said that nothing had really changed. I drew her back to her earlier comments on a change in her temperament, asking what she thought might be responsible. She said, "I don't really know. I think living at mum's, I'm not able- you know, you had to be careful how you let off steam, yeah, cause we had words, but I've sort of just walked away and let her have (mumbled) way. I just walk away now. I don't, I DON'T umm I don't retaliate like I used to. No, I just sort of walk away" (CS2/L179-190).

Brenda no longer lived with her mother, as she had recently moved into a place of her own. In asking how her life might have changed over time, she said "I helped mum with the house and that when I lived with her. Now I've got to do it all myself, so I sort of do it when I want to do it. When mum comes over she says 'have you done this today, have you done that today'? No, not yet. When I'm ready I'll do it" (CS2/L66-70). Issues with her mother also emerged in talk of how friends and family might see her. Brenda first said that she didn't know, but after rephrasing and asking the question for a second time, Brenda replied "oh, mum is- mum said to me

that she'd like to see me, that I'm really tidy in the house. In particular about my house, so, and that and I'd decided that in the New Year I'm gonna really make the effort and keep my house clean and tidy and how I used to" (CS2/L202-208). This directing from her mother was furthered in later talk of how others might influence the way that she saw herself. At first Brenda said there was little influence from others, but I reminded her that she said that she was going to tidy her house up a bit more as her mother wanted. I asked if this might have influenced her and she replied, "might, might just a little bit cause mum's very particular about her house, so she expects everyone else to be the same as her" (CS2/L402-404).

A sense of a demanding and perhaps domineering mother also came through in talk of the way that her family members treated her, and whether this had changed over time. Brenda said, "umm, no not really. They just say to me if I stop taking my medication they'll help me through it. Mum wants me off my medication" (CS2/L468-471). I clarified that her mother wanted her to stop taking her medication and Brenda said, "mmm, yeah, cause I've been on them now for four years, so she sort of said 'oh its time you got off those tablets. You don't need them anymore. You've been on them for so long you don't really need them' (higher pitch). So I talked to my doctor and she said 'well you gotta take them' " (CS2/L473-479). I asked her what she thought that her mother might be worried about. "She's probably very worried that umm that I'll get hooked on them, probably, yeah cause I only take one tablet once, and I take three antidepressants. So, I think she's a bit worried that I've been on the antidepressants for such a long time" (CS2/L484-485). As to whether her mother might be concerned that the medication might change Brenda as a person, she said "YEAH the



umm the antidepressants help me sleep, so I take them quite early, so I usually go to bed early, say half past eight, nine o'clock..." (CS2/L494-497).

When I asked Brenda how she felt about her future, she spoke of her son saying; "Not too sure about the future. Tim's not got any work at the moment, so, he's my whole world at the moment so, I'm more or less putting everything on hold until I get him settled cause he just finished Year 12" (CS2/L106-109). Tim's schooling was important to Brenda, and when I asked her of any major events that came to mind she focused on this, comparing herself to her son. Brenda stated, "So I was very proud of him for doing that cause I, eh, I didn't do year twelve. I only went to year ten, then I went to tech, umm, you know, a business college. So I didn't go the full distance, so" (CS2/L334-340). This self-criticism came through again in talk of whether she had wished that she'd stayed at school and completed too. Brenda responded, "no, no I didn't think I would have coped" (CS2/L373-375). I reminded her that she said she had gone to business school. She said, "yeah that was just to brush up on uh shorthand and typing and umm stuff like that" (CS2/L377-378). I started to say that at least she had those skills, but Brenda quickly replied, "I can't remember any of it now (laughing)" (CS2/L380-381).

We spoke of change over time in herself, and I asked Brenda how her friends and family might see her now as compared with before. Brenda said, "hmm, probly, mum's probly noticed that I'm more settled, ahh now that Tim's home fulltime. I wasn't settled while he was away. I've always sort of blamed myself for him being away. Kind of got sicker while he was gone, BUT it turned out that he's turned out to be a wonderful young man,

so. (Laughing softly) It was maybe for the best that he wen away, as he was going off the rails a bit" (CS2/L279-293). I commented that with maturity he might settle down too. I then restated what Brenda had just said, talking of how her mother sees her as more settled and relaxed now that her son was back. Brenda confirmed this, saying "yeah hehehe, yeah I've got him home full-time now. It's been a long four years (laughing) (CS2/L304-306). As her son was in his late teens, I remarked that he was at an age where he would be going out a lot more and making his own life in the world. Brenda said "well not too far away. I'd like to help him (mumbled), make up for the lost years" (CS2/L311-312).

## **Carl**

On his demographic form, Carl indicated that he was a single, Anglo-Australian male, aged between 48 years and 57 years. He had no children, lived with a parent, was unemployed, and in addition to a diagnosis of schizophrenia had been diagnosed as having a secondary personality disorder. Throughout the interview I found it difficult to engage Carl in conversation. He tended to answer my questions with a couple of words or a sentence at most, talking little of himself, and had difficulty at times finding the words to describe the meaning that he wanted to convey. The only time he said more was when he was talking of the mental health system, his experiences within this system, and of the people who worked in this area.

In the year that I had known Carl, I found him to be warm, friendly and amicable. We often talked about research, music and books, and he was the first person to volunteer to participate in my study. Generally keeping

to himself, Carl tended to go along with the wishes of others rather than bucking the system. As he explained to me one day, you learn to 'play the game'. When I inquired what he meant by this, Carl said that you learn to say what 'they' want to hear. 'They' in this case referred to mental health professionals. Carl was not the only consumer to say this to me, as Carol in this study has also mentioned it, although like Carl, not during the interview.

To start the interview I asked Carl for a general term to describe consumers within the mental health system. Carl laughed and responded with 'guinea pig'. I asked if there was any particular reason for 'guinea pig' and he said, "AHHH, doctor's the boss, patient's the patient, ill person, you know. You've got the family on one side and the, what's the word to describe the (spoken slowly) organisation behind the doctor? AMA, behind them" (CS3/L10-15). This gave a sense of consumers being caught in the middle of family and the medical establishment.

When I asked Carl how he saw himself, he offered "ahhh, an intelligence- intelligent loner" (CS3/L25-27). I repeated this back to him and he continued, "ba- oh ba- not loner, bachelor" (CS3/L29). Again, I repeated his statement, and as Carl did not add any more to it, I continued, asking him if he thought that he had changed over time. Carl responded "uhhhh, yeah, I'd say I was more carefree when I was young" (CS3/L35-36). Pressing for additional information, I questioningly suggested that he had become more conservative, to which he agreed. I enquired if he had changed in any other ways over the years, and he laughingly stated "uhh well I've aged" (CS3/L42).

Carl's relationship with his family may not have been close, as when I asked how friends and family members would see him, he put forward terms such as 'obtuse' (line 107), 'wacko' (line 109), 'batty Carl' (line 167), and 'a little bit weird' (line 174). Later, when speaking of how he felt about family and friends in general Carl revealed "I haven't got too many friends, and family, well family's family" (CS3/L272-273). Carl's discourse was scant on most topics, but talk surrounding mental health drew a much greater response. I asked Carl how staff members at the service centre might see him, and he replied "tell you the truth, I don't really care. Underlings worry about superiors, superiors don't worry about underlings (smiling voice)" (CS3/L118-122). Later, and again talking of staff members, I asked how support staff at the centre might influence the way that he felt about himself. Carl said "ahhh, I'd say they've got a mildly interested perception o-o-o-of my behaviour, so they don't have to call the police" (CS3/L251-253). I suggested that it appeared that he did not really care too much about staff, and Carl continued, "no, I don't care what people think about me, basically" (CS3/L257).

In talk of how mental health staff outside of the service centre might behave toward him, Carl said, "well, really, I deal with the receptionist, duty nurse, and doctor. Uhh, as for me file, I wouldn't understand it if I read it so what's the difference" (CS3/L135-143). I commented that he did not see any difference between staff members, and Carl further explained: "uhh, I mean, some organisations, some big organisations, use common names, you know, like Cathy for receptionist, you know. Cathy's on all the time, you know" (CS3/L146-148). I asked, even though that may not actually be her name? Carl said, "yeah, you know, that's just pu- pu- pu- oh, I know the

name of the word I'm trying to say but it just isn't coming out" (CS3/L150-153).

Carl's experiences within the mental health system may not have been positive ones, as talk about major events that he could recall evoked worry. "When I was in Graylands for the first time there was a memory loss there, and that worries me. You know, a great big blank" (CS3/L187-192). I rephrased this stating that he was not really sure what had happened, and Carl said, "I got no idea" (CS3/L196). I wrapped up the account of this event by saying that it was one major thing that had happened to him, and then asked if he could recall any other events that he felt good or bad about. Again, Carl spoke of his time within mental health institutions. He said, "yeah, uhh, a nurse asked me uhh inmate, I use the term loosely, inmate from uhh, I forget the name of the ward, gave me a packet of smokes, you know, and the nurse uhh, I was due to get dis- discharged that day, so she asked me if I'd leave em for uh, you know, she reck- gave em away. You know, she might wan um, and I reckon that's a good deed" (CS3/L211-222).

## **David**

David identified himself as a single, 28 year old Anglo-Australian male, who lived alone and had no children. He had a part-time job, and attended TAFE (Training and Further Education) on a part-time basis. Initially, David was cautious about the interview. Yet, the moment he closed the door to the room we were using for our talk, it all started to pour out: his story. His narrative covered his high school years to the present day; approximately ten years. His constant worry of relapse and his mother's worry over his problems were evident in the tellings. I felt,

though, that the most prominent issue for David in his story was his desire to grow up: his need to work things out for himself, and his striving for independence from his parents.

I found David to be a big man who was very aware of his size. At times at the service centre, he tended to use this to his advantage in intimidating other consumers and, in particular, Mike, a staff member who worked at the centre. I also had the sense that David was emotionally immature, as he sometimes used the phrase 'us kids' in conversations with me and others. Yet, he appeared to be trying very hard to act in a more mature manner, conveying a desire to be taken seriously.

I had asked David if he thought he had changed over time, and he said "yeah, very much" (CS4/L86). He described his past behaviour as, "sort of being a loner, and sitting at home, you know, day after day by yourself" (CS4/L88-90). This was furthered later in the interview when David was talking of the stress his problems had placed on his mother. "The problem is I got a mental illness when most kids were leaving home with their friends, girlfriends, had cars, you know, started to spend money n bet- earnin big bucks, and like, yeah like I'd be 18 and I'd be sittin at home. Most kids had cars by then, you know, Monaro's and umm you know, all that stuff, and like down the pubs and I couldn't do any of that, you know. I was like by myself, on medication" (CS4/L347-357).

In explaining a change over time that others may have seen in him, David again went back to when he first became unwell. "You see, when I got umm mentally ill I stopped seeing a lot of people that I knew. They had jobs and all that and they all moved, and like it was a really quick decision not to umm go round there anymore. It's like I used to ride around the

block and stuff and they blokes still sort of say giddy to some of em, an an some of em are even in here now know what I mean. Like kids I went to school with, kids that umm used to be the big fellas at school an all this, an I thought I won't hang around em. I start comin here [service centre] an doin my own thing, and now sort of these are the blokes that I know. These are the blokes that I hang around sorta and like, the people I met at school, some of them, like three or four of them, I've noticed are in here now. Coupla girls that I met in hospital were there when I was at school. I catch up with them, they sometimes they're here, sometimes I just catch up with them down the shops. You know, 'how are ya'? 'How's ya medication', 'are you getting better?'" (CS4/L665-692).

David's perceptions of a change in his self over time conveyed awareness of his own limitations. "Pretty much doin the best I can yeah. I know that umm I can't handle noise, so I can't really get, get any jobs in industry around here" (CS4/L107-110). I commented that this would be quite restricting for him and he agreed. "With my medication, it's different. Like, you gotta be uhh, you know, I can't sort of start work at nine in the morning because- I suppose I could, but- I-, like it takes me a long time to get used to people. Oh I could walk in to a shop, get a job, I suppose, but after a while, you know, if I have a relapse, which I usually do cause they strike at any moment, you know, that's when I worry you know. Yeah, that's when I worry" (CS4/L115-127). I asked if this made gaining employment and keeping that job hard for him. "It does cause like you can get to umm you can get work maybe, but sometimes you can walk around and you don't hear what anybody says" (CS4/L132-134). We talked some more about David's study and the cost of medication while working. David

then drew the conversation back to his performance on the job. "See I get a bit bossy as well so, you know" (CS4/L142-143). I laughingly commented that perhaps he should be a foreman, and he replied "nah, can't handle noise. I'd be there half an hour and I'd be, you know, and I wouldn't umm, I'd be by, I'd be beside myself sort of, you know what I mean? I'd be umm stressin out too much" (CS4/L145-151).

Still on the topic of employment, David and I talked about the kinds of jobs he'd like to do based on the activities he enjoyed. As he enjoyed fishing, I suggested that it might be a good area for him to get into. David replied "Yeah, cause I know I always have a mental illness. That's the problem, and it's like a struggle knowing that every day. You know, people can go to work and think 'no worries'. You get up every morning, you know you have to take medication, you know. You know you got a mental illness every day of the week. It's not something that you, just like, after a while don't worry about. It's every day of the week and you gotta, first you gotta sort yourself out. Then you gotta sort the way you live out, and then for a job, with a job in that time as well it can be very stressful" (CS4/L192-206).

We went on to talk of how David thought that his friends and family members might describe him, and a current view of his relationships with family members emerged. "My sister doesn't take much notice of me anymore. When she was young, you know, maybe she was around sometime, but like, most of the time she just says giddy and that's it. She doesn't really bother. She's young, she's got her own friends. She's earning big money" (CS4/L252-259).

David then spoke of his parents. "My mum and dad they just don't, you know. They ring up every now and again. I used to fight with them



like cats and dogs, you know. Like they'd be say out of line, and I'd just, you know. I'd like, you talk to the blokes round here I worked out, what does your mum think of your mental illness? Dad? They reckon it's no good you know. My parents just sort of, you know. I'm not worried I'm old enough. I've decided like, when I got into my new house like four or five years ago, I decided I'm not gonna have much to do with them, you know, they're still there, you know, be polite, but umm I'm not gonna run to them with every little problem, you know, grow up sort of like. Be more independent, you know, yeah. They didn't sort of know what I was going through when I first got a mental illness. Like, they'd be wonderin what to do all the time, and it was quite a stress on em. So, like now I'm in my place, you know. I don't ring em up. I don't, every day and complain and complain, you know. Independent, actually totally independent I am, you know. On my own compared to with my parents" (CS4/L261-291).

David appeared conflicted in his views of his mother. As soon as David had walked through and closed the office door for this interview, he spoke of how his mother would not allow him to grow up, to be independent. I drew David back to this topic now, but he was reluctant to repeat what he had said earlier. "Yeah but uh there's that but like, you've got like, it was also hard for em, you know? But they might be bossy an all, but they, they tried to, I suppose when I first got ill like I'd be home all day. Mum would get home and she wouldn't know what to do. She'd get very upset. She wouldn't know how to cope, you know, so I got out of there, and once I was out of there she was good. She used to ring up quite often, but now it's like every, I might hear from her every two weeks for five minutes on the phone. You know, jus 'how are ya'? It's like they live a stress free

life compared to what they used to when I was at their house. All the worrying all the time, you know, 'is David going to be alright?'" (CS4/L300-317). David then gave an example of how his mother would behave toward him. "You know, she'd get home, 'oh, how come the dishes aren't done' and she'd say, 'David are you alright' an all this an I could, the way she said it was just like 'oh yeah, matter of fact', but I could tell the stress on her was you know sort of unbelievable you know " (CS4/L322-328). David spoke of how he did not want to go back home once he had gotten out of hospital due to the stress he felt he was placing on his parents, particularly his mother. "I could tell. It was like they wouldn't show it but like the stress on them was unbelievable. It was like I could just tell when mum got home over a few dishes. You know just the way she act, walk around the house, you know" (CS4/L336-339). David then went on to explain the difference between himself and other teenagers when he first became unwell, talking of sitting home alone and on medication (see earlier paragraph). He concluded, "Yeah, the stress on them was really bad so I just thought, get out of home, go my own way, and it's paid off. Don't have to worry about them; they don't have to worry about me" (CS4/L361-368).

I asked David if his family might have seen a change in him over time. "They have changed. They probly umm you know, they probly umm they're always ready for when something goes wrong, as parents usually are. You know, like you, soon as they notice you're sick they're in the doctor. You know, that's, that's the thing about it, but I don't want mum to like, that's what I mean. You know, they're always there. They're always ready to help you, an umm, when you're at home they, you can tell. They always

wandering round and they're always wondering, you know, 'are you alright' " (CS4/L698-710).

Talk of his family's reactions to his mental health problems were expanded upon further when I asked David how he felt about his friends and family in general. "I know they're there. I know they're gonna be there till they heh till they die (laughs), so yeah, I don't worry with em. I can ring up mum and say 'oh mum, I'm not too good today', and she would panic and say, 'are you sure? I'll get Tanya [support worker outside of the service] to call round there. I'd prefer if Tanya calls around. Can you tell Tanya to ring me? Do you think you need to go to the hospital?" (CS4/L813-826). I commented that it did not appear that he could have an off day. David replied, "Well no, like I'd be okay now like, but if I told my mum that she would panic" (CS4/L832-833). David continued to talk of the stress that his mother experienced. "She'd think about it all the time. I'd go to hospital. She'd think about it all the time, while I was in hospital, and she would say 'don't let him out till he's absolutely well, an you know he's not gonna have a relapse like in two weeks' like. Get out in two weeks and don't know what to do. You know, she would say 'keep him in there then', you know. 'Wait till he's sorted himself out cause I'm not gonna be, you know, fussin around ya'" (CS4/L855-864).

I asked David how it made him feel when his mother started stressing over him. He said, "ohh, bad, yeah. I mean, I think it's very nice that, oh yeah, she would do that, but then again, I think, you know, it's not their problem. It's my problem. I gotta know what to do. I know I gotta know how to deal with it. I gotta know, you know. I gotta, I've gotta do everything myself now, you know, I'm 28. Its not one of those ages where

you can run back and forth to your mum all the time, you know what I mean?" (CS4/L871-882).

Earlier, when talking of staff perspectives of his self David introduced the topic of anger, as he did not believe that staff members were afraid of him. I enquired whether he found this of other people, and David replied, "when I was, when I used to get like, when I was like 20, 21 I was in Heathcote and I w- you kno- my parents used to say I'd get very angry, but like, you know, I thought that's something I have to sort of umm, you know, figure out. You know, keep calm and don't lose your temper, because umm, they jus, the more you lose you're temper the less people that understan ya. You know what I mean? They don't understand, you don't get anywhere" (CS4/L418-430). David talked quite a lot of his time in the Heathcote psychiatric institution, saying "it was when I had to work myself out. Like, I was good as gold and next minute I couldn't handle any situation at all. You ever get like, I dunno, have you had uhh I get, you get so bad you think you're just about to die" (CS4/L553-560).

On the topic of Heathcote, I asked David if he saw any difference between the staff at the service centre and the staff at Heathcote. "Heathcote was very umm, like umm, yeah a lot different, a lot, lot different. I actually had to wait two weeks to see a doctor, and I'd see him for five minutes, and he would just say 'time's up, catcha later', and you'd say 'doctor any chance of getting out of this locked ward', 'any chance at all of any sort of information'? You know, they wouldn't tell you anything. It was like they wouldn't tell you if you could umm if you could ahh get out. They wouldn't tell you if you could get [out of] locked ward. I had a really bad doctor, doctor [name], and he wouldn't tell you anything. It was like,

'oh, hi doctor', go to shake his hand. He wouldn't shake your hand" (CS4/L447-464). I then asked David how he thought the doctor might have seen him as a person. He said, "I don't reckon he liked me at all, as a person. I reckon he couldn't stand me for some reason. I don't know, it was like 70 years it'd been there, the, the hospital, and like this doctor, he just wouldn't tell me anything. He talked to my dad, but like umm I was getting depressed because the doctor wouldn't, yeah he wouldn't tell you anything. It was like, 'giddy', talk talk, you know, 'how are you today', all this, and then it was like 'can you tell us when I'd be able to go to an open ward at all?' 'Sorry, can't tell you that'. Umm any chance of a- any sort of umm wait? You know like 'am I gonna get discharged'? 'Sorry, I can't tell you that' " (CS4/L475-494). I started to ask if there would be any difference between staff members, and David quickly continued, "There is definitely because as soon as I got another doctor, I was umm a lot, lot better really, really quick. Yeah, yeah, this black doctor, he was South African, he just wouldn't- he wouldn't even, he was so stuck up he wouldn't even say hello to ya if you were walking past him. You could say hi and he wouldn't even notice, just keep walking" (CS4/L497-509).

David spoke of getting better, and mentioned the closing of the Heathcote institution and his being transferred to another institution called Alma Street. He concluded, "Heathcote wasn't bad for like, treatment. Once you sort of knew what you were goin on about. I had to do, like, I couldn't just blame it on the doctor. I had to work it out for myself you know. I had to work out what was going on" (CS4/L529-534). David spoke of the eventual easing of restrictions on his freedom within Heathcote, but returned to the issue he had with his first doctor. "I can't

remember much is the problem, but the bits I do remember was this black doctor who was very, very unpolite" (CS4/L543-547).

A comparison was given between the two psychiatric institutions of Alma Street and Heathcote. "I got to Alma Street. Doctors there were a lot younger. Umm, they're like, they'd park their cars outside. It's not as if you had to run away just to go down the shops and buy some stuff. You could walk around all day once you're, you know, you're allowed to" (CS4/L569-575). I commented that Alma Street was in a popular area and that there were plenty of things to do. David said, "yeah, like in Heathcote, it was like umm lock and key. Know what I mean? It was like, I used to jump the fence every day, and I did it for two, three weeks, and I would bolt and I'd go down, I met up with these people. Umm, I run, I, we started partying and we ended up umm going somewhere in a car and spendin the weekend drinking and all that sort of stuff. I ran away. I tried to jump off a bridge, an umm, I tried to umm, I run into a building site and I got a little cut there [indicating a mark on his forehead]" (CS4/L579-591). David wasn't sure of the exact place of the cut on his forehead, and pointed to another possible area close to the first.

He then went on to tell of an event that had occurred while he was on the run from Heathcote. "Yeah, an I walked into this bloke's house in Dalkeith, and I said 'oh, hey, can you help me mate', and he sat me down and said 'what's wrong, what's this an that. Here, have some lollies, have some cool drink. Are you alright'? Really, really kind bloke, and umm then I remember that, and then I can't remember a thing, and umm the next day I woke up and, oh, ambulance was dr- pushin us into Heathcote, and umm got out [of the ambulance], and about two days later this bloke calls around and

he goes, 'David, is that you? How are ya', and its the bloke from Dalkeith, and he sat me down and I remember he- I said 'what happened? I can't, I can remember being in your house. I can't remember you, but I know it is you. I wo- sort of umm, yeah, 'how are you', and he bought me umm fish and chips and jelly beans and uhh couple of bottles of coke, and so we sat down and ate that, and he lived in a really posh house. I knocked on the door and I walked in and said, 'can ya help me'? and sat down and he said umm uhh you need si- read the bible or just do something to umm to uhh bring yourself to a better level. I told him I can't understand what's going on. I said there's this doctor and he won't tell me anything, an, you know, I get into fights when I'm just about ready to get well, an, an umm, nobody takes any notice of me but umm I'm enjoying myself, but I just can't handle being cooped up any longer, and he sat down and said this is what you gotta do, and yeah he called around yeah, and he lived in a really posh house, and he said 'you passed out. I was talking to ya for about half an hour an hour' and he said 'you passed out, so I rang the ambulance and umm they took you to Freo' [hospital]. He said, 'where did you wake up'? I said 'I woke up here' [Heathcote]. He said, 'oh, they must have brought you back here in the morning'. I said, 'yeah' " (CS4/L579-641).

David appeared to come to the end of his recollection of this event, and went back to his first topic of Heathcote. "Heathcote wasn't too bad when you were by yourself cause when I was there, it was the same company all the time, and there was also like people who would be in there a day and get out, discharged, you know, straight away. But I was in there for a while. I just wanted to get out. I was young, young enough to make mistakes, you know what I mean? " (CS4/L645-654).

## Carol

Carol identified herself as a single Anglo-Australian woman, aged between 38 years and 47 years. She lived alone, had a teenage daughter, was unemployed, and had been diagnosed with a secondary anxiety disorder. Carol's narrative primarily dealt with the physical problems that she had endured in her past, and from her perspective, once these had been addressed, both her physical and emotional health had improved.

I found Carol to be a friendly, sociable woman, and very easy to talk to. She tried hard to overcome the negativity of her past, a past that was still very much a part of her present. She appeared to have little confidence in herself, and tended to dwell on the negative events that had occurred in her life. Despite this, she actively tried to organise get-togethers with other consumers outside of the service centre. Others looked to Carol for comfort and understanding, and she was happy to provide this.

Carol and I had been talking about doing things the hard way, and she gave an idea of how life was for her when she was young. "Well, I've always had it hard, cause of not being able to keep up, and not being, being the way I was when I was younger. Like I said, it was hurt and I was angry and I had these problems, and nobody seemed to care if Carol kept up. Well, she kept up. If she didn't, well stiff shit. 'Hurry up you, you're bloody holding us up' " (CS5/L532-539).

Carol spoke of the problems she had over the years. "Well, the heart op [operation] at 16 had a big influence on things, the ectopic pregnancy, me daughter, the biggest impact I had was the last of five foot operations and an ovary removed a week apart. They have made life a lot better because they were the things that were causing the pain. I had



endometriosis, and even though I'd seen specialists, including those at King Edward [hospital], they did nothing about it. So I had that for 13 years, and when they removed my ovary and took the pain away, life was wonderful, and with both feet fixed at the same time, it was even more wonderful, once I got back on em. After having, like I said, a week- feet operated on one week and the ovary removed the following week, that was the biggest change, and then I guess, I spose when me daughter decided she'd rather go and live with her grandmother rather than me, changing schools" (CS5/L438-467). I asked Carol if she had been going through a bad time when her daughter had decided this, and Carol said "no, actually it was her going through the bad time not me" (CS5/L470). I echoed her statement, and Carol replied, "Well she's had issues, yeah. She still won't discuss a lot of them or anything" (CS5/L473-474). I suggested that her daughter might need to get to a stage where she feels comfortable in talking, and Carol responded, "Well that's up to her. I can't do that for her. We talk about things, but we haven't really talked about that side of things. What I put her through and all that. She remembers it. Yet, she's really angry at me for it (voice wavering), but I couldn't help the way I was" (CS5/L481-487).

In talk of how Carol saw herself, I had commented that it appeared she did not like her past self very much. Carol said, "Not with the hurt and the anger and the pain that I had and everything. It just- I was just- I reacted to things all the time and I had pressures and stuff that I was overreacting to, which is where me illness came in I think. It started from postnatal depression, but it was never picked up in the young- early days, considering I tried to get the help, but nah, nothing happened" (CS5/L122-132). I asked for the period of time that Carol was talking about, and she replied that it

was about 18 years ago. I remarked that perhaps they did not know about such problems back then. Carol said, "Well yes and no. I mean, it was a case of, 'hey, something's going on. What's happening', you know, 'I need- I need some help'. I'm being pressured from different things and my reactions were angry and stuff all the time, and it was just a matter of not coping or being, you know, I mean, I didn't even get pain (voice breaking) management, and yet I know it was around cause I knew a couple of people who had been put through it, but it was never even suggested for me, and umm, all the different things and different operations I've had over the years have been in different stages, and it's just, it should have all been done in one hit, and it wasn't. Oh, well, some of them anyway, but it' made life and its stretched life out too hard and too far for the first- till the last lot of operations, and since then I've been a different person, which doesn't help my daughter, but never mind. She grew up angry because of me. I can't help that" (CS5/L138-164).

In discussing her future, Carol saw her health as quite good. She said, "The majority of them [problems] are gone. I laugh a lot more; don't cry as much. I think a lot of it's the friends I've got too, even though we've all got our problems. I mean everybody's got problems of one sort or another, the majority of us have got ours recognised and we're all getting on top of what we've got and all that. You know, it's been the case of, we've admitted we've got problems and we're getting sorted out and looked after, and it makes it easier for people cause we all understand each other, and yet the friends I had before that never understood cause they never had the health problems to understand, physical or mental. Half of them, maybe they'll twinge of a back ache or something. Other than that" (CS5/L223-

250). I suggested that it may have been difficult then, for others to understand what she was going through. Carol replied, “well I used to sound like a cracked record 'I'm sore', 'I'm sore, 'I'm sore', 'I'm sore', 'I'm sore'. 'Well what are you gonna do about it'? 'I dunno, I can't do anything', and I couldn't back then (CS5/L253-257).

Talk moved on to how Carol’s friends and family might see her. She said, "The friends I've got now would be more- a lot more positive about me even more than my family would, I think. I don't think my family think a great deal of me in a lot of ways. They'll do things to help and be there if I need em sort of, but generally, ours is a sort of a fairly dysfunctional sort of a family" (CS5/L261-268). Later, when talking of whether her family might have noticed a change in her over time, Carol explained a little more of what she meant by her use of the term dysfunctional. She said, "Well if they have they haven't really picked up and said anything or whatever, but then my family doesn't say much about anything anyway" (CS5/L364-366). I questioned whether they tended to keep to themselves, and Carol replied “In a lot of ways, yeah. Saves having to discuss the hurts and the agonies and stuff I spose, I don't know. Saves hurtin themselves, probably" (CS5/L365-373).

We discussed the benefits of talking about problems, and Carol drew the conversation back to her issues with her family. “I've never been understood by my family. Well, that's how I felt anyway, but they haven't had to live with the pain. The only one who had any similarities was dad, but then he copped it when he was older. I copped it from birth" (CS5/L382-387). I asked if her dad’s problems were similar to hers, and Carol said “well he did have yeah. He’s dead now, has been for a while, but

he copped his through arthritis and stuff like that, more than anything, so, I dunno. I mean he may have had problems when he was younger, but I dunno. We never talked about things. Our family just don't talk about things. You put- sort of put- really personal or intimate, sort of thing" (CS5/L391-403). After talking of moving residence a few times and how this had affected the friendships she had made along the way, I asked Carol if she had noticed a change over time in her family. She said, "a little bit, but not enough to really understand or to support properly. Not umm, well, financially they'll help me if I need it. Financially they'll help me anytime, even though they grizzle and groan about it, they're still willing to do it, but when it comes to support and everything, there's not a lot of it there, really. I had a fairly good talk with me brother the other week, and that sort of se-opened his eyes a little bit, but it's like, we don't care. We just 'oh, okay, gotta spend time together'. Its not that they don't care, they do, but just not the sort to show it as well as others are" (CS5/L603-621).

Carol appeared to have a close relationship with her eldest brother, and I asked if the 'good talk' that she had with him might have brought them closer together. She said, "It did a little bit" (CS5/L625). I suggested that it might have helped his understanding of her. Carol replied, "Oh well, a lot of it was when we came over here [Carol and her family had moved to Western Australia from Victoria when she was 12 years old], he was old enough to go away for work cause he's nearly 10 years older than me. So he, basically lived away as I was growing up as a teenager, and when I hit 19 he had some trouble with a girl, and I sort of gave him some advice and he turned around and looked at me and said 'you're not my little sister anymore'. I thought, 'beg your pardon, I'm always gonna be your little

sister'. He says, 'you're not my little sister anymore. You've grown up'. I was talkin little. I mean 10 year old, 12 year old. There I was, old enough and relationships of me own and stuff. It was a surprise to him. We didn't see a lot of each other back then cause he was away working" (CS5/L628-650). I asked whether she saw more of him now, and Carol responded "I saw him more when I lived in one area between him and mum, because he used to drop the car off and go to work by train so I could take the- take me daughter to kindy [kindergarten] and stuff like that, cause we had a fair distance to go. Then I got the car. Mum bought herself a new one and gave me the old one. Umm, then I moved count- moved down to (suburb), and then moved to Ha- then moved to (suburb). Didn't see a great deal of him there unless he was coming up to do some work and umm down here, every now and then if I'm lucky, if he's on his way to (suburb) he might call in and say gidday (laughing). Just depends what he's gotta do" (CS5/L628-668). I inquired of Carol's other siblings, who were closer to her own age. She said, "Closer to my own age, yeah, but not in any other regard. I wouldn't know me other brother" (CS5/L671-672). I commented that although they were similar in age, they were not close, and Carol replied "well no. My sister's in Melbourne. Me brother, well, nobody knows him. He's an enigma in himself, mmm so (laughing) I leave him out of everything (laughing)" (CS5/L671-681).

Nearing the end of the interview, Carol said, "I don't really like talking about myself in a lot of ways, but, well, not when it comes to feelings and things like that. I'll moan and groan about my aches and pains over the years and things like that, but these days, like I said, I'm not a cracked record" (CS5/L713-720).

## **Karen**

Karen identified herself as an Anglo-Australian woman aged between 38 years and 47 years, and in her second marriage with one adult son. She was unemployed, and had been diagnosed with secondary mood and anxiety disorders, in addition to the primary diagnosis of schizophrenia. Karen's tellings dealt with her experiences of her emotional problems, and her family's reactions and behaviour toward her.

My impression of Karen during the interview was that she held little conviction or belief in the medical discourse she used; that she was simply repeating the words of others. Karen said that she liked to think, but kept much of what she thought to herself. I felt that there was much more that she could say, but that she was not willing to reveal this to me.

In the 12 months that I had known her, I found Karen to be a quiet woman, friendly but distant. She appeared to have little confidence in herself and her own decisions, and thus, relied upon others to direct her, particularly her husband. I also noticed that Karen seemed to have quite rigid, black and white, ideas about herself and world. She would listen and nod her head to the suggestions of others that may be different to hers, at times verbalising her agreement. Yet, if asked later about the same topic, her original beliefs did not appear to have altered.

In describing herself, Karen said, "Well, if I wasn't taking my medication, I would have mood swings umm very impatient, depression, suffer with depression, so I need to take my medication to lift my moods umm yeah, no, I would be all those things if I wasn't taking my medication" (CS6/L34-45). Karen then spoke of enjoying car rides, the beach, and "...socialising with people, not that I'm a very good socialiser anyway. I'm

a very, sort of, quiet type person, so if I go to parties, I tend to end up being by myself, because I've got- umm inferiority (slurred) complex, so I tend to end up sitting by myself at parties instead of joining in" (CS6/L71-76). I rationalised that she may prefer smaller groups of people to larger groups, and suggested that as there tended to be larger groups at parties she would end up sitting alone. Karen agreed, and gave an example of what she meant. "I went to my husband's nephew's place for Christmas night, and people were all in groups talking, and because my husband was playing badminton with his sister and niece for quite some time, I found myself just sitting there by myself, and I felt really, really bad about that, you know, because I- I just not the type of person to just go up and start a conversation. I'm not a very good conversationalist, so" (CS6/L87-96). I asked if it was different for her when she knew a lot of people at the party. Karen said, "well, it just depends. Umm, even when I am- I am with people I'm with I don't tend to talk very much. I'm a thinker. I'm more of a thinker. I think a lot" (CS6/L102-105).

Discussion turned to how Karen thought that she may have changed over time as a person. Karen's response to this question was an immediate affirmation that she was taking her medication – "changed as a person, umm yes, I'm well aware that I need to take my medication to keep well" (CS6/L111-112), but she then said "when I think back over the years, as a young child and teenager, and I think about different situations, I realise that I was, was sick then but didn't really come to the surface until about 10 years ago" (CS6/L114-117). I asked if she reacted to situations differently now as compared to back then, and Karen replied "umm, so long as I took my medication. When I'm not well I don't, I don't know it. Do you know

what I mean? The way I'm acting is, is a real thing for me. Whatever is happening around me, or in, in my head is real, but now that I'm better after taking my medication, I do look back on certain situations and sometimes I find myself thinking, umm did that really happen or didn't it really happen" (CS6/L122-133). Later, when talking of major experiences that stood out in her mind, Karen returned to her experiences of illness. "There were things that when I was sick that were happening that stand out in my mind, like I thought I was being followed. I thought my house was bugged. I thought I had a TV lens in my eye and a hearing device in my ear. All those things tend to stand out. Thinking things were happening when they really weren't happening" (CS6/L355-366).

From talk of experiences of illness, Karen went on to speak of the effect that it had upon her life. "I've had jobs, or I've lost work because of my illness, and I tried going back to work this year, but I just was, couldn't do it. I tried doing some work experience, but I found myself that I just couldn't do it. It was too much, physically as well as mentally" (CS6/L135-149). We talked about how Karen currently felt about herself, and moved on to talk of her future. Karen said, "I tend to take one day at a time" (CS6/L173). I responded that she did not look too far into the future, and she said "well, I do. I do, yes. I worry about different situations, which I really can't bring up, umm what, personal, personal things I really can't talk about, umm about the future. I find myself really not talking about it except for keeping it to myself" (CS6/L175-184).

In terms of how others might see her, I asked Karen for her family's perspective. Karen replied, "umm, pretty easy going, to get along with. Uhh, they know I've got mental problems, so they tend to treat me with a



little bit of ease. There are a couple of members of my family that don't understand my situation, which I find very frustrating, because they're not understanding what mental illness is all about, even though you try to explain it. It's like my sister. She's in hospital at the moment. She had open-heart surgery a couple of weeks ago, and she has a psychological problem as well. Just going through the, the experience that I've been through, and knowing what, what help there is and what help there isn't. I, I been trying to stress to my family to get the doctors to look at my sister when she's physically better, to look at her mental situation, because she's not cope- she can't cope at home. Well, specially now since she's had the operation, but, but because she wasn't coping mentally, it showed in her, her, her life. Like, she wasn't keeping her house clean, and she was takin valium one an hour, and umm, so I ge- I get a little bit frustrated with my family when I try to explain to them what mental illness is all about, and they're still not really listening" (CS6/L274-314).

We then went on to talk of any change in Karen that she thought her family might have noticed. "Well, they have noticed because I'm taking my medication that I'm, I'm, I'm a more be- better person for it. Umm, they could pick up on different things that were wrong when I was sick. The- cause they were the ones that put me into the mental institution anyway, against my will. Umm (voice quavering), sometimes I'm not- I don't feel very happy about that. Different things go through my mind, and so I have days where I think about negative things instead of positive, umm but I'm sure they can see the difference in me since I've been taking my medication. I haven't umm I haven't had a relapse for a couple of years now, so" (CS6/L326-346).

## Scott

Scott indicated that he was a single Anglo-Australian male, aged between 28 years and 37 years old. He lived with his parents, did not have any children, and was unemployed. It appeared that Scott's main objective in talking with me was to tell how his problems had disrupted his life.

Scott talked of being 'quite alright' before his problems began. He stated that he had trouble learning, and I was unaware of this before the interview. During our talk, he showed difficulty understanding the questions: "some I can't understand. Some of them it's a bit hard" (CS7/L248-251), and I found myself rephrasing much of what I was asking him. Yet, he appeared to have no difficulty understanding and filling out the written demographic form before the interview commenced. He did miss a question on secondary diagnoses though, and his difficulty with verbal language resulted in a short interview.

Scott did not attend the service centre on a regular basis, but went to functions such as the barbecues and dinners. From this, I gained an impression of Scott as a very frustrated young man, who had many problems and few solutions. He appeared to be a lonely, isolated young man, who had difficulty understanding others and this seemed to hinder his ability to form relationships and make friends.

In describing himself, Scott said, "uhh not confident enough, umm good to people, don't hit anyone, you know. That's about it" (CS7/L23-28). I asked for his likes and dislikes, and he replied "well, I like driving my car, you know. Umm I wanna do scuba diving but I can't causa my illness, so the doctor says why don't you do skydiving, and you know, I haven't done it. I should do it" (CS7/L31-37). Further into the interview I had asked

Scott how he felt about himself, and he responded with "lonely" (CS7/L78). We went on to talk of how he saw his future, and Scott said "I hope to get married. Well, some people never get married, I know that. I don't know my future" (CS7/L84-88). I suggested that some people marry later in life, and Scott added "I wanna become a dad one day if I can, you know. I hope" (CS7/L92-96).

I moved on to ask if there was anything that Scott did now that he did not do before his problems began. Scott replied, "No, no, I I should be doing a hobby or something. I should be workin. I can't get a job, labouring, you know, I haven't got an apprenticeship" (CS7/L104-111). I suggested trades assistant work where he would not need too many qualifications, and Scott said, "yeah, I know. I've been tryin to get nightfill but I I jus, I've tried so many times to get into nightfill but I can't" (CS7/L118-119).

In talking of his mental health problems, Scott gave comparisons of past and present. I had asked him if he thought that he had changed over time, and he said "no, before me illness I was quite alright, but now I got an illness. You know, nothing, nothing's not that excellent" (CS7/L55-58). I asked if Scott thought he was a different kind of person now, and he said 'yes'. Searching for more information, I asked in what ways he thought he had changed. Scott said, "well, uhh, sometimes arguing with my mum. I didn't really argue with her before I got ill, you know" (CS7/L66-70). Later in the interview, when talking of whether his friends and family might have noticed a change in him, Scott spoke again of his mother - "yeah, I whinge to mum sometimes, I, you know, I got to stop it" (CS7/L171-172).

When I asked Scott how he thought that friends and family members might describe him as a person, he did not appear to understand the question. I rephrased the question to ask what kind of a guy they would say that he was. Scott replied that he did not know, and I repeated his words back to him. He then said, "There's only two cousins that don't really like talking to me, and the rest do, you know? They, they know I have trouble learning, so they don't really talk to me, you know" (CS7/L136-141). I suggested that he did not really get along with them, and Scott said "they just don't talk to me" (CS7/L145). I asked if he got along with his family, and Scott said, "yeah, yeah. Som- umm mor- my cousins, my other cousins talk to me, and my aunties and uncles. There's just two, you know" (CS7/L147-152). I commented that you cannot get along with everyone. Scott continued, "They, they did talk to me, but not very nicely, you know, yeah" (CS7/L156-158).

To gain an idea of the impact of others upon Scott, I asked him if he thought that friends and family influenced the way that he felt about himself. Scott did not understand the question so I rephrased this and became more specific, asking about things said to him that may affect the way that he felt. Scott said, "well, there is a friend that devastated me. He stole money off my mum and took off you know, so that, that's one thing. I still- he's still like a brother to me. Yeah, I know he devastated me, but if they catch him and put him in gaol, he'd pay his debt. You know, I'd still be a friend to him" (CS7/L182-193). I said that the friend had made a mistake, and Scott continued, "yeah, my mum doesn't trust him anymore, but you know" (CS7/L195-196). I went on to the next question of major events that had occurred in Scott's life, rephrasing this as 'big things', and asking if

there was anything that stood out in his mind. Scott said that ‘nothing big’ had happened to him and the conversation petered out, so I returned to the friend that he had spoken of, which Scott picked up again quite quickly. “He's the only best friend I've got, you know. I used to have more friends at school, but you know what happens. One- you know, they just go” (CS7/L205-211). I asked about his making different friends, and Scott said “yeah, well, I've made friends here but then, they're not exactly friends” (CS7/L216-217). I clarified if he socialised with other consumers at the service centre, and Scott replied “Well, I should ask them if they wanna go see a movie or go to speedway or something, you know” (CS7/L219-222).

## **Rick**

Rick indicated that he was a single Anglo-Australian male, aged between 28 years and 37 years old. He had children who did not live with him as he lived alone, was unemployed, and in addition to a diagnosis of schizophrenia, had been diagnosed with a secondary substance-related disorder. Rick’s dialogue surrounded his past experiences with drug addiction, friends and family, and stigma and discrimination. Rick spoke of the conflict in his life, through drugs, family, and mental health. A change in self appeared to be the focus of his tellings. From his perspective, mental health workers knew him well – there was nothing wrong with him, and he believed that he had changed for the better as he had seen it all.

Rick did not attend the service centre often, but over time, I found him to be a likeable, friendly man, who tried hard to be helpful. Staff members told me that he could be unreliable on occasion, and said that it was possible that he would not turn up for the appointed interview. I also

saw Rick as an insecure man, as quite defensive, and often he would take casual comments made by others very personally. In this sense, Rick would react first and think about the consequences later.

Early in the interview I had asked Rick if he thought that he had changed over time. He said, "I had a lot of problems as a child, but I'd rather not get into that. Umm, basically, what changed my life was going clean. On top of the mental illness, I had a drug addiction for- drug and alcohol abuse and substance abuse, and uhh alcohol and drug dependent for over ten years, so to get- kick that habit was- I had a cocaine and speed habit. Well, basically cocaine and pot use and all that sort of shit, but I'm past that now. I used to- I used to take- oh, I dried out when I was about 21. Started dryin out only on the (mumbled) (voice breaking) my nana, who's no longer here (voice breaking), but yeah, it took me many years and even now I still get cravings. But I st- I got off the cocaine and did the pot for a few years to take the edge off the (mumbled). Instead of doin harder drugs I'd rather use a substance that was not as hard to get off, and umm I've had maybe one or two pots in the last six months. Well, I've got to go for drug tests oh- In my last job I had to go for drug tests once every six to twelve months anyway, and I had to stay off it. I had no choice" (CS8/L47-82). I commented that some jobs demand drug tests, and Rick replied, "It was either that or lose my job" (CS8/L84).

Drugs were an issue when Rick spoke of friends. I had asked Rick how his friends and family might see him now as compared to before his problems began. He responded, "I don't, I don't really know. I've had a friend of mine of 30 years give up a friendship. Umm, I don't, I don't particularly know. A lot of them now, I don't particularly care either"

(CS8/L170-175). I inquired if there were a lot of people that he no longer associated with, and Rick said "yeah, there are a lot of friends that I don't have a lot to do with because of the old adage, basically" (CS8/L180-183). My response of them not understanding was corrected, as he replied "no, a lot of them are ivory drug users, ones that don't wanna get off the shit" (CS8/L185-187). To my comment that he had moved past that, Rick said, "well, I have tried. I've moved past that. Now that I've moved out of that life, I don't wanna go anywhere particularly near it, sort of thing. I'd rather not see em. I do have a contact with a few that I used to go to school with, but they're still ivory drug users. My best mate was an ivory drug user and still is, for many years, but I've had too many good friends and family die of- or good friends and mates, sometimes family, die of overdoses or some sort of link with drugs to do with their death, so" (CS8/L189-202). He continued, "even though I myself saw people commit suicide a few times. One got murdered through drugs, a couple OD'd in front of me, and I've picked street kids up off the street who've had epileptic fits not taking their medication and shit like that. Yep, working for a charity- I worked for St. Pat's for like two and a half years before I come back here [service centre], and we- that was part of our job, was to pick em up off the streets basically, where they collapsed" (CS8/L208-220).

I had responded that Rick possibly had a better idea of where these people that he had picked up off the streets were coming from. Rick answered that he did not always know, and then went on to talk of an incident that happened during his time working for St Pat's. "I think- I think one day there I was working on the floor room. Some young bloke come in. He was wantin somebody in the centre, that was in the centre, and

he come in with an axe handle in his hand, wantin to find this certain bloke, and I was working on the floor that day on me own, and what am I supposed to do on me own (laughing)? You come to the door with a fuckin nine foot axe handle, I'm lookin for ra ra ra, carryin on. How'm I fis- sposed to diffuse a situation like that on my own?" (CS8/L231-244). I agreed that it would be very difficult, and Rick replied "Just the other end of drug abuse, a lot of times" (CS8/L247-249). I suggested that in his position he would get to see both sides. Rick said, "A bad deal or whatever. I've seen it all, I've seen it all" (CS8/L251-254).

A little later I returned the conversation to talk of people that Rick did not get along with anymore. Again, he focused on friends and talk of drugs, saying, "a few, yeh, yeh, oh then again, I don't really wanna see a lot of em anyway. I only keep ones that sort of still- like I'd like to keep as friends, but you know, what can you do? They're smackin a needle up their arm 24 hours a day. But I don't need that. Too much of a temptation. Not, not in the needle aspect, but the drugs. You can snort cocaine as well as you can snort heroin" (CS8/L277-287).

After Rick's initial talk of his addiction to drugs and alcohol, we went on to talk of how he currently felt about himself. Rick commented, "I still have to put up with the stigma of mental illness, even from my own family. It's just my- my family's told me straight out in front of people I'm a burnt out unit, that I don't really bother" (CS8/L88-92). I asked him how he felt about that, and Rick replied, "What's the point? What do you do? What are you supposed to do? How are, how are you as one person gonna change their, their thinking? You just can't do it. You're wasting your time" (CS8/L94-101). I commented that his family would say such a thing



in front of people, and Rick continued, “Yep. Well, my nurse, my, my brother is actually a nurse, so he should have some insight. He's done the mental health shit. He should have some sort of insight into mental illness, and he said straight out I'm a burnt unit. So yeah, ever since then I just have very little to do with my family at all” (CS8/L103-112).

I then asked how Rick thought his family would describe him, and he stated, “I don't know. My mother sort of walks in and walks out of my life when she feels like it, and I'm not willing to put up with that, so I would rather if she can't be in my life full-time, well, don't bother” (CS8/L115-119). I moved on to other members of his family, suggesting that his brother might not have a very good opinion of him, and Rick said “no. My sister, I don't really know what my sister thinks but I've ou- I've asked her once and everybody reckons that me as a brother, even though I'm different, is like, 'I don't care, I love you, you're my brother'. When, when it comes to my mum or my sister and that, and my step-father, when he was alive we never got on. Never saw eye-to-eye, but yeah, he was a real asshole to me anyway. He was always good to the kids and me sister, though. When it came to me or anybody else, yeah, got buckleys” (CS8/L88-136).

As Rick has raised the issue of stigma and discrimination earlier, I inquired how bad Rick found this to be in the workplace. He replied, “Well you get that all the time. You get used to it after a number of years” (CS8/L296-299). I asked whether it was the general community that he was talking about, and he said “no, not always. You do get it in the workplace as well, but not as much. If they don't know, well, but some people can pick it, some people can't. Some people can pick that there's something wrong” (CS8/L299-308). We talked of different reactions from different people,

and Rick said "Some people just take you on face value and leave it at that, you know. Lot of people don't really care where ya- what ya brain's like" (CS8/L316-320). I suggested that perhaps others had problems of their own that they were dealing with. Rick responded, "well, everybody's got problems. No matter what, everybody's got problems, family, every single issue. Somebody's got a problem somewhere. There's always somebody worse off than you are (laughing)" (CS8/L323-331).

We went on to talk of how Rick saw his future, and he said "Don't, don't really know what my f-future holds for me at the moment. Apart from, well, I got into a rental on my own. Got my own place. I'm renting here in (suburb) and umm, yeah, I don't know where I'm going from there. Umm, I've gotten a list- my name on a list for Homes West in (suburb) housing. That may take some time" (CS8/L338-347). I remarked that sometimes it took years. Rick replied, "Well, that's the other thing too. Sometimes it's just a matter of waiting on the waiting list, and that's all you can do. Can't do any more than that" (CS8/L351-353). I agreed, suggesting that it was a 'hurry up and wait' kind of situation.

Rick then introduced an incident that had occurred in his past. He said "well, I'm heading for Homes West. I've already lost a Homes West house once and umm, it came down to the fact is, you know, check your fuckin records. See how old it is, and they did, and they suddenly realised that Mrs Jones, my other mother, had put one- a claim in for me when I was 15. I didn't see my house until I was 32, so I was on the list for fuckin 17 years. Yeah, they only just realised that my name coincided with that one, and yeah, so I wrote a letter in the local paper, and went to see my local Member of Parliament, and says, 'right, now, what are ya gonna do? It's

your job on the line here mate. What are ya gonna do (laughing)? You're the Member for local housing. I've been sitting on this ho- on this list for 17 years, and you haven't been bothered to get off your ass and tell me where me other mum was'. So, I think within three months, I had a house, rather quickly (laughing). Oh well, it was mainly, the main reason was righteo, fair enough. I've gone to the local paper. How would you like me to go to the West Australian [major newspaper] and Channel Seven? Cause I've done it before and I'll do it again" (CS8/L341-395).

During the interview I asked Rick's opinion of the support staff at the service centre, and he spoke of his relationships and interactions with the two male staff members in particular. "Umm, I've had a run in with Mike [support worker at the service centre], long, long time ago, and yeah, I got over that (laughing). Uh yeah, but I actually used to work with Luke [support worker at the service centre] many years ago, in the, in the old industrial organisation that used to get run by mental health. I used to work for them- worked for them for about three, four years. I used to work under Luke" (CS8/L139-153). I remarked how it was amazing that they had met up again many years later, and Rick said, "I was actually the next in charge from Luke at one stage" (CS8/L156). I asked if they got along okay, and Rick replied, "yeah, most of em. I don't see a lot of em anyway (laughing). I only have contact with a few members of staff basically anyway" (CS8/L158-160).

In regards to staff members, I had asked Rick if he felt that there was a difference in the way that professional and non-professional staff members treated him. Rick said, "uh, it all depends on their hierarchy" (CS8/L402). I asked if this was a difference between clinical and non-clinical staff, and

he replied “not really. I know most of the clinical staff anyway, quite well. Umm, most people in the hierarchy down here I know anyway. Most of them were nurses or student nurses in Heathcote or Graylands. So, I know most of the staff members by first name anyway” (CS8/L405-413). I went back to the question that I had posed and confirmed that Rick did not feel that he was treated differently according to the position of the staff member. He replied, “nuh, nuh. Well, they've known me since I was 12, 13, so they know what I'm like, they know where I've come from, they know the case history, the whole lot just (snaps fingers) like that. They don't have to look in a file, they know it straight up. Even a lot of the hierarchy in Fremantle Hospital I used ta- be nurses, student nurses, in Heathcote. Yeah, I know all of the staff off the bat, so, oh, which in other times is bad cause they know me that well that (laughing) I can't get what I want sometimes. They'll tell me like straight out, yeah, I'm in- yeah, I'm here, 'what are ya gonna do'? They just, straight out, 'fuck off, we don't want ya (laughing). There's nothin wrong with you' " (CS8/L405-439).

## **Deb**

Deb identified herself as a single Anglo-Australian woman, aged between 28 years and 37 years old, with no children. She lived with her parents, was unemployed, and had been diagnosed with a secondary anxiety disorder. At the time of the interview, Deb did not have a car and was unable to attend the service centre. For convenience, we conducted the interview in my car, outside of her local mental health service. Deb spoke of her emotional problems, how they began and her experiences with them.

She spoke of her fears, her need to belong, and gave her perspective of the people at the service centres she had attended.

My impression of Deb was of a friendly, vivacious woman, yet a very worrisome woman. She commented that others had told her that her personality had changed for the better, and although she acknowledged an improvement with her problems and relationships, Deb said, 'I'm not really the same' (line 111-112). From Deb's perspective, there may still be a long way to go.

Deb attended the service centre on a regular basis, and in her conversations with others I noticed that she generally tended to place her troubles into the background, focusing on the other person's issues. If the occasion arose though, she was quite forward in discussing her own problems. It was also very evident that Deb did not like change, that she liked the familiarity of routine. Her impending discharge from the service centre had evoked a large amount of worry for her, as this was a prominent topic of discussion with others at the service centre.

After describing how she saw herself, I restated her comment of being happier and invited her to expand upon how she might have changed over time. Deb replied, "yeah, my personality, everybody who knows me in the past five year period has said my personality's changed for the better. Yeah, I was very intolerant towards people and I was very judge-judgemental, and I umm used to take offence quite easily" (CS9/L42-49). I asked if that was how other people saw her, and whether she noticed this in herself. Deb said, "no, I didn't notice that. I thought I was, you know, quite normal (laugh)" (CS9/L42-59).

In talking of a change in herself, Deb spoke of being more open to experience now. She enjoyed travelling and had talked of her second trip to England, and I clarified whether this trip had occurred before or after her problems began. To better explain the change in herself, Deb talked of her childhood. "Umm, yeah, I was- I been- I've never been happy. Umm, like, in high school, umm I was constantly picked on and bullied, umm and I was always put in the slower classes. I- I knew I could do the work, but I couldn't concentrate for very long, and nobody picked up on it. So, I had a whole lot of trouble at school" (CS9/L400-408).

Deb also spoke of her childhood when I asked her if she thought that others such as friends and family might influence the way that she saw her self. She responded, "Nah, I've always been an individual. Yep. Nah, nobody's- umm nuh, a lot of umm their beliefs have been put on to me but if I don't agree with it I don't agree with it, you know what I mean? Yeah, I make up my own mind if I think it- if that's right. Like, we were forced to go to Sunday School, and I think that's wrong because it should be a choice, and she [mum] said, 'when you turn 13 you don't have to go', and so I didn't go (laughing). Yeah, and they were umm, they're not anymore, but when we were growing up we used to go to church quite regularly, and I used to absolutely hate it" (CS9/L475-483). I asked if she had always felt that way, and Deb said "yeah, umm if somebody was doing something brand new, I'd do something totally daggy. I'd, I'd be the opposite. I never used to follow the trends or anything like that. Yep, don't know why, but (laughing), I used to be stubborn I think" (CS9/L489-497).

After talking of her trouble at school, Deb went on to speak of her family and how she believed her problems began. "I always felt like my

family didn't understand me, cause I couldn't talk to my- the only pa- friends I had were like my grandparents, and then umm I had to look after my granddad, who was dying of cancer. My nana was in hospital, and that's when I started getting freaky, cause I thought 'I don't want em to die when I'm looking after em', and umm, I couldn't sleep. Umm I couldn't go out much because I didn't have- oh my mum was really good but, you know, just to go out for half an hour an- by yourself. To not have to worry about him for half an hour (laughing), and umm, yeah, just no- I had no respite at all, hardly. Umm yeah, and then I started drinking” (CS9/L409-427). I commented that it would have placed a lot of stress on her, and Deb replied, “yep, and then umm that's when I started hearing voices, and umm I- the TV was like sending out messages and the radio was sending out messages. Umm I thought everything was booby trapped in the kitchen (laughing), and I thought the electrical appliances were something really horrible with, and that's wi- that's the only part I can remember. The rest of it I don't really remember much, yeah but I get like flashbacks and that now. Like, wooo, I remember that (laughing). Apparently I chucked my sister's mobile phone down the toilet (laughing), cause it was an electrical appliance and I go- it- she's about to use it and I go, 'no, you can't use it', shooo, threw it down the umm toilet (laughing)” (CS9/L431-454). I laughingly stated that I bet her sister was not happy, and Deb agreed saying “She wasn't very happy. Yeah, so, that was freaky” (CS9/L409-458).

Problems talk also occurred earlier when I had asked Deb if she found any difference between the ways that professional and non-professional staff members might see her as a person. Deb repeated, "see me differently. Well, I didn't realise that they knew my case history at

(service provider). I was (laughing) so I- yeah umm I- my psychiatrist, I've got a really good rapport with him now, but to begin with I was very- I didn't trust anybody in the profession because I thought they were all out to get me, cause I was very paranoid, and I didn't wanna tell em what was wrong with me cause I would- I had this really big fear that they were gonna lock me up at Graylands, cause I had this really (shaky voice) bad. I was thinking these horrible thoughts and everything like that, and I didn't want them to find out what I was thinking because I knew they were horrible things but- when they fin- when I finally started to open up and that, yeah, I considered it the same really" (CS9/L265-285). Deb said that she felt comfortable now but had reservations at first. I asked who she warmed up to first, and she said "umm, my psychiatrist. Yeah, yep, cause I was in hospital for quite a while so I was seeing him and someone from (name of a service provider) on a regular basis. So, when I first saw him I told him to get stuffed, I don't need to see you'se (laughing), and by the end of it I was like, I was actually tryin to make extra appointments so I could say stuff" (CS9/L295-304). I asked whether it was to let them know how she was feeling, and Deb said "Takes me a lot to trust people cause I been hurt so much previously with friends and boyfriends and all that. I can't trust people very easily" (CS9/L308-312).

This issue with trust was explained a little further on when I asked Deb about any major events or experiences that stood out in her mind. She asked if I was enquiring about good or bad things, and I said either. Deb replied "Either? Umm, well it was like a good thing and a bad thing. I u- I was umm, for my 21st I got to go to England and umm, but my boyfriend at the time kept on ringing me every day saying 'come home, come home,



come home'. So, I was supposed to go there for a year. I was there for six, umm seven weeks, came back home, and then I found out he slept with my umm best friend (laughing). Yeah and I said 'why shouldn't I- why didn't I stay in England'? (laughing), and umm yeah so that wa- the highlight was that I got to travel, which is a passion of mine, and the second thing is I found out how rotten guys are (laughing). So, I've been single- I've had boyfriends on and off, but seriously, I prefer to be single. It's umm a lot happier. You're either a- umm he was always abusing me and umm, yeah so I'd rather be by myself and have a couple of good girlfriends, and that's it (laughing)" (CS9/L323-350). I commented that it sort of fed into the trust issue that she had been talking about. Deb said "yeah, cause every time after- I noticed umm after him, umm all my other boyfriends, I jumped the gun and dumped them because I didn't wanna be the, you know, dumped on again cause it hurt too much, and there was this one guy that my dad really liked. He goes, 'why did you get rid of him for'? (laughing). Funny enough, I was actually going back to England and I says 'I wanna have a good time', and so I dumped the poor guy (laughing). So, but that's just umm uhh, you know, me" (CS9/L355-369).

Deb focused on family when I had asked her how she thought friends and family might see her. She had been talking of working through her problems, and socialising more. "My family and I now get along a lot better. Umm, we, we were always fighting before cause umm, now they understand why I was like that. They understand the problem and I can tell mum things now. Like, before I couldn't really say how I was feeling, and I can- even my dad now. Now I've got a good communication thing going, and they know when I'm not well, even if I don't know it myself. So, like

before I thought they were just being annoying and saying 'you're not well, you're not well', you know (laughing), but now I just listen to em. So, I used to have this huge wall against em, cause I used to think they favoured my sister" (CS9/L148-170). I asked how they might have described her in the past, and Deb replied "Uh, back then umm, oh they- like- a lot of umm, mmm, they would describe me as being umm impossible to live with (laughing). Umm, they were concerned about my drinking habits, cause I was getting into that, and umm jus- yeah, not very nice person to be around with" (CS9/L176-183). I then asked how her family might describe her now. Deb said, "umm, very umm, very umm, giving person cause I get-give a lot of time to people now, yep, and they're- they're just glad that they umm, they know what's wrong with me, cause now they can understand me, yep" (CS9/L187-194). To my comment that it would make things easier for them, Deb added "and I understand me a lot better now too" (CS9/L196).

We went on to talk of how support staff at the service centre might see her, and Deb laughed, "oh, now, umm I tend to liven things up actually, when I'm at [service centre] (laughing). Uh, they're giving me the responsibility of doing the volunteer library, umm which I did last year. Haven't done so much this year cause I try not to go in there so much cause they wanna discharge me from there now. Umm, but- nah- I've- every- I've got lots of friends. There's only a couple there that I totally have got no time for, but the majority of the group there is really good, and I get along really well with Mel [support worker] and Viv [support worker], and-actually, I get along really well with all of them, yeah, so" (CS9/L204-219). Later talk revealed a comparison between the support staff at her current service centre and other centres Deb had been to. This came through

discussion of how Deb saw the current staff members. She said, "Yeah umm, yeah no, they're really great. It took me a while to get to know all of them, yeah. Yeah, they're like pretty much down to earth. I used to go to the one in Fremantle, and I was there for quite a while cause I used to live in Freo, umm and when I went- you couldn't have the, you know you can't- couldn't have the, jus the conversations that you do now" (CS9/L503-512). I inquired whether that had to do with the way that the service was set up, or perhaps the people who worked there. Deb responded, "I think umm the people down here are more easy going than up in Fremantle and all that, up that way anyway, so" (CS9/L520-521). I asked in what way were they more easy going, and she said "umm, they don't worry t- I mean, they're pretty laid back. They probly worry, but they're like laid back sort of people" (CS9/L525-527).

In her talk of her imminent discharge from the service centre, Deb explained her unhappiness. I had asked how she felt about it, and Deb replied "Depressed (laughing). I'm not very happy cause I'm finally umm, I'm finally- all my life I've never really felt like I belong anywhere, and at [service centre], I feel like I bel- I belong there. Yeah, so- and they don't judge ya, you know, and if you wanna have a bit of a whinge, you know, I'll just get one of my friends and sit outside and have a coffee and have a good old whinge, and you feel better (laughing). Yeah, so, no I'm- I'll miss it, cause umm, well when I first got there I I used to go in there for about five minutes and umm, I'd just say- I'd panic and I'd just leave (laughing). Yeah, but now I stay- can stay there for nearly a whole day, so" (CS9/L229-248).

The biographical sketches presented here work to introduce the primary participants of this study to the reader. My presentation of their life stories provides the context in which I can then examine their sense-making and constructions of self identity and relationships. The way in which mental health consumers renegotiate their self identity once a diagnosis of schizophrenia has been received will be explored in the next chapter.

## CHAPTER 4 – Constructing the Self

*“The self, then, as a performed character, is not an organic thing that has a specific location, whose fundamental fate is to be born, to mature, and to die; it is a dramatic effect arising diffusely from a scene that is presented, and the characteristic issue, the crucial concern, is whether it will be credited or discredited”*

*(Goffman, 1959, p.252-253).*

The self as a social performance, indicated by Goffman (1959), needs others, an audience, to validate it. In this way, a person's identity is not intrinsic and unchanging, as many different constructions of self will emerge through conversational sequence (Adams, 2003). A person's sense of self is embedded in the social contexts and interactions in which they find themselves; thus, people tend to present themselves in a socially positive light to invoke acceptance rather than rejection. For people with mental health problems, their versions of self have been questioned through diagnostic labelling, resulting in a diminished sense of self and identity (Goffman, 1959) due to the negative connotations associated with mental illness. The negotiation and construction of a more socially acceptable self occurs through relational interaction.

In participant's descriptions of themselves, I have attended to what the person has said to me. That is, to the content of their descriptors. I have also taken note of the functional aspect of each account; to the situated deployment of discursive devices bringing about a particular view of themselves. My focus in this analysis was on the ways in which primary participants oriented their accounts of themselves to the overarching

emergent themes of needing to rationalise and normalise their behaviour and experience. That is, people tended to rationalise themselves by engaging in sense-making activities to manage their behaviour and personal experiences. They then proceeded to normalise themselves by likening themselves to others in the general community, all working to reduce stigmatisation.

### **Rationalising Self**

As discussed in Chapter One, clinical descriptions and social stereotypes of people with schizophrenia emphasise instability, erratic behaviour, and disordered and bizarre thoughts as possibly biological characteristics of people diagnosed with schizophrenia. Acting as a counter to this image of an irrational self, three major sub-themes emerged from primary participants' descriptions of themselves. Participants attended to the issue of continuity between past and present selves. Although most participants noted changes in aspects of themselves over time, care was taken to account for any such changes as having been the (reasonable) result of some change in physical, personal or social circumstances. Potter, Edwards, and Wetherell (1993) suggest that careful attention in the use of 'personal history' resources indicates that a major issue is at stake; for the participants in this context, the issue appears to be the production and protection of a coherent and reasonable self. Participants also made frequent use of a sick identity in accounting for past behaviour. This provides a justification for problems and behaviours.

### Sense-Making: Explanations of a Troubled Self

In Carol's accounts, emphasis was placed on her physical problems, and these were put forward as the main source of her emotional problems. When asked of major events that had occurred in her life, Carol gave a list of physical operations that she had undergone. An inquiry as to how she felt about herself now, revealed that she was happier, more relaxed, and that she liked herself much more. Focusing on this latter comment, I concluded:

*Extract 1. (Sue-Carol/CS5/L121-132)*

- 121 S: so you didn't really like yourself before  
 122 C: ʘnahʘ ((whisper)) (0.5) not with the hurt and the anger and  
 123 the pain that I had and everything it just- I was just- (0.5) I  
 124 reacted to things all the time and I had (.) pressures and  
 125 stuff that I was overreacting to  
 126 S: mmm  
 127 C: which is where me illness came in I think it started from  
 128 post natal depression but  
 129 S: yeah  
 130 C: it was never picked up in the young- early days considering  
 131 I tried to get the help (0.5) but ʘnuhʘ ((whisper)) (.) nothin  
 132 happened

This extract centres around providing an explanation for negative experiences in Carol's past (see Potter & Wetherell, 1987 for a full account of blamings). Carol described herself in the past as hurt, angry and in pain (past and present selves will be investigated more thoroughly later in the chapter). First, there is a justification for the hurt, anger and pain that she talked of through an explanation of reacting to 'pressures and stuff' (lines 124-125). That is, it would be typical to react to pressure that brought about such intense feelings and pain. Yet Carol is critical of this past self in that

she inserts that she was 'overreacting' (line 125). This works as a moderator of blame (or what Edwards (2000) would call a 'softener'), suggesting that she could have reacted differently, and perhaps her reaction at the time was extreme. In the same sentence though, there is an attribution of causality for the psychological problems that she has had. Carol states that this 'is where me illness came in' (line 127), attributing causality to post-natal depression. Carol then concludes the blaming, stating that 'it was never picked up in the young- early days' (line130). 'It was never picked up' manages to blame someone or something (perhaps the health system itself) for failing her, and once again, a moderator is used with the addition of 'early days'. This acknowledges non-diagnosis as being a common occurrence for this problem, yet the blame is still established. Finally, Carol manages personal accountability (see Potter et al., 1993) as she states that she 'tried to get the help' (line 131), but 'nuh' ((whisper)) (.) nothin happened' (lines 131-132). In this way, Carol conveyed that the negative experiences and patterns that she had experienced in the past were not her fault as they were triggered by an external cause (post-natal depression), and she had tried to 'get help'. This help was not forthcoming, so once again, others had failed her, reinforcing the blaming.

Drawing upon past events, this account explains Carol's disdain. Presented in logical sequence, Carol showed herself as having been troubled, yet as having awareness and insight into her problem. In her account she attempted to do something about that problem, received no assistance, and concluded with a blaming of the health system that she believed had failed her. Past hurt, anger and pain then, had produced this troubled self.



Deb also gave an explanation for her problems. My talk with Deb prior to Extract 2 surrounded her account of a trip to England, and issues of trust with past boyfriends. She had since visited England a second time, and from this I asked:

*Extract 2. (Sue-Deb/CS9/L397-427)*

- 397 S: so (.) was that sort of (.) before or after (.) you started  
 398 having a lot of problems and ended up in h[ospital?]  
 399 D: [u::m y]eah (.) I  
 400 was- I b↑een- I've never been happy  
 401 S: mmm  
 402 D: u::m (1.0) like (.) in high school (.) u:m I was constantly  
 403 picked ↑on and bullied (.) u::m (.) and I was always put in  
 404 the (.) slower classes I- I knew I could do the work but (.) I  
 405 couldn't concentrate for very long and nobody picked up on  
 406 ↑it  
 407 S: mmm  
 408 D: so I had yeah a whole lot of trouble at school (1.0) u::m  
 409 (0.5) yeah (.) and I always felt like my family didn't  
 410 understand me cos I couldn't talk to my- the only pa-  
 411 friends I had were like my gr↑andp↓ar↑ents (.) and then  
 412 u::m (0.5) I had to look after my grandad who was u:m  
 413 (0.5) dying of cancer my nana was in hospit↓al (.) and that's  
 414 when I started getting freak↑y  
 415 S: mmm  
 416 D: cause I thought (.) I don't want em to die (.) when I'm  
 417 looking after ↑em  
 418 S: yeah  
 419 D: and u:m (.) I couldn't sleep (0.5) u::m (.) I couldn't go out  
 420 much because I didn't have- oh my mum was really good  
 421 but (.) you know (.) jus (.) to go out for half an hour an- by  
 422 yourself (.) to not have to worry about him for half an  
 423 h(h)our ((laughing))  
 424 S: yeah

- 425 D: and umm yeah (.) just no- I had no resp<sup>↑</sup>ite at all (.) hardly  
 426 S: mmm  
 427 D: u::m (.) yeah and then I started drinking

In this passage of talk I had instigated the issues of problems and hospitalisation. Deb did not answer the question directly though. Instead, she began an explanation of self, stating that she has 'never been happy' (line 400). Deb draws on past experiences, such as being 'picked ↑on' and 'bullied' (line 403) in high school, and being placed in 'slower' (line 404) classes to account for her unhappiness. This invokes reason and rationality for her audience in that no one would be happy in such a situation. The latter part of the passage shows the use of an extreme case formulation (Pomerantz, 1986, see later explanation with Extract 3) with the use of the term 'always' (line 403). To say that she was 'always' placed in the slower classes acts to compound her unhappiness, suggesting a lack of choice in the matter. Deb then states that she 'knew' (line 404) that she could do the work, but presents the self as having had a problem in not being able to concentrate in her high school years. This background information works to set up the talk that followed. Deb has presented herself as being unhappy in her younger years, and much of this unhappiness was due to the behaviour of others. Others were to blame for picking on her, bullying her, and placing her in remedial classes when she 'knew' she could do the work. The blaming (see Potter & Wetherell, 1987) continues, as she told that her problems were not 'picked up' (line 405), and it appears to be directed toward the Education Department. The inference is that they did not help her when she initially had problems. They had failed her, and due to this, she had many troubles at school.

With the initial explanations for problems of self in place, Deb goes on to outline events that led to her diagnosis. In lines 409 to 410 Deb establishes a lack of understanding from family. Troubled talk is apparent when it looks like she was going to say that she couldn't talk to her parents, but stopped herself, instead proposing that her few friends were her grandparents (lines 410-411). This acts to set the scene of a lonely, troubled girl, whose only source of comfort was her two elderly grandparents. Deb then outlines the situation she was in at the time, and provides an attribution of causality for her psychological problems. Due to her fear that the only people she was close to would die while she was caring for them, she started behaving oddly. Her choice of terms for her reaction to the situation ('freak↑y' – line 414) is suggestive of an extreme, of something more severe than worry or anxiety. This draws an implicative link between events occurring at the time and her resulting diagnosis.

An interesting move occurred in the latter part of this extract when Deb spoke of her lack of respite in caring for her grandad. She started to say that she had no respite, yet stopped herself in mid sentence and inserted a reassurance that her mother was 'really good, but...' (lines 420-421). This was followed with a reinforcing claim that she had little relief from the burden of caring for her grandad. This section of the extract showed an awareness that an attribution of blame by others may be directed toward her mother. The underlying implication here is that her mother should have been taking much more responsibility for the caring role of the grandfather. Deb has introduced her mother into this talk, and although she did not directly blame her mother and worked to subvert this, the blame was set in place through underlying inference. To conclude this telling, Deb adds 'and

then I started drinking', suggesting that due to a lack of respite, she turned to drink to cope with the pressure.

Deb's account of her past experiences is organised around providing a rationale and legitimising explanation for her eventual problems of self. She presents a person who was troubled and had difficulty concentrating, a person who had few friends, yet was kind and caring, a person who was misunderstood, stressed and had little support, and a person who eventually succumbed to the pressure of circumstances beyond her control. The situated deployment of blame manages Deb as helpless in the face of the behaviours of others and unfolding circumstances. In this way, Deb was able to rationalise how her problems came about, and the effect it had on herself.

Ken, too, presented an account of himself by drawing from past experiences. I had asked about major events that had occurred in his life, and if any stood out in his mind. Ken responded to this question by presenting a brief synopsis of the key problems that he had encountered in his childhood, his teenage years, and early adulthood.

*Extract 3. (Ken/CS1/L291-323)*

291 S: okay umm (3.0) what else have we got (1.5) okay are there  
 292 sort of any kind of expe:riences or anything that you might  
 293 have had say umm in your life that sort of really stand out  
 294 (0.5) in your mind?

295 K: uhh (2.5) oh when I was a kid at a (.) place called Moffl↑yn  
 296 ◦which has all been (0.5) uhh knocked d↓own now but  
 297 >when I was a kid it was there< and uhh I went through a  
 298 lot of physical abuse◦

299 S: yeah (2.0)

300 K: I don't know (.) if I ◦went through sexual abuse◦ but

- 301 physical abuse was (mumbled)
- 302 S: m↑hm (0.5)
- 303 K: ◦I tried to commit suicide when I was a little kid◦
- 304 S: yeah? (1.0)
- 305 K: and then uhh h↑igh school was really bad (0.5) cause I used
- 306 to work on the farm a l↑ot
- 307 S: mmm
- 308 K: (0.5) I didn't look that good (mumbled) ((laughs)) (.) five
- 309 hours a day on the f↑arm
- 310 S: mmm ((smiley voice))
- 311 K: you know (0.5)
- 312 S: which a lot of kids wouldn't of had to do
- 313 K: no (.)
- 314 K: so I (.) because I was different they (.) the kids used to pick
- 315 on me and it (.) ◦took a long time for me to get that out of
- 316 my system◦
- 317 S: mmm
- 318 K: ◦then afterwards it didn't◦ worry me (mumbled)
- 319 S: mhm (0.5) okay
- 320 K: but then the army was like that as well (3.0) I don't mean to
- 321 be rude but it's called bastardisation and it's really b↓ad
- 322 S: yeah
- 323 K: ◦I'm lucky cause I seem to have grown out of that as well◦

Throughout this account, Ken invokes the image of a very troubled youngster with his statements of abuse and attempting suicide as a child. He uses several extreme case formulations to convey the severity of the issues he faced as a child and in the Army. First investigated by Pomerantz (1986), this particular device may be used to justify or defend descriptions, particularly if those assessments face challenge. Extreme case formulations may also show a speaker's investment in a particular issue, such as displaying certainty or determination (Edwards, 2000). Ken starts out by

setting the scene, talking of 'Mofflyn' (line 295), a children's home that he had been sent to early in his life. Here, there is a claim of physical abuse, and the extreme case formulation of 'a lot' (lines 297-298) conveyed that this had occurred on more than a couple of occasions. The personal impact of this abuse was given in his statement of attempted suicide, where he quietly presents; 'I tried to commit suicide when I was a little kid' (line 303). Ken previously spoke of being 'a kid' (lines 295 & 297), yet here there is emphasis on being a 'little kid' (line 303). This worked to stress how young he was at the time, and gave added impact to his resulting statement of his time in Mofflyn.

Ken described his high school years as not simply a bad period of his life, but 'really bad' (line 305). The use of an extreme case formulation here prompted justification for this statement. Background information is provided through claims of extensive farm work, resulting in poor physical appearance. This information sets up an image of Ken as having been subjected to a set of circumstances that led him to be very isolated in his teenage years. Having established the difficulties that he faced as an adolescent, Ken then went on to distinguish his current self from his past by reporting that he eventually got '... that out of my system' (lines 315-316), and that it no longer worried him.

Ken then turned to the third stage of his life presented in this account, his time in the Army. He compared the Army to his high school years, asserting in line 320 that they were similar. Further explanation came with the coupling of high school and Army experiences and the suggestion of bastardisation (lines 320-321), which inferred that Ken had been a victim of this practice both at high school and during his time in the Army. The

severity of this bullying behaviour came through another emphasis of ‘really bad’. Yet, for this section of talk, Ken does not speak of the impact that it had on himself. Instead, he quietly states, ‘I’m lucky cause I seem to have grown out of that as well’ (line 323). This last sentence works as a conclusion for the preceding information, as it suggests the resolving of problems through maturity. The declaration of ‘I’m lucky’ is in complete contrast to the rather bleak picture Ken had painted of his life. Another comparison between himself and others is drawn here, as others might not have been able to put such experiences behind them. Ken, therefore, has presented himself as one of the lucky people who have been able to do this, and reinforces a sense of satisfaction.

For Carol, Deb and Ken drawing on past events enabled the explanation of themselves and their problems. All three presented troubled past selves, where hurt, anger and pain, a lack of understanding from others, outside pressure, or abuse occurred. The issue at stake in these accounts was to present a credible and positive account of self, in which problems were acknowledged but attributed in a way that deflected blame from the person themselves, and allowed for optimism about the future.

### **The adoption of a ‘Sick’ Identity**

Explanations of themselves as ‘sick’ given by three primary participants worked to make sense of the self, and to account for both past and current events and behaviours. In many respects, accounts of a past self were incorporated into versions of a current self.

Karen and I had been talking about how she might describe herself, and she had outlined her behaviour in social settings. We then went on to

talk about changes that she had noticed in herself over time (Extract 4). I had asked her if she thought she had changed as a person since she first started experiencing problems.

*Extract 4. (Karen/CS6/L108-117)*

- 108 S: o↑ka↓y (.) umm (0.5) do you th↑ink maybe (.) that you've  
 109 changed (.) over time (.) say since you first started having  
 110 problems do you think maybe you've changed as a pers↑on?  
 111 K: (3.0) ◦changed as a person◦ (1.5) u::m (.) yes I'm well  
 112 aware that (.) I need to take my medication to keep well  
 113 S: mmm  
 114 K: when I think back (.) over the years (.) as a young child and  
 115 teenager (.) and I think about different situations I realise  
 116 that I was (0.5) was sick then but didn't really come to the  
 117 surface until about 10 years ago

Karen's first response was to show that she considers the key element of the question in repeating '◦changed as a person◦' (line 111), but then went on to give what could be taken as a defensive reply. She stated 'I'm well aware that (.) I need to take my medication to keep well' (lines 111-112). The emphasis placed on the words 'aware', 'need', and 'well' tie in with Australia's alignment to a traditional medication regime for severe emotional problems, where compliance in taking medication is often linked to insight into self and behaviour (see Baier & Murray, 1999; Lysaker et al., 1994). That is, by not conforming and taking medication to control the self, a person is deemed to show a lack of insight into their condition and the need to manage it. Karen's account then, can be seen to be oriented to heading off any possibility of a conclusion of lack of insight or non-compliance that might have been drawn about her.



Reinforcing the notion that she has gained insight into herself, Karen presents her reflection of past situations which can then be understood in terms of her past illness. She thinks back to her childhood and teenage years (lines 114-115), and presents her realisation that she was ‘sick then’ (line 116). This act of remembering helps to construct the role that she now fills – as a person responsibly managing a chronic mental illness – and is a powerful resource for making sense of self (Potter, 1996). Her telling that her sickness did not ‘surface’ (line 117) until about ten years ago suggests that it was always there. This assists with the notion of permanency, highlights the need for medication, and abdicates her responsibility for control of self. That is, she presents herself as having always been sick, and therefore, her personal history and past behaviour is accounted for in terms of this relationship to the identification and management of her illness.

David also drew on elements of the notion of a 'sick' identity in producing an account of the difficulties he faced in finding work. Prior to Extract 5, David and I had been talking about his prospects of employment, and he had introduced the difficulties associated with taking medication and how long it took him to get to know people.

*Extract 5. (David/CS4/L120-127)*

- 120 D: and after a wh- you know (.) then (.) you know I'm okay  
 121 and but I'm a- oh I could walk in (.) to a shop get a job I  
 122 suppose (0.5) but after a while (0.5) you know if I have a  
 123 relapse which I usually do cause they strike at any moment  
 124 (0.5) you know (1.0)  
 125 S: yeah  
 126 D: umm that's when I worry (.) you know (.) that's when I  
 127 worry yeah

In Extract 5, David proposed that it would be possible for him to get a job (line 121), suggesting that he is capable and has the skills necessary to do this. He then introduced his rationale for not working; the possibility of relapse. Relapses are presented as both regular ('usually' -line 123) and difficult to predict ('they strike at any moment'), and are associated with sickness. However, unlike Karen, who presented an optimistic view of her ability to manage and control the problematic effects of her illness through medication, David presents his illness as uncontrollable. Throughout this short extract, David continually injected the term 'you know'. In this context, they may be appeals for understanding. Alternatively, 'you know' may work to present his situation as normal and unremarkable for a person with schizophrenia, but suggesting that the statements that he is making about his own situation are obvious and self-evident. Presenting himself as being at the mercy of an unpredictable illness allowed David to manage his claim for the exclusion from employment.

A little further into the transcript, but still talking of employment, the issue of a sick self was reintroduced and became more specific. As David had said he enjoyed fishing and boating, I had commented that it might be a good work area for him to get into (see Extract 6). Although agreeing, David immediately restated the limits of his ability to work caused by his mental illness.

*Extract 6. (David/CS4/L192-206)*

- 191 S: yeah (1.0) that sounds like a good area for you to get into  
 192 D: yeah >cause I know I< always have a mental illness that's  
 193 the problem and its like a struggle knowing that every da:y  
 194 S: (0.5) mmm  
 195 D: you know people can go to work and think 'no worries' (.)

- 196           you get up every morning you know you have to take  
 197           medication  
 198    S:       mhm  
 199    D:       you know (.) you know you got a mental illness every day of  
 200           the week  
 201    S:       yeah  
 202    D:       it's not something that you just like- after a while don't  
 203           worry about (.) its e:very da:y of the week and you gotta-  
 204           first you gotta sort yourself out (0.5) then you gotta sort the  
 205           way you live out (0.5) and then (.) for a job- with a job in  
 206           that time as well it can be very stressful

This account is somewhat different from the previous extract. Earlier, it was the ever-present possibility of relapse that was presented as the major barrier to employment. In this extract, although it is still the mental illness that is the problem, it is the extra burden of having to live with and manage a mental illness rather than the specific symptoms of the mental illness that makes employment more difficult for David than for other people. The invocation of a membership category device (Sacks, 1992), provided reason for David not to enter the workforce. He stated, 'I know I < always have a mental illness' (line 192), thus placing himself into the general membership category of 'mentally ill'. He described this 'knowing' as the problem and a 'struggle' (line 193) that he faced every day. To elaborate this point, he then deployed a comparison between self and others. He offered a generalisation in that 'people' (line 195) could go to work without worry, whereas he, on the other hand, would get up every morning knowing that he had to take medication. To construct the role of a person belonging to such a category as 'mentally ill', actions and events would need to be proffered that reinforced this identity (Sacks, 1992). The

action of taking medication, a category-bound activity, emphasises the difference between himself and other people and supports the general claim that employment is more difficult for David than for others. David heavily emphasised the 'knowing' that he was sick 'every da:y' (line 193), explaining that mental illness was not something that could be easily dismissed. As was mentioned earlier, he presented the 'knowing' as the issue rather than the illness itself. The inference here is that behaviours such as taking medication work to reinforce this 'knowing', therefore reinforcing his worry. In addition, a 'knowing' in this sense acts to suggest insight into self, and like Karen, manages to head off any attributions of a lack of insight that may be directed toward him.

Another feature of this talk is the use of personal pronouns to indicate the self. David starts out employing the term 'I' (line 192), but then changes this to the term 'you' (lines 196-197). The use of 'you' functions as a normalising practice (Wooffitt, 2001), here worked by David to show that taking medication every day is a normal occurrence for any person fitting the membership category of 'mentally ill'. This routine behaviour supports his claim that his difficulty in holding down a job is something that anyone would experience under these circumstances.

Both Karen and David drew upon aspects of a sick identity to account for and rationalise what may otherwise been seen as irresponsible and negative behaviour. They both managed a circumvention of attributions concerning lack of insight, and implied little control over the self. Karen drew on the idea of the sick identity to create and manage a distinction between her dysfunctional past and functional present, to explain herself, and to reframe responsibility for control of herself in terms of compliance

with a pharmacological treatment regime. David's account worked to make sense of his behaviour in the context of employment, drawing upon a sick identity to show why getting a job would be very difficult for him.

Extract 7 displays a short excerpt from my interview with Scott. I had asked Scott about his likes and dislikes and he draws on his status as a person with an illness as a reason for not being able to live his life to the fullness that he might otherwise have done.

*Extract 7 (Sue-Scott/CS7/L29-37)*

- 29 S: yeah (.) what about sort of things like likes and dislikes what  
30 sort of things do you like to do  
31 Sc: well:: (1.5) I like driving my car (.) you know  
32 S: mmm  
33 Sc: umm I wanna do scuba diving but I can't cause of my illness  
34 S: yeah  
35 Sc: so the doctor says 'why don't you do skydiving'  
36 S: oh yeah ((smiley voice))  
37 Sc: and you know I haven't done it (0.5) I should do it

In this extract, Scott draws on his illness to produce a complaint, stating that he wanted to do scuba diving but his illness prevented this (line 33). Here, Scott worked to show how his illness had restricted his activities. In the next passage of talk, he gives an active voice (Wooffitt, 1992) to his doctor. Active voicing is a technique drawn upon to show how events really happened, and here Scott claimed that his doctor had suggested an alternative of skydiving (line 35). The emphasis on skydiving suggests that Scott responded to this activity as being a more 'extreme' sport than scuba diving, and then concludes the subject by saying emphatically that he should do it. So here, it can be seen that what begins as a standard attribution to illness account of why Scott cannot do something he would

like to do, this limitation is quickly minimised by Scott's reporting that a doctor (i.e. someone who understands the nature of his limitations) has suggested that he could do something more extreme. Scott's endorsement of this shows his own willingness to minimise the limitations imposed by his illness.

For Karen, David and Scott, problems of self control, employment, and restrictions placed on desired activities were managed through the invocation of membership in the category of 'mentally ill' persons. David was specific with this role, speaking of mental health issues, whereas Karen and Scott drew upon the term 'illness', which are much more inclusive of general health, but which in this context clearly index mental illness. References to illness allowed the participants to produce accounts of themselves and their behaviour that present a sense of responsibility and agency for the self while at the same time acknowledge negative or problematic aspects of their behaviour and/or experience.

### **'Normalising' Self**

Primary participants drew on a number of normalising resources in their accounts of self. In response to questions about change in themselves over time, a past self was often aligned with 'disorder' whereas the present self was managed to convey 'normalcy'. Another technique for normalising one's problems to align with others in the community was that of generalising. Although participants expressed troubled aspects of themselves and their behaviour, others in the community were also presented as experiencing problems of some sort. That is, no one is problem free. Finally, an analysis of self descriptors given early in the

interview saw that all primary participants generally tended to present the self in a positive light, adhering to notions of social acceptability. Here, an attention to lexical choice, the terms that people chose to mobilise their accounts, reveal a particular means of linking of behaviour to self and a preference for lay terminology as compared to medical discourse.

### **Contrasting Identity Over Time**

Contrasts and distinctions drawn between the past and the present were prominent in accounts of a change in self over time. The past self was often presented as negative, at times coupled with problems people had experienced, relating to their eventual diagnoses. The past self, then, represented a 'disordered' person. Versions of current selves drew linkages between self and behaviour, along with implicit inferences of 'normalcy'.

Early in the interviews and before questions of change were introduced, I asked people to describe themselves. Extract 9 shows Deb's account of herself.

*Extract 9 (Deb/CS9/L28-32).*

- 26 S: umm (.) as a person how would you describe yourself? (1.0)  
 27 as a person what kind of a person do you think you are?  
 28 D: u::m (.) pretty easy going  
 29 S: mhm  
 30 D: u::m (.) like to help other people with the same problem  
 31 S: yeah  
 32 D: and umm (.) I'm starting to be (.) a bit more happ↑ier

This account presents a self who is calm and relaxed, and perhaps accepting of difference, inferred from the phrase 'pretty easy going' (line 28). A positive presentation of self is indicated by a reference to helping others – a socially desirable activity. The third part of this account (as per

three-part listing techniques, Jefferson, 1990) is suggestive of a change that has only recently begun, where Deb's happiness was still in progress (line 32). Happiness was included here as a part of the self and, through this, proposed as what the self should be. It is not lost that the corresponding emotion to happiness is sadness, and sadness in its extreme is grounds for the diagnosis of depression (APA, 2000). Therefore, Deb has described herself in terms of both behaviour and emotion, and presented herself in a positive light, perhaps leading away from any view of her that might be suggested by her diagnosis. In contrast, when invited to talk about changes in herself over time, Deb gave a much less favourable description of herself in the past (see Extract 10).

*Extract 10 (Deb/CS9/L47-49).*

47 D: yeah (.) I was very: (.) intolerant towards peop↑le and I was  
 48 very judge-judgemental and I umm used to take offence  
 49 quite eas↓ily

The use of the past tense here, 'I was' (line 47) and 'I umm used to' (line 48), works to show another self that is no longer. The use of extremes (see Pomerantz, 1986), such as 'very: (.) intolerant' (line 47) and 'very judge-judgemental' (line 48) emphasised the negativity of these behaviours. Deb accounts for herself as being overly sensitive to the actions of others, yet by locating these aspects of herself in the past she is suggesting that she has become more tolerant and less reactive. Underlying this is the implication of what a 'normal', healthy self should be; easy going, helpful, happy, tolerant, non-judgemental, and should not take offence easily.



In the following extracts, Ken, Carol and Brenda made use of a temporal separation between the negative aspects of themselves in the past and the more positive characteristics of their present selves.

*Extract 11 (Ken/CS1/L119-123).*

- 119 K: ummm (4.0) ahhh- I think I show a lot more (.) initiative  
 120 and common sense than I did before.  
 121 S: [mm]  
 122 K: [(mu)mbled] (1.5) I'm not in such a rush to do things (.)  
 123 like before

*Extract 12 (Carol/CS5/L26-30)*

- 26 C: a lot more outgoing than I used to be  
 27 S: yeah  
 28 C: easy to get along with (.) usually  
 29 S: mhm  
 30 C: u::hh (2.5) a lot more confident than I was (1.5)

*Extract 13 (Brenda/CS2/L45-46)*

- 45 B: YEAH I'm n↑ot as ((sigh)) I'm not not not (0.5) don't lose  
 46 my temper as quick as I used to

*Extract 14 (Brenda/CS2/L187-188)*

- 187 B: [I d]on't (.) I DON'T (0.5) umm (1.0) I don't retaliate like I  
 188 used to.

As in other uses of the past/present contrast, these accounts work to present the speaker as being different in some important way from how they once were. It is interesting to note though, that the negative pasts against which Ken, Carol and Brenda contrast their present selves, are not described in terms that are characteristic of the problems that are associated with schizophrenia. Rather, participants can be seen to be presenting a favourable view of both the past and present selves; the present is good by being an improvement on the past, and even the past was nothing out of the

ordinary (lacking ‘initiative and common sense’ (Ken - lines 119-120), being in a ‘rush to do things’ (Ken – line 122), being under ‘confident’ (Carol – line 30), or losing your temper and retaliating (Brenda – Extracts 13 & 14) are unremarkable problems that anyone might experience).

One person who did not see a positive change in himself over time was Scott, although he had initially presented himself in a positive light. I had asked Scott if he thought that he had changed at all since before his problems had begun.

*Extract 15 (Scott/CS7/L55-58)*

- 55 Sc: [no before me illness I was (.) quite alr<sup>↑</sup>ight but now I  
 56 got an illness (1.0)  
 57 S: mmm  
 58 Sc: you know (2.0) nothing (1.0) nothing's not that excellent

Contrary to other primary participants, Scott presented his past self as positive and his present self as negative. His orientation toward ‘illness’ aligned to a ‘sick’ identity (see Sacks (1992) for membership category devices), and Scott bolstered this with the next line: ‘nothing's not that excellent’ (line 58). In this way, Scott conveyed a sense of himself as a person defined by his problems, problems that directly flow from his illness.

When asked about changes in himself over time, Rick talked about his history of drug abuse. As mentioned earlier, Rick offered that ‘going clean’ (Rick/CS8/L47-50) had transformed his life. He presented this problematic, drug-addicted self as belonging to the past. The view of himself as having ‘recovered’ from whatever problems he had experienced in the past was strengthened by presenting the reactions to him of mental health staff in the region.

*Extract 16* (Rick/CS8/L435-439)

- 435 R: they'll tell me like straight out (.) yeah (.) I'm in- yeah (.)  
 436 I'm here (.) 'what are ya gonna do'? they just (.) straight  
 437 out 'fuck off we don't want ya' ((laughing))  
 438 S: ((laughing))  
 439 R: 'there's nothin wrong with you'

In this extract (Extract 16), Rick starts out by using the technique of active voicing, where voice is given to another to manage the claim of something said at the time (see Wooffitt, 1992; Hutchby & Wooffitt, 1998). Rick states 'they'll tell me' (line 435), giving no names but drawing upon the generic form of 'they', people working within the mental health system. This lends some authority to the claims of what is said, as these people are professionals within their field who have specialised knowledge and experience relevant to detecting signs of mental illness. In this context, it is suggestive that what 'they' had to tell him occurred within a mental health institution as it infers that he had been taken to this institution ('I'm in-' line 435). Rick's question to 'them' of what will be done to him works to set up a claim of their response to him – 'they just (.) straight out 'fuck off we don't want ya' (lines 436-437). The precursor of 'straight out' conveys the clarity of their response, inferring that he did not misinterpret what was said to him. To not want him at the institution suggests that there was no reason for him to be there. To reinforce this claim, Rick concluded with another active voicing statement, proposing that people in authority saw nothing wrong with his mental health.

In this small section of talk, Rick attends carefully to the management of his stake in his own claims about his mental health. Rick managed potential dismissal of his claims as simply what someone in his

position would say by reasoning (through direct reported speech) the expert opinions of those who have no personal stake in Rick's mental health status (i.e. mental health workers).

In the accounts of many people, past selves were presented as 'abnormal' or negative and current selves were presented as 'normal' or positive. One person gave an opposing account. To view the self as 'normal' is to be like others in the general community. The obverse technique of gaining this inclusion then would be to view the general community as troubled.

### **Generalisations**

In my conversations with people at the service centre over the past two years, the issue of problems had come up on a number of occasions. These conversations ranged from general issues to more specific and personal issues. During the interviews, Brenda, Carol and Rick all generalised their problems. That is, they presented the particular problems they experienced as typical of those expressed by other (non-mentally ill) people. This is a normalising technique that assists people in placing the problems that they face into a broader perspective, a way to possibly stop the isolation that they may have been facing, and to ease themselves back into the general community. In the extracts that follow, each person who drew upon this normalising generalisation did so for a different purpose. That is, the indexical nature of the specific invocation allowed for the management of different local objectives at different points in the interviews.

In her interview, Brenda and I were talking about the service centre staff, and she had introduced her ease of interaction with her doctor, and how Brenda had likened her doctor to herself. I suggested that we tend to get along better with people who are more like ourselves. Her statement following this was inclusive of all people at the centre; both consumers and staff (see Extract 17).

*Extract 17 (Brenda/CS2/L269-271)*

269 B: yeah we're all on the same level here

270 S: mmm

271 B: we've all got our problems

To manage the business of generalising problems, Brenda drew upon Membership Category devices (see Sacks, 1992). First, she establishes an overarching category, inclusive of staff members as well as consumers at the centre, by claiming that 'all' (lines 269 & 271) people at the centre were 'on the same level' (line 269) removing (or at least reducing) an 'us and them' distinction between consumers and staff at the centre. Then, she introduces problems as a characteristic of the group as a whole rather than as a means of distinguishing between the 'helpers' and those requiring 'help'. That is, if everyone has problems then she is no different to anyone else.

Carol's generalisation came about through talk of self in the past as compared to self in the present. Prior to the talk in the extract, she spoke of current behaviours such as laughing a lot more and not crying as much, and put this down to the friends that she had made.

*Extract 18 (Carol/CS5/L234-237)*

234 C: even though we've all got our problems I mean everybody's  
 235 got problems of one sort or another (0.5) the majority of us  
 236 have got ours recognised (.) and we're all (.) getting on top  
 237 of what we've got and all that (1.0) umm

In Extract 18, Carol begins by establishing that problems are a regular occurrence of everyday life, but unlike Brenda, Carol did not avoid more specific categorisations within the broader 'everybody'. She went on to categorise 'us' and others by drawing a distinction between different types of problems ('of one sort or another' (line 235) emphasises that there are different types of problems and that not everyone's are the same). Having these problems 'recognised' (line 236) and talk of 'what we've got' (line 237) draw attention to particular types of problems that need to be acknowledged by outside forces. The use of terms such as 'us' (line 235), 'ours' (line 236), 'we're' (line 236) and 'we've' (line 237) all work to show that she is not the only person with such problems, and that others accessing the facilities of the service had also expressed similar problems. Having established that 'we' have particular problems that may be of a different 'sort' from others, Carol then subtly implies that those with 'recognised' problems (like herself and others at the centre) may in fact be doing better than people with problems that they don't acknowledge because she (and others like her) are 'getting on top' (line 236) of their problems.

Rick too, managed a generalisation of problems. Rick's account came about through talk on stigma and discrimination. Before the talk shown in Extract 19, he was speaking of the way that others in the general community and past workplaces had reacted to him. He said that people do not really care what your brain is like. In this instance, I had introduced the

possibility of others having problems of their own. Rick's response to this was:

*Extract 19 (Rick/CS8/L323-331)*

- 323 R: [well everybody's got]  
 324 problems  
 325 S: exactly  
 326 R: no matter what (.) everybody's got problems  
 327 S: yeah  
 328 R: family (.) every single issue somebody's got a problem  
 329 somewhere  
 330 S: mmm (.) yep (.) I agree  
 331 R: there's always somebody worse off than you are (laughing)

Rick started out with a similar statement to Brenda and Carol in claiming that ‘...everybody's got] problems’ (lines 323-324). My response of ‘exactly’ (line 325) shows agreement with his assertion, and may have acted as a prompt. To justify this initial claim, Rick continued with examples of family issues and specific problems. Extreme case formulations are apparent, with ‘everybody's’ (lines 323 & 326), ‘every’ (line 328) and ‘always’ (line 331) working to accommodate all people in this claim of the commonality of problems. He concludes with a comparison between himself and others, downplaying the problems that he had by presenting the notion that ‘there's always somebody worse off than you are’ (line 331).

The indexical character of the phrase 'everybody has problems' worked to do different things for each of the people who drew upon it. In a broad sense, it worked to reformulate mental health problems as a sub type of the general category of problems, presented as something that everybody has. In this way, members of the category ‘people with mental health

problems' are characterised as being different from others at a minor level of categorisation, while at the same time sharing membership of the broader category 'people with problems' with 'everybody'. Thus, having problems was not unusual or out of the ordinary, and was presented as a minor rather than fundamental difference between the self and others.

### **Social Acceptability**

Finally, I looked for commonalities within the initial section of the transcript where I had asked people to describe themselves. All primary participants had initially presented themselves in a positive light. For the self to be perceived as similar to others in the general community, socially acceptable characteristics, behaviours, thoughts and feelings would need to be presented. Most people in this study had listed constructive attributes or self descriptors, in some cases changing possible negative attributes to positives. Also, participants' choice of terminology in preferring lay discourse to medical discourse suggests an avoidance of the stigma associated with mental health conditions.

Normalcy can be seen in Carl's self descriptors, where he initially stated that he was 'an intelligent loner' (line 28), but then changed the term 'loner' to 'bachelor' (CS3/L29). A 'loner' may draw negative connotations such as solitude or isolation, and does not necessarily suggest self direction, as people may be isolated by others. A 'bachelor' may be suggestive of choice in single status, and fun when coupled with other common terms such as 'swinging bachelor' and 'bachelor pad'. Here, then, a potentially negative self descriptor is turned to a positive by substituting a term that implies choice.



One thing that was apparent in my initial scan of the transcripts was that many people employed the technique of three-part listing (see Jefferson, 1990). This was where they listed three characteristics or behaviours, drawn on to summarise a common or general way of being. These all worked to show a socially acceptable image of self, although not necessarily in the same fashion. In all interviews, the discussion preceding the question on self descriptors had centred on a preferred term for people receiving assistance from mental health workers. Following this, I asked participants to describe themselves as a person. Extract 20 shows how Rick managed his initial descriptors of self.

*Extract 20 (Sue-Rick/CS7/L36-41)*

- 33 S: ((laughing)) yeah (0.5) if somebody were to ask you what  
 34 kind of a person you are (.)  
 35 R: yep  
 36 S: to to describe yourself how would you describe yourself?  
 37→ R: u::m pretty honest (.) to a point  
 38 S: mmm  
 39→ R: u::m (0.5) easy going easy to get along w<sup>↑</sup>ith  
 40 S: yeah  
 41→ R: hard work<sup>↑</sup>ing (0.5) shit like that

For ease of understanding, the arrows mark the three parts of the list. Rick's first utterance, 'pretty honest' (line 37), is followed by 'to a point'. The use of this qualifier works to establish the credibility of his claim, as it may not be reasonable to expect a person to be honest at all times. He then continues his list with 'easy going' (line 39), and then adds 'hard work<sup>↑</sup>ing' (line 41). Rick impresses the desirable qualities of honesty, amicability and a hard working disposition. Of interest in this excerpt is that it finishes with the generalised list completer (Jefferson, 1990) of 'shit like that'. This

completer works to minimise any pretentiousness associated with the descriptors by downplaying his comments of self, yet it also works to reinforce the generality of the claims by producing them as specific examples from a potentially longer list. Therefore, Rick's account of himself appears credible, unpretentious, and indicative of a larger store of similar, desirable characteristics.

Karen's three-part list provides a contrast, as she outlines a negative self kept under control by the mental health establishment. Karen works to describe negative symptomology that would be apparent if she were not taking her medication (see Extract 21).

*Extract 21 (Sue-Karen/CS6/L31-45)*

- 31 S: okay (0.5) so (.) if you had to sort of describe yourself to  
 32 someone as a person what sort of person do you think you  
 33 might- that you are?  
 34 K: (3.5) well if (.) I wasn't taking my medication (1.5)  
 35 S: mmm  
 36→ K: I (.) would have mood sw↓ings (1.5)  
 37 S: yeah?  
 38→ K: umm (1.0) very impat↓ient (2.0)  
 39 S: mhm  
 40→ K: depression (0.5) suffer with depression  
 41 S: yeah  
 42 K: so I need to take my (.) medication to lift my moods  
 43 S: mhm  
 44 K: u::mm (2.5) yeah so I would be all those things if I wasn't  
 45 taking my medication

I started to ask Karen to describe herself as she 'might- [be]', but stopped myself, rephrasing this to the more definite 'that you are?' (line 33). After a long pause of 3.5 seconds, Karen started out her descriptors with

‘well if (.) I wasn't taking my medication’ (line 34). This statement sets up the list that follows, and establishes a piece of information that Karen was putting forward - that Karen was indeed taking her medication. It also provided the frame for Karen’s description of herself, which was not so much a direct claim of positive attributes, but a contrast with the negative attributes she would have displayed had she not been taking her medication. There was another pause, minimal speech from myself, and then in line 36 Karen revealed ‘I (.) would have mood sw↓ings’. The emphasis on ‘mood’ and the downward intonation on the term ‘sw↓ings’ accentuated a negative value placed upon this behaviour. There was a 1.5 second pause, and I gave a prompt of ‘yeah?’ (line 37). Karen considered her next descriptor, and added very ‘impat↓ient’ (line 38). Again, there was emphasis and a downward intonation, conveying negativity toward the descriptor. After a long pause (two seconds) and a prompt, she added ‘depression’ (line 40). The turn-taking of pausing, prompting and response here managed to compile Karen's list. To conclude the list, Karen states that she needs to take her medication to lift her moods (line 42). The important pairing of medication and self here, conveyed that medication could change Karen’s behaviour, and hence, her sense of self.

My response to Karen’s conclusion was minimal (line 43). This may not have been the response that Karen was expecting, as she pauses for two and a half seconds, and then concluded again; reinforcing that she was taking her medication. The expected response may have been praise for medication compliance or assurance that she was doing the right thing by taking her medication. Not receiving this praise or assurance may have instigated the rephrasing of her conclusion. If she were not taking her

medication, she ‘would be all those things’ (line 44). In Karen's three-part list she had offered a positive self by inferring the absence of these particular characteristics or symptomology; an ‘other’ self. In her account, this positive self was due to medication. The constant referral to taking medication, however, may also be indicative of her perspective of me, in that she may have viewed me as working within the mental health system that enforces compliance. Therefore, she may have been assuring me that she was acquiescing to medical authority.

David's response to my request to describe himself also utilised a three-part list. Of interest here, was the discourse preceding the list in which he worked to manage issues concerning his stake and accountability (Potter et. al., 1993) (see Extract 22).

*Extract 22 (David-Sue/CS4/L57-66)*

- 57 D: u:mm (2.5) a:h very a:h (0.5) I'm tryin to remember cause  
 58 um (0.5) a:h Viv wrote a (.) like a  
 59 resume type thing  
 60 S: mmm  
 61→ D: and she reckons I'm very umm active in the- like at  
 62→ ((service provider's name)) an that (.) I've got myself pretty  
 63 much sorted ↑out  
 64 S: yeah  
 65→ D: umm (1.0) I umm I'm punctual (.) I'm all th- all this that n  
 66 (.) all the good stuff

Lines 57 to 59 worked to establish where the information about his self was coming from. That is, David made it known that it was not his opinion that he was telling, but that of Viv's, as she wrote his resume. He was simply ‘tryin to remember’ (line 57) (see Edwards and Potter, 1992, for a discussion on remembering). In this way, David's stake, or possible self

interest, in giving a positive account of himself, was managed by producing the account as another person's opinion of him. David's version of remembering was occasioned to attribute responsibility and accountability to Viv (a mental health support worker) for the truthfulness and accuracy of the self descriptors. By contextualising Viv's account of him as something she had written in a resumé David bolsters the reliability of Viv's description of him by inferring that there may be a certain level of accountability to the general public for the accuracy of the information it contains.

To describe himself, David went on to claim that Viv 'reckons I'm very umm active' (line 61), and 'that (.) I've got myself pretty much sorted ↑out' (lines 62-63). This positions the teller as credible and rational. The statement was also an appeal to authority, as Viv (the authority figure) was proffered to have said this. In effect, there is a rhetorical move to counter any opposition to his claims of self by positing that there was little reason to doubt this account. That is, David's descriptors of himself are proposed as the opinion of an authority figure, and that this authority figure wrote it in a resumé. Furthermore, as this authority figure believes that he had 'sorted himself out', he was, therefore, trustworthy and believable. David finished his list by stating, 'I'm punctual' (line 65), and followed this with a generalised end list completer of 'I'm all th- all this that n (.) all the good stuff' (lines 65-66). This works to conclude the descriptors, and confirm that David is well, giving a positive account of himself.

One person who did not use the three-part list technique was Ken. Rather, Ken's descriptors tended to be paired, with qualifiers or generalising

comments at the end of each. Yet, Ken appeared to have difficulty with describing himself, as seen in Extract 23.

*Extract 23 (Sue-Ken/CS1/L21-28)*

- 21 S: so umm (4.5) w<sup>↑</sup>ith that sort of in mind sort of getting onto  
 22 you being in this sort of situation how would you describe  
 23 yourself as a person?  
 23→ K: (0.5) <sup>↑</sup>ummm (5.5) kind of quiet I suppose but I do like  
 24→ talking to people better ‘not too much though’ (5.0) it’s a  
 25 hard one though  
 26 S: mmm?  
 27→ K: (0.5) I enjoy the work and stuff like that (.) I enjoy helping  
 28→ people out and things.

When I initially asked this question I had trouble tying in the previous talk of a preferred term for people receiving assistance in mental health to the question on descriptors of self. I used the words ‘sort of’ (lines 21-22) three times in the preamble of the question, and was not specific with my talk. This may have caused some confusion for Ken as he took five and a half seconds to respond. Ken started with ‘kind of quiet I suppose’ (line 23), which could be taken as a negative quality. To counter this, he added that he liked ‘talking to people better’ (lines 23-24), working to show positive change, although he tempered this by softly saying ‘not too much though’ (line 24). Rather than a large change in himself, he inferred a small positive change. There was another long pause of five seconds, and the difficulty that Ken had with the question was evident (line 24-25).

After receiving minimal comment, Ken went on to list activities that he enjoyed or liked such as ‘work’, and followed this with a generalising comment of ‘and stuff like that’ (line 27). This technique was repeated this with his next descriptor of ‘helping people out’ where he added ‘and

things.’ (lines 27-28). This talk conveyed Ken to be a work-oriented, helpful kind of man, and that this was a fairly typical depiction of him. Although Ken appeared to have trouble with the question of describing himself, his account was managed as positive and socially acceptable as he was changing for the better.

Identity and problems are indelibly linked, particularly in the context of mental health, and it is worthy to pay attention to how people discursively produce themselves in relation to the problems that they have or have had. The preference for lay terminology rather than medical discourse works to avoid the stigma and discriminatory effects associated with diagnostic labelling, thus managing a normalisation of self. Primary participants had received their diagnoses at least two years ago. This allowed time for the realisation of any possible negative connotations associated with their diagnoses and in the use of medical terminology in general. By using lay terms, the self could be distanced from the extremes of diagnostic categories.

Primary participants generally chose to talk about their experiences using the term that I had introduced – problems - or else used more generic terms such as sick or mentally ill when referring to mental health concerns. A notable absence in the talk of any primary participants was the term 'schizophrenia'; participants simply did not apply this term to themselves. Karen, Deb and David spoke of psychosis, hearing voices, relapse, and at times outlined symptoms such as bizarre thoughts. They stopped short of naming their problem in terms of their diagnostic category; schizophrenia. The other six primary participants appeared reluctant to use medical terminology at all.

When speaking of things that she does now that she did not do before, Deb focused on social activities. She talked of going out more often, suggesting that, although she had improved in this area, she still experienced difficulty - '(0.5) but it's I- I get very anx↑ious like if I'm gonna be meeting peop↑le so that's just part of the umm (.) thing I've got' (Deb/CS9/L124-127). Here, Deb concedes anxiety, but rather than using the clinical term schizophrenia she states that it is a 'thing I've got'. Talk of a 'thing' suggests an entity and ties in with notions of the objectification of problems. Her avoidance or reluctance to name this problem suggests that she does not wish to apply this category/label to herself.

As stated earlier in the chapter, Ken avoided using medical discourse to describe his experiences. Twice he used the lay term 'nervous breakdown' rather than the clinical term psychosis. Prior to Extract 24, Ken had been outlining past issues that he had with anger.

*Extract 24 (Ken/CS1/L95-98)*

95 K: [and u]mm (0.5) yeah ↑I think its been quite good  
 96 (mumbled) I know that it sounds quite strange but it's good  
 97 that I had the◦ >nervous breakdown< (cause it kind of)  
 98 cleared my mind (mumbled)

It is evident here that Ken avoids medical terminology, yet is hesitant in using lay talk in the interview. Ken presents the benefits of his emotional distress, and in line 97, his tone of voice lowers as he said '◦had the◦', and he then speaks quite quickly when he says '>nervous breakdown<'. It suggests a reluctance to talk of such issues, and could also be working to put forward his version of his emotional problems with a concern that I might correct him with medical terms. Speaking quickly in



this sense works to give voice to his preferred terminology before any such correction can be made.

In the context of people attempting to reintegrate back into the community, this kind of discourse is inclusive rather than exclusive. For Ken, telling friends that he had a nervous breakdown may engender more sympathy and understanding than if he were to say that he had a psychotic episode, possibly prompting a fear reaction from others. The use of lay talk then might be seen as a strategy for rationalising the self and distancing themselves from problems, increasing the chances of social survival and acceptance in the general community.

## **Conclusion**

Throughout the interviews, accounts of self presented by primary participants showed a need to attend to explanations or reasons for self and behaviour. Techniques such as drawing on past experiences or a sick identity were managed to rationalise and make sense of the self and the problems that they had encountered. From this, participants could then work to normalise and destigmatise themselves and their behaviour. For example, to view others in the community as also troubled allowed for a sense of normalcy in that problems were generalised and not simply the domain of the diagnosed. Also apparent was that no primary participants used the classification of schizophrenia to describe themselves in their accounts and instead favoured lay terminology over medical discourse. This worked to manage a socially acceptable self by presenting socially valued or desirable qualities and behaviours. Ease of passage back into the general community then, necessitates anticipating how others might see them.

## CHAPTER 5 – Problems of Relationship: Understanding and Care

Mainstream notions promote the self as stable, knowable, biological in essence, an autonomous entity separate from the social world of others (Carver & Scheier, 1996). Focus on an ‘essential self’ works to relegate relationships to secondary level of import in defining the self. Yet, it is this social world that creates a sense of self, born of interdependence, constructed and reconstructed in a multitude of contexts. A sense of self is negotiated in relationship with others (Gergen, 1997; Harre, 1993; Maines, 2000). In this way, the self is a product, sustained in relationships.

*“The invitation for one construction as opposed to another is, after all, issued from the social surrounds; and the fate of this construction is also determined by other persons. One’s own role thus becomes that of participant in a social process that eclipses one’s personal being”*

*(Gergen, 1991, p.156).*

A person’s perception of how others might view them could then impact upon this agreed upon conception of self. This is most apparent within close personal relationships such as those with family members and friends, and in the case of people with a diagnosis of schizophrenia, staff members. Inherent in the accounts of this study is the problematic nature of those personal relationships.

Most participants’ accounts were negative, and centred on two main issues; lack of understanding and care. Each focal group (family or staff) evoked different issues for participants, with people’s perceptions of their

family's perspectives of their self predominantly downbeat, and views of staff members' perspectives of them primarily positive. Participants gave extended responses and explanations of their family dynamics to manage accountability for their disappointing family relationships, and many discursive devices were deployed to manage stake and accountability (see Potter et al., 1993) for these views – complainings were commonplace.

## **Understanding**

The questions I asked did not distinguish between friends and family, yet participants tended to focus on their relationships with their families in their replies. Many people did not mention their friends' perspectives of them at all. For those few people who did, their accounts were very brief. For example, Carol presented her friends as viewing her quite positively, listing attributes such as outgoing, lively and bubbly (Carol/CS5/L270-271). Ken drew on his image of past Army buddies saying that they would not understand the problems that he had (Ken/CS1/L266-267). Scott and Carl stated that they did not have many friends. In response to my questions about how he thought his friends and family might see him, Carl laughingly proposed the terms 'obt(h)use' and 'wacko' (Carl/CS3/L107 & L109), invoking derogatory associations of madness. I then asked him if he thought that his family understood what had happened to him, and he replied 'I doubt it' (Carl/CS3/L113).

Claims of a lack of understanding from family members appeared in many accounts given by primary participants. Some participants differentiated between the current relationships they had with their families

and the nature of those associations in the past, while others drew distinctions between their relationships with different family members.

### Contested Selves

Brenda's response to my question about how her friends and family would describe her was framed in terms of changes that she thought her mother would like to see in her (see Extract 25). In this way, Brenda conveyed a sense that she believed her mother was not exactly approving of her, without implying any direct criticism.

*Extract 25 (Sue-Brenda/CS2/L195-208)*

- 195 S: mmm (1.0) ok↓ay (0.5) so how do think ↓umm say maybe  
 196 your friends and family would describe you?  
 197 B: (0.5) don't kn↑ow HAAH [((laughing))]  
 198 S: [((laughing))]  
 199 B: an interesting question ((smiley voice)) I don't know  
 200 S: you don't know what sort of >what sort of a person< do you  
 201 think (.) they might see you  
 202 B: oh >mum is- mum said to me< that she'd like to see me  
 203 that I'm really tidy in the house in particular about my house  
 204 so (0.5) and that and I'd dec↑ided that in the New Year I'm  
 205 gonna really make the effort and keep my house clean and  
 206 tidy and  
 207 S: [mhm]  
 208 B: [how I] used to

Initially, Brenda said that she did not know how others would see her. I reformulated the question into a statement, and Brenda's response to this was not how her mother would actually see her, but how her mother would 'like' (line 202) to see her. To manage the delivery of this information, Brenda first deals with accountability (see Potter et al., 1993).

By proposing 'mum said to me' (line 202), Brenda is inferring that this is not simply her perception of what her mother thinks, but something she actually said. Brenda endorsed this as a reasonable thing for her mother to expect by stating that she had decided that in the New Year, she would make an effort to keep her 'house clean and tidy and [how I] used to' (lines 205-208). Brenda presents herself in a positive fashion, in that she shows agency and a willingness to change herself. Thus in this extract, Brenda presents her mother as being somewhat critical of her, although these criticisms are expressed as a desire to see a positive change. Her mother's implied criticism is accepted by Brenda through her stated intention to make the desired change, although her proposal that she would do this in the New Year added a lightness to the idea, perhaps that of a New Year's resolution.

Ken's account of his family's views of him are mildly negative, portraying him as unengaged and a little lazy. Extract 26 outlines his perceptions of how he is seen by his family, and in Extract 27 Ken explains where these views might have come from, and why he thinks they are a misrepresentation of him.

*Extract 26 (Sue-Ken/CSI/L129-136)*

- 129 S: umm hmmm (.) okay (0.5) so say if we were talking about  
 130 friends and family and things how do you think that they'd  
 131 describe you?  
 132 K: ummm (2.5) my sister thinks I'm (.) h↓mpf too dreamy type  
 133 of thing (.) heh (.) so:  
 134 S: mmm  
 135 K: (2.0) they >probably think< I'm too relaxed and, laid back  
 136 and everything

Although Ken reports his sister's assessment of him as 'too dreamy' (line 132), his disagreement is registered by his exclamation of 'h↓mpf'

before offering 'too dreamy type of thing'. At the end of this assertion, he gives a little laugh – 'heh'. The laugh here works to confirm that Ken did not agree with this opinion, and may also have been an invitation for me to laugh with Ken (see Jefferson, 1979), to confirm an agreement between us to dismiss his sister's opinion. My minimal response to his laugh conveys my declining of the invitation. Jefferson (1984) proposes that when a person presents 'troubles' talk, sometimes the response of not laughing may show sensitivity toward the person. That is, not laughing at the person's problems, even though an invitation is offered, may invite the person to proceed further into discussion of the troubling matter. The two second pause after my decline to laugh suggests that my minimal response is interpreted as a request for further explanation.

Ken then expanded his response from his sister to the rest of his family (and perhaps friends), as he continued by saying 'they >probably think< I'm too relaxed and, laid back and everything' (lines 135-136). The use of the term 'probably' allowed Ken to show that 'too relaxed and laid back' was an assumption, and by contrast, suggests that he was more confident about his sister's views about him. It also suggests that Ken might not have discussed this matter with anyone other than his sister. By making it obvious that this was an assumption and presenting a distinction between his sister and other family members, Ken had worked to support the initial presentation of his sister's views as true and having actually occurred. His show of disagreement with his sister's views adds weight to this claim, as he could have easily given a positive account that would be difficult to question. The negativity of his other family members' views of him was presented quite tentatively, as the actual characteristics mentioned ('laid

back', 'relaxed') are generally positive, only being made negative in this context by the qualifier 'too'. Thus, it seems that Ken's family could easily come around to a more positive view of him – it is all presented as a matter of degree.

Later in the interview, when I asked if friends and family members' views of him might have changed over time, Ken further explained the labelling of himself as 'dreamy'. In Extract 27, Ken associated being dreamy with drug-taking activities.

*Extract 27 (Sue-Ken/CSI/L194-213)*

- 193 S: so do you think that they would have seen you any  
 194 differently before say as compared to ↑now?
- 195 K: ↑umm (2.0) well when I came out of the ↑arm↓y I was  
 196 (mumbled) or something I you know I (.) wouldn't  
 197 recognise people (0.5) and they thought I was on drugs  
 198 or something (0.5) and very dreamy (.) ◦I've never taken  
 199 any illicit drugs◦ (1.5) and uhh (0.5) yeah well (.) when  
 200 I came out of the army I wasn't (0.5) that good
- 201 S: mmm (.) so (.) you don't think they would have had a very  
 202 good opinion [of you]=
- 203 K: [not rea]lly n↓◦
- 204 S: = (.) back then?
- 205 K: no
- 206 S: but (.) it's better n↑ow?
- 207 K: y↑eah (0.5) much better
- 208 S: that's good
- 209 K: yeah ((smiley voice))
- 210 S: okay (0.5) umm so do you get on >sort of< really well with  
 211 your family?
- 212 K: umm (0.5) no not that well ◦I suppose◦ (.) I live by myself

In this extract Ken worked an explanation of 'dreamy' (line 198), starting with a three-part list; 'I wouldn't recognise people and they thought I was on drugs or something, and very dreamy' (lines 196-198). The use of the term 'wouldn't' rather than 'couldn't' recognise people suggests that perhaps people believed that Ken had somehow resisted recognition, and recognition of people is something that was (or should have been) within his control. Ken proposed that his family accounted for his failure of recognition by assuming that he had been taking drugs, a claim he flatly contradicted. He finished his explanation with the summary that he 'wasn't (0.5) that good' (line 200) when he left the Army. This manages that something was wrong, but that it was not due to drug taking. Ken's talk here presents him as misunderstood by proposing that his failure to acknowledge people known to him had been reinterpreted by family members as evidence of drug-taking activities.

As Ken had left the Army a few years earlier, there may have been a change in his family's understanding of him over time. I first determined that Ken's family did not have 'a very good opinion' of him at the time (lines 201-202), to which he agreed. I then asked if their opinion of him was better now, and Ken replied 'y↑eah (0.5) much better' (line 207). Ken and his family were not close though, and this was borne out in the following talk, where he stated that he did not have a good relationship with his family, and that he lived alone. The account that Ken had given then, conveyed that despite a great improvement in his family's opinion of him, there were still unresolved issues, and the family, his sister in particular, still saw him as 'dreamy' (line 198).



Deb's response to my question about how her friends and family see her emphasised an improvement in her relationship with her family. In Extract 28, she gave a comparison of past and present family interactions.

*Extract 28 (Sue-Deb/CS9/L146-156)*

- 146 S: yeah (.) ↑ok↓ay (.) ho-how do you think say maybe your  
 147 friends or or family might (.) see you?  
 148 D: u::m my family (.) and I now get along (.) a lot bett↑er  
 149 S: yeah?  
 150 D: u:m we- we were (.) always fighting (.) before (.) cause  
 151 u:mm (.) now they understand (.) why (.) I was l↑ike that  
 152 (.) they understand the probl↑em  
 153 S: yeah  
 154 D: and (0.5) I can tell mum things n↑ow like before I couldn't  
 155 (.) really say how I was feeling (.) and I can- even my dad  
 156 n↑ow (.) now I've got a good communication thing go↑ing

To the question of how friends and family might see her, Deb stated that she and her family 'now get along a lot bett↑er' (line 148), immediately suggesting that this was not the case in the past. Deb confirmed this by adding 'u:m we- we were always fighting before' (line 150). Her use of an extreme case formulation (Pomerantz, 1986) 'always' gave depth to her claim, inferring constant conflict between herself and her family, and marking the extent of the change in their relationship.

Deb accounted for the change in her family's view of her by emphasising the role of understanding - 'now they understand why I was l↑ike that' (line 151), 'they understand the probl↑em' (line 152). The use of the present tense 'understand' suggests that the 'probl↑em' orients toward the present, and that understanding is still required. Problems in the past are produced as being caused by a lack of understanding ('now they

understand', 'my family (.) and I now get along (.) a lot better') in terms of the characteristics or qualities she believed they attributed to her. Deb then stated that she could now talk to her parents and tell them how she was feeling, suggesting that understanding from her parents had opened up avenues of communication.

Brenda started out on a positive note, offering positive affect self descriptors from staff members (see Extract 29). Her account transformed into a complaint though, and the issue of understanding appeared to dominate.

*Extract 29 (Sue-Brenda/CS2/L199-207)*

- 218 S: okay (0.5) alright (0.5) umm what about say maybe the  
 219 support staff here? ho-how do you think they might see  
 220 you?  
 221 B: (1.5) hmm (0.5) don't know (.) probably find me a bit  
 222 outgoing and that (0.5)  
 223 S: mm? (0.5)  
 224 B: umm I'm always happy I never complain about any↓thing  
 225 but then no one would listen if I compl(h)ained anyway  
 226 [(laughing)] so  
 227 S: [(laughing)]  
 228 B: heh that's what I've been told 110 times ((smiley voice))  
 229 S: [ah:::] ((smiley voice))  
 230 B: [ohh g]et on with it ((smiley voice))  
 231 S: yeah  
 232 B: so (mumbled) ◦about◦ growing

In responding to how staff members might see her, Brenda evoked a 'complaining' to manage her dissatisfaction with the attention she received from staff members. After talking of friends' and family's perspective of herself, Brenda said that staff members would 'probably' see her as 'a bit

outgoing' (lines 221-222). She further explained, saying that she was 'always happy' (line 224) and never complained. Brenda then went on to do a 'complaining'. She said, '...but then no one would listen if I compl(h)ained anyway' (line 225). Although she was laughing when she said this, Brenda had conveyed that the reason she did not complain was that no one would listen to her. That is, when she did complain, she had been 'told 110 times' (line 228) to 'get on with it' (line 230). To be 'told 110 times' is an obvious exaggeration, but it managed to show that this was a typical response she received whenever she did complain.

In this section of talk, the very act of complaining supported Brenda's inference that the self she presented to staff members was a false self. Rather, Brenda presented them with a happy, outgoing, easy to get along with self. The issue of not being listened to was raised by primary participants in their talk of views of family member's perspectives of them. It highlighted the theme of a lack of understanding. That is, a person could not be understood if no one actually listened to them. In this sense then, Brenda had claimed that staff members did not understand her, as they did not listen to her. Brenda presented staff members as seeing a false persona, a situational self, brought about through their lack of understanding of her self. The self she chose to show staff members, perhaps a self that she believed they wanted to see, was also a contrary presentation of the negative affective symptomology aligned with the schizophrenias.

### **The Misunderstood Self**

Karen and Scott started out their accounts on a positive note, but quickly led into negative views of them held by their families. In Extract

30, Karen considered my question of how her friends and family members might see her. She started by saying that they would see her as an easy going person, easy to get along with. I gave minimal response, encouraging her to continue. There was a two second pause, she took a deep breath, and a longer pause ensued. Karen then introduced her account of 'mental problems' (line 276-277).

*Extract 30 (Sue-Karen/CS6/L272-288)*

- 272 S: okay what about say maybe friends and family members (.)  
 273 how do you think they might see you as a person?  
 274 K: (3.0) ◦u::m◦ (2.0) pretty easy go↑ing (.) to get along with  
 275 S: mmm  
 276 K: (2.0) (deep breath) u::h (3.5) they know I've got mental  
 277 problems  
 278 S: yeah  
 279 K: so they tend to (.) treat me with (.) uh with a little bit of  
 280 ease  
 281 S: mmm  
 282 K: u::mm (3.5) there a::re (.) a couple of members of my  
 283 family that don't understand my situation  
 284 S: yeah  
 285 K: which u::mm (1.0) I find very frustrating  
 286 S: ◦mmm◦  
 287 K: because they're not understanding (.) what mental illness is  
 288 all about (.) even though you try to expla::in (1.0) its its  
 289 like (.) my sister  
 290 (0.5) >she's in hospital at the moment she had open heart  
 291 surgery a couple of weeks ago<  
 292 S: oh n↓o  
 293 K: and she has a psychological problem as well  
 294 S: mmm  
 295 K: and just going through (.) the (.) >the experience that I've  
 296 been< through (0.5) and knowing what what help there is

- 297           and what help there isn't
- 298    S:       yeah
- 299    K:       I I been trying to stress (.) to my family (.) to (.) get the  
300           doctors (.) >to look at my sister when she's< physically  
301           better (0.5) to look at her mental situation
- 302    S:       mmm
- 303    K:       because she's (.) not cope- she can't cope at home (.) well  
304           specially now since she's had the operation but
- 305    S:       yeah
- 306    K:       but because she wasn't coping (.) mentally (.) it showed in  
307           her her (.) her life
- 308    S:       mmm
- 309    K:       like (.) she wasn't keeping her house clean and (0.5) she  
310           was takin valium one an hour
- 311    S:       mmm
- 312    K:       and umm (0.5) so I ge- I get a little bit frustrated >with my  
313           family when I try to explain to them what< mental illness is  
314           all about and they're still not really (.) listening

Karen said of her family and friends, 'they know I've got mental problems', 'so they tend to treat me with, uh, with a little bit of ease' (lines 276-280). Here there is an emphasis on the terms 'mental' and 'ease', where Karen suggests that her family's treatment of her is predicated by her emotional problems. After making this claim, another long pause followed, and then Karen began to discuss problems in her relationships with some family members based around the issue of understanding.

Karen stated that a couple of the members of her family did not understand her 'situation', and that she found this 'very frustrating' (line 285). To make it clear to me what she meant by this, Karen went on to give the example of her sister who had recently had open heart surgery. Karen presented her sister as having 'a psychological problem as well' (line 293),

thereby including them both in the shared category (see Sacks, 1992) of 'people with mental problems'. Karen then worked to present herself as knowledgeable in the area of mental illness by drawing on her past experience, stating that she knew what kind of help was available and what was not available. She had been 'trying to stress' (line 299) to her family that her sister needed attention in this area, thus managing the self not only as knowledgeable of mental health concerns, but as a caring person and sister. Karen's frustration seemed to centre around the observation that although they accepted her 'mental problems' and treated her with 'ease' because of them, her family did not seem to respect or appreciate the inside knowledge of mental health issues that she had gained from her experience, and were unwilling to see parallels between her situation and that of her sister. Thus, Karen emphasised care and understanding for her sister, which contrasted against the complaint of little understanding from her family.

### **The Dangerous Self**

An issue that emerged in the talk of primary participants when discussing how staff members might see them was that of dangerous behaviour. Here, the issue of psychoticism was negotiated through the inference of dangerousness. David and I had been talking about how he saw the staff members at the service centre. I then turned the question around and asked how he thought they might see him (see Extract 31).

*Extract 31 (Sue-David/CS4/L409-413)*

- 409 S: how do you think that they sort of see you as a person  
 410 D: u:mm (2.0) umm (0.5) they're ver- like they're tolerant  
 411 towards me  
 412 S: mhm  
 413 D: they know who I am they're not afraid of me:

David introduced the notion of dangerousness, yet dispelled it by claiming that staff members knew him, that they knew not to be afraid of him. He considered the question, pausing for two seconds, started his response and then stopped. His trouble with this question was apparent. He said that staff members were 'tolerant towards' (lines 410-411) him, suggesting that they understood him. The emphasis on tolerance conveyed that this wasn't always the case, that others may be intolerant towards him. He went on to say 'they know who I am they're not afraid of me:' (line 413). This implied that people who are afraid of David do not know who he is; that he is not dangerous, but is perhaps often misrepresented in this way. That the topic was mentioned at all suggests the salience of the stereotypes and fear surrounding mental illness, fears that staff members may hold and that David was aware of.

Carl had also alluded to dangerousness in his talk of staff members' perceptions of him. First, though, he broached the issue of power. After talking of family members' views, I led on to staff members' views. When I asked how he thought staff members might see him, Carl replied that he did not care (see Extract 32).

*Extract 32 (Sue-Carl/CS3/L114-122)*

- 114 S: yeah? (1.5) okay (0.5) what about say the support staff  
 115 here?  
 116 C: mm?  
 117 S: how do you think they might see you?  
 118 C: tell you the truth I d↓on't really c↑a::re  
 119 S: yeah? (1.5) okay (1.0) do [you think]  
 120 C: [underling]s worry  
 121 about superiors superiors don't worry about underlings  
 122 ((smiling voice))

I gave a questioning 'yeah?' (line 119), and waited to see if he would continue or explain further. When this did not look likely, I started to ask another question, and then Carl explained, '[underling]s worry about superiors superiors don't worry about underlings' (lines 120-121). Given his earlier statement about not caring, there is the assumption that Carl was positioning himself as superior to staff members, as a superior would not 'worry' about someone below them.

Later in the interview, the issue of staff members' perspectives of him arose again, this time in regard to how they might influence Carl's self perspective. We had been talking of the influence that family members might have on Carl's view of self, and had progressed on to staff members (see Extract 33).

*Extract 33 (Sue-Carl/CS3/L247-257)*

- 247 S: (2.0) that's good (1.5) yeah (1.5) okay (0.5) say (.) what  
 248 about say maybe the support staff here (.) do you think they  
 249 might influence the way that you see yourself and the way  
 250 that you feel?  
 251 C: (4.0) ahhh (0.5) I'd say they've got a (2.0) mildly interested  
 252 (1.5) perception o-o-o-of my behaviour (.) so they don't  
 253 have to call the police  
 254 S: oh r↓ight (.) yeah (0.5) so it sort of sounds like you're not  
 255 really i- you don't really care too much about (.) about staff  
 256 and  
 257 C: no I don't care what people think about me basically

Here, Carl conveys that staff members did not care about him beyond an inferred alert to potential violence. I asked Carl whether he thought that staff members might influence the way he saw himself or the way that he felt. After a long four second pause, Carl said '(4.0) ahhh (0.5)



I'd say they've got a (2.0) mildly interested (1.5) perception o-o-o-of my behaviour' (lines 251-252). The pauses in this statement show that Carl had carefully chosen his words. The claim that staff were 'mildly interested' in him is sarcastic, yet suggests that Carl believed himself to be of no great importance to them. Adding to this was the implication that staff members were only interested in his behaviour rather than Carl as a person. Carl positioned this 'mild interest' as a kind of monitoring task, going on to say '(.) so they don't have to call the police' (lines 252-253). That is, the only reason for this interest was the threat of his possible dangerousness, that staff members at the service centre only watched him to ensure that he did not act up and threaten to harm either himself or others. Any potential resentment of being interesting to others in this limited way was dismissed by Carl's final statement: 'no I don't care what people think about me basically' (line 257).

Carl had talked of power in terms of superiors and subordinates. He had also talked of care. He did not perceive staff members as caring about him, and had voiced his opinion that he did not care how others saw him. Both Carl and David, however, had introduced the notion of dangerous behaviour, and Carl inferred that staff members saw him as a potential threat to their safety. Dangerous behaviour is often linked to psychoticism (Coid, 1996), suggesting that some primary participants were well aware of behaviours and stereotypes pronounced as 'typical' of schizophrenia.

### **The Non-Symptomatic Self**

This awareness of stereotypes may have led some people to present themselves as non-symptomatic, where self descriptors aligned to socially

acceptable behaviours. Carol and I had been talking about how friends and family might see her, and this had progressed to staff members at the service centre she attended (see Extract 34). She was the only person to specify which staff member she was referring to, whereas other primary participants tended to generalise across staff members.

*Extract 34 (Sue-Carol/CS5/L275-286)*

- 275 S: yeah its its one of those hard questions (.) if you sort of  
 276 think about it we::ll (0.5) yeah okay what about say maybe  
 277 the support staff here (0.5) so ho-how do you think they'd  
 278 describe Carol?  
 279 C: well Viv would describe me as pretty umm (2.0) >pretty  
 280 bright pretty intelligent pretty capable I spose<  
 281 S: mmm  
 282 C: Luke I dunno (.) I dunn↑o what Luke and the others would  
 283 sa↑y (1.5) Luke I'd normally have the most to do wi↑th  
 284 S: yeah  
 285 C: confident I think Luke would put me as (0.5) or more  
 286 confident

In response to how support staff might see her, Carol's talk oriented to intellectual and personal capabilities. Carol spoke quickly and deployed a three-part listing technique (Jefferson, 1990) giving a view of how Viv would see her. She utilised the moderating term of 'pretty' - '>pretty bright pretty intelligent pretty capable I spose<' (lines 279-280). Offering these attributes in a quick manner enhanced the comprehensive nature of the claims that the listing technique had allowed. The use of the moderator toned down any extreme impression that the characteristics may have engendered.

Carol then went on to describe how Luke and other staff members might see her. She said that she did not know what they would say, despite

her regular contact with Luke. Carol offered 'confident', and then changed this to 'more confident' (Lines 285-286). The use of the term 'more' once again acted as a moderator, toning down any implied extremes.

Ken also utilised a trait characteristic approach in saying '...I'm not quite sure (.) oh they'd probably think I'm hard working' (Ken/CS1/L170-171). Here, Ken emphasised effort in his daily activities. These types of descriptors actually oppose the negative behaviours and symptomology said to characterise the schizophrenias.

Accounts that appeared to be oriented towards contradicting negative symptomology were also presented by both Deb and Brenda. Extract 35 shows Deb's perceptions of how staff members might see her, and like Carol, this talk followed friends and family's view of herself.

*Extract 35 (Sue-Deb/CS9/L199-207)*

- 199 S: okay umm (.) what about the (.) the support staff (.) say  
 200 like at umm ((service provider))  
 201 D: mhm  
 202 S: umm (.) yeah ho-how do you think they'd sort of see you as  
 203 a person?  
 204 D: oh now u:m (0.5) I don't know I tend to liven things ↑up  
 205 actua↑lly when I(h)m at ((service provider)) ((laughing)) uh  
 206 they're giving me the responsibility of doing the volunteer  
 207 I↑ibra↓ry

Unlike Carol and Ken, specific descriptors were not used in Deb's account of how staff members would see her. Rather, Deb's account inferred a lively, outgoing, responsible view of self that staff members held of her. Deb first drew a distinction between past and present behaviour, saying 'oh now u:m...' (line 204). This inferred that in the past, staff members may not have seen her in the way that she was going to claim.

She then said, 'I don't know I tend to liven things ↑up actua↑lly when I'(h)m at ((service provider)) ((laughing))' (lines 204-205). The use of 'actua↑lly' tends to suggest that the claim was counter to what might have been expected, and the laughter in her statement served as a further behavioural warrant for the claim.

Deb then went on to state 'they're giving me the responsibility of doing the volunteer l↑ibra↓ry' (lines 206-207). The claim was rhetorically organised to counter any refutation of Deb as a responsible person. By placing the word 'responsibility' before the task, 'doing the volunteer l↑ibra↓ry' was constructed as a responsible task and position to hold. That staff members had 'given' Deb this task worked to enforce the notion of Deb as a responsible person. That is, staff members would hardly give an irresponsible person a responsible position.

Primary participants drew upon many different discursive devices to manage a non-symptomatic self from the eyes of staff members. All perceptions of self in this instance were oriented to oppose the symptomology and behaviours said to surround schizophrenia.

## Care

The second major issue appearing in many accounts given by primary participants was a lack of care. There appeared to be a differentiation between family members and support staff as to the amount or extent of care that was expected. The two extremes of neglect from others and dependency upon others arose, highlighting the delicate balance between how much care to accept and the possible clash with independence.

## The Neglected Self

When I asked Rick how he felt about himself, rather than giving his own views about himself he instead discussed how he thought his family saw him. Here, Rick invoked mental illness to his advantage, which was in contrast to the rest of his interview, where he had placed problems in the past and taken care to present himself as not having a mental illness. Talk prior to Extract 36 dealt with drug abuse, and Rick had explained that in his last job he had to undergo drug tests - 'It was either that or lose my job' (Rick/CS8/L85).

### *Extract 36 (Sue-Rick/CS8/L86-119)*

- 86 S: yeah (1.0) yeah okay (0.5) so (.) how (0.5) how do you sort  
87 of generally feel about yourself now?(0.5)
- 88 R: u::m (0.5) o:h I still- I still have to put up with the stigma  
89 of mental illness even from my own family
- 90 S: yeah?
- 91 R: its just my- m↓y family's told me straight out in front of  
92 people I'm a burnt ↑unit (.) that I don't really (.) b↑other
- 93 S: mhm (.) and how do you fe[el about that?]
- 94 R: [what's the poi]nt?
- 95 S: mmm
- 96 R: what do you d↑o?
- 97 S: yeah
- 98 R: what are you sposed to do? (0.5) how are- how are you as  
99 one person gonna change their (.) their thinking?
- 100 S: [mhm]
- 101 R: [you j]ust can't do it (.) you're wasting your t↑ime (0.5)
- 102 S: yeah (1.0) and sort of saying it in front of[ pe]ople as we:ll
- 103 R: [yep]
- 104 well my nurse (.) my my brother is actually (.) a nurse (.) so  
105 he should (.) have some insight he's done the mental health  
106 shit

- 107 S: mmm
- 108 R: he should have some sort of insight into mental illn↑ess and
- 109 he said straight out I'm a burnt ↑unit
- 110 S: yeah
- 111 R: so yeah (.) ever since then I just (0.5) have very little to do
- 112 with my family at a↑ll
- 113 S: yeah (.) so how how do you think they would describe
- 114 [you?]
- 115 R: [I don]'t know (.) my mother sort of walks in and walks out
- 116 of my life when she feels like it (0.5) [and I]'m not willing=
- 117 S: [mhm]
- 118 R: =to put up with that so I would r↓ather (.) if she can't be in
- 119 my life fulltime well (.) don't bother (1.5)

The issue of care was paramount in this extract. Rick presented this as a hopeless situation, and worked to show that he was merely treating his family as they treated him. In this section of the interview, although I had changed the direction of talk, Rick continued from the last topic of implied discrimination with a complaint, stating 'I still have to put up with the stigma of mental illness even from my own family' (lines 88-89). Here Rick suggested that there were certain expectations of stigma from the general community surrounding mental illness. The emphasis he places on 'family' conveys that Rick expected his family to show a better understanding of (and care for) him than he might receive from the general community.

He then went on to give his family's perspective on himself - that he was a 'burnt ↑unit' and that he did not 'really b↑other' (line 92). Rick managed accountability (see Potter et al., 1993) for this viewpoint through stating that his family had told him this in front of other people. The implication was that it would be possible to ask others for confirmation of the telling, that it was not simply his perception of the situation.

When I asked Rick how he felt about this, he responded with a series of rhetorical questions - 'what's the point? what do you d↑o? what are you sposed to do? how are- how are you as one person gonna change their ...thinking?' (lines 94-99). He concluded that the situation was hopeless, that he could not change it. This aligned with the perspective of his self that he posed his family had given, that he did not bother. Here, Rick had worked to explain why he did not bother, confirming the opinion of his family, yet revealing a retaliatory response; they did not think he bothered and, therefore, he was not going to bother with them.

I pointed out that his family had made these remarks in front of others, and Rick went on to narrow this family perspective to that of his brother's perspective. He revealed that his brother had made the remark about him, and invoked the term 'insight' twice in this section of talk (lines 105 & 108), implying that his brother should have known better given his training and experience in mental health. Throughout the interview, Rick had avoided inference of mental illness, and although he did not quite place himself into the category of mentally ill, Rick was able to claim culpability on his brother's part by inferring that given that his brother believed him to be mentally ill, he should have treated him with greater understanding and care. Rick concluded that ever since this incident, he had little to do with his family.

Although Rick clearly described distant and acrimonious relationships with his family, I asked him how he thought his family would see him, seeking to add to the descriptor of a 'burnt ↑unit', of someone who did not bother. He said that he did not know, and went on to give an opinion of his mother. In Rick's view, his mother did not care for him as

she 'walks in and walks out of my life when she feels like it' (115-116). He said that he was not willing to put up with this behaviour, and finished with the stated words of his brother - 'don't bother' (line 119).

Underlying this entire passage of talk was the issue of care. Rick claimed that his family did not think that he cared, and he counter-claimed that they did not care for him. It could also be read as Rick managing accountability for any responsibility in maintaining relationships with his family or managing disappointment over their absence in his life.

Carol also believed that her family had a low opinion of her. Rather than giving a specific description of how her family might see her, she gave a generalised negative perspective (see Extract 37). Later in the interview, she further explained the dynamics of her family interactions (see Extract 38).

*Extract 37 (Sue-Carol/CS5/L259-268)*

- 259 S: (2.0) so ho-how do you think maybe friends (.) and family  
 260 (.) would describe you (.) as a person?  
 261 C: well the friends I've got now would be more- a lot more  
 262 positive about me even more than my family would I think  
 263 S: yeah?  
 264 C: I don't think my family think a great deal of me in a lot of  
 265 wa↑ys (0.5) they'll (.) do things to help and be there if I  
 266 need em sort of (0.5) but generally (0.5)  
 267 S: yeah  
 268 C: ours is a sort of a (.) fairly dysfunctional sort of a family

Carol first gave a view of how her current friends – ‘the friends I've got now’ (line 261) - would see her. She began to say that they would be 'more' positive about her, then upgraded to 'a lot more' positive (lines 261-262), implying a dramatic change between past and present friends. She



went on to compare her present friends to her family, saying that her friends would be more positive about her than her family would. This background information worked to set up the following statement about the nature of her relationship with her family.

Carol said, 'I don't think my family think a great deal of me in a lot of ways' (lines 264-265). The use of first person here denotes that this was her perspective, and that she had acknowledged this. 'I don't think' worked to show that she was unsure, that her family may not have made their opinions evident to her, and that she was perhaps drawing her perspective from events and family behaviours toward her. It also allows for the possibility that her family may think more of her, but may not show it. Rather than attributing negative characteristics, Carol framed her family's low opinion of her in terms of not seeing much that was good in her: 'I don't think my family think a great deal of me' (line 264). This was quite a strong statement to make, and was softened through a further explanation that her family would 'do things to help and be there' if she needed them, 'sort of' (lines 265-266). The addition of 'sort of' here acted to balance the latter positive information with the strong negative statement. That is, a family who would assist Carol and 'be there' for her when she needed them suggested that they were not negligent and couldn't be accused of abandoning her. 'Sort of' mediates the two claims by toning down the positive statement and acknowledging the contradiction.

Carol then gave a general view of her family: 'ours is a sort of a fairly dysfunctional sort of family' (line 268). 'Sort of' is utilised twice here, and again works to tone down the strength of the dysfunction claim. It also minimises accountability for needing to be able to describe the nature of the

dysfunction. The tempering of negative statements about her family's opinion of herself was characteristic in this section of talk. Later in the interview, when speaking of whether her family had changed over time, Carol expanded upon her earlier characterisation of her family (see Extract 38).

*Extract 38 (Sue-Carol/CS5/L598-620)*

- 598 S: yeah (1.0) okay do you think that maybe you're family has  
 599 changed I mean we talked about say you changing as a  
 600 person (.) over time do you think you're family (.) has  
 601 changed?  
 602 C: a little bit  
 603 S: mmm  
 604 C: but not enough to really understand or to support properly  
 605 S: (1.5) yeah (1.5)  
 606 C: not umm well financially they'll help me if I need it  
 607 financially they'll help me anytime (0.5) even though they  
 608 grizzle and groan about it they're still willing to do it  
 609 S: yeah  
 610 C: but when it comes to support and everything there's not a  
 611 lot of it there (.) really  
 612 S: mmm  
 613 C: I had a fairly good talk with me brother the other week and  
 614 that sort of se- opened his eyes a little bit  
 615 S: yeah?  
 616 C: but (0.5) its I↑ike we don't care (.) we just 'oh okay gotta  
 617 spend time together'  
 618 S: mmm  
 619 C: (cough) it's not that they don't care they do but just not the  
 620 sort to show it (.) as well as others are

In Extract 38 Carol manages her claim of a lack of support from her family by drawing a distinction between pragmatic support and the

emotional support that would come from feeling understood. Carol believed that there had been a 'little bit' (line 602) of a change in her family over time, but not enough of a change for them to be able to 'understand' or to support' her properly (line 604). She elaborated upon her earlier talk detailing the type of assistance she received. Stating that her family would 'grizzle and groan' (line 608), Carol conceded that they would assist her financially if she needed it, 'but when it comes to support and everything, there's not a lot of it there really' (lines 610-611). A specific meaning appeared to be reserved for the term 'support', that of emotional support. For Carol, emotional support from her family was lacking, although she went on to say that she 'had a fairly good talk' (line 613) with her brother recently. Being able to talk freely with family members was also evident in Deb's account, where thoughts and feelings were at issue. Carol presented her talk with her brother as having 'opened his eyes a little bit'. This suggested that her brother now had a greater awareness of Carol and the problems that she had faced in her life.

Emotional support and understanding in this piece of talk are aspects of the more basic issue of care. Carol had offered that financial support was available from her family, yet these deeper aspects were not 'really' there. She said, 'it's like we don't care, we just 'oh okay gotta spend time together' (lines 616-617). The obligation of family interaction was proposed through attributed speech, and Carol's use of the term 'we' clearly marks the self as a member of this group (family) that 'really' did not care for each other.

The last two lines of the extract appeared to reverse much of what Carol had previously said, conveying a reconsideration of familial care. Carol said, 'its not that they don't care, they do, but just not the sort to show

it as well as others are' (lines 619-620). In this correction of speech, 'we' had become 'they'. Carol had presented herself as no longer a part of that group. This separating of self from family allowed Carol to position the self in the group of 'others', who were able to show their care, inferring that she was a more aware and caring person than the other members of her family. Thus, Carol had conveyed that the shortcomings of the emotional quality of the relationship she had with her family are clearly attributable to failures of understanding and 'real' care on the part of her family members. The possibility that those relationships could perhaps become more supportive in the future was tentatively raised by suggesting that the care existed but was just not expressed.

### **The Dependent Self**

Another direction relating to the issue of care was apparent in David's account of familial interaction. Here, a struggle emerged as he tried to find a balance between the amount of assistance to accept from his parents and his need for independence. Extract 39 shows David establishing his need for independence from his parents, and in Extract 40 he explained where this need had come from. In this first section of talk, I had asked David how he thought his friends and family would describe him. He spoke of his sister not being bothered, and went on to an account of his mother and father.

#### *Extract 39 (David/CS4/L270-291)*

270 D: =my parents just sort of (1.0) you know (0.5) I'm not  
 271 worried I'm old enough (.) I've decided like (.) when I got  
 272 into my new house like four or five years ago (.) decided I'm  
 273 not gonna have much to do with them

- 274 S: mmm
- 275 D: you know they're still there you know (.) be polite (1.5) but
- 276 u:mm (gulp) I'm not gonna (.) I'm not gonna run to them
- 277 with every little probl<sup>↑</sup>em get- you know grow up sort of
- like
- 278 umm (0.5) be more independent
- 279 S: yeah
- 280 D: you know yeah (.) they di- they didn't sort of know what I
- 281 was goin through sort of when I first got a mental illness like
- 282 (.) they'd be wonderin what to do all the time
- 283 S: mmm
- 284 D: and it was a quite a stress on em (.) so like now I'm in my
- 285 place (0.5) you know (0.5) I don't (.) ring em up (.) I don't
- 286 (.)=
- 287 S: yeah
- 288 D: =every day and complain and complain you know so (.)
- 289 independent actually totally independent I am
- 290 S: yeah
- 291 D: you know on my own compared to with my parents

David started out as though he was going to give a description of how his parents would view him, but then oriented his talk toward showing his maturity and independence from his parents. He said, 'I'm not worried I'm old enough' (lines 270-271), and spoke of a decision that he had made about not having much to do with his parents once he had moved into his 'new house' (line 272). The issue of being 'old enough' to live independently from his parents would not ordinarily be raised, as David was 28 years old. To raise this issue and claim that he was not 'worried' worked to promote the opposite; that David was indeed 'worried' about living apart from his parents. There was also trouble in this piece of talk, as past and present tended to overlap. David had referred to the present by saying 'I've

decided' (line 271), and talking of his 'new house' (line 272). He then said that it was 'four or five years ago' (line 272) that he had moved in to this house. It is possible then, that for David, events and issues of the past were still very much in the present.

David went on to say that he knew they (his parents) were still there and that he would be polite, but would not run to them with his problems. He would 'you know grow up sort of like umm (0.5) be more independent (lines 277-278). This was suggestive that although he lived apart from his parents, he still had some security in knowing that they were there, that he was not completely alone. Here he positioned himself as independent by restating that he did not ring them up and complain. He finished with a confirmation of his autonomy – 'independent, actually totally independent I am. You know, on my own as compared to with my parents' (lines 289 & 291). This emphasis on being 'totally' belies the security that David suggested that he obtained from knowing his parents were 'there'. The tension between these positions again suggests that independence is a problematic issue for David, and a source of ambivalence.

Conflict appeared within David's talk, as he presented the self as independent from his parents and wanting to 'grow up'. Yet, it was also apparent that he wanted the security of his parents to help him with his problems. His portrayal of his parents' view of him was not clear, but the underlying impression was that his parents saw him as a child. This came from his talk of age and independence. David attempted to reverse this parent/child image, however, impressing his independence from his parents and showing insight into and concern about the amount of stress that his problems had placed upon them.

Later in the interview, I asked David if he thought that his parents had noticed a change in him (see Extract 40). He appeared to consider this, as a three and a half second pause ensued. David then stated, ‘they know I’ve got a mental illness’ (lines 695-696), implying that a ‘mental illness’ may bring about a change in self, which his family may have noticed. In addition to this, the statement also reveals the impact that ‘mental illness’ has on relationships. It makes salient the role that having David’s diagnosis would play in how his parents might notice, respond to, and anticipate his behaviour. David then went on to talk of how his parents had changed over time.

*Extract 40 (Sue-David/CS4/L693-714)*

- 693 S: yeah (0.5) so so what about your family (.) do you think  
 694 they might [think you've cha]nged?  
 695 D: [my family u:::h] (3.5) they know I've got  
 696 a mental illness  
 697 S: mmm  
 698 D: (1.5) they have changed they probly (0.5) s- umm you  
 699 know they probly u::mm (0.5) they're (.) always ready for  
 700 when something goes wrong (.) as parents usually are  
 701 S: yeah  
 702 D: you kno<sup>↑</sup>w (1.0) like you (.) soon as they notice you're sick  
 703 they're in the d<sup>↑</sup>oct<sup>↓</sup>or  
 704 S: mmm  
 705 D: you know that's that's the thing about it (0.5) but I don't  
 706 want mum to like- that's what I mean (.) you know they're  
 707 always there they're always ready to help you (0.5) an  
 708 u::mm (0.5) when you're at home they- you can tell (.) they  
 709 always wandering round and they're always wondering (.)  
 710 you know 'are you alright' (.) you know (0.5) yeah so (0.5)  
 711 [ye]ah (0.5) my pa- my parents always (.) they don't mind  
 712 S: [oh]

713 D: they don't mind I think they're over the worst of it you know  
 714 the shock (0.5) my sister (.) I don't think she even (.) cares

In addressing the issue of a change in how his family see him, David's response tends to centre on the way in which their current attitudes toward him have focused on his potential for problems. David spoke of his parents' behaviour toward him, and how this had changed. He said, 'they're (.) always ready for when something goes wrong', adding '(.) as parents usually are' (lines 699-700). This additional remark worked to present his parents as no different from any others, as being prepared was a behaviour fitting people who belonged to the category of parent. This categorisation of his parents was followed by the example of: as 'soon as they notice you're sick they're in the d↑oct↓or' (lines 702-703). The category bound behaviour of notifying a doctor when a child is sick is something that David had inferred parents do. Therefore, in contrast to when he was initially ill, David had indicated that his parents were now ready for him to be 'sick'.

This parental behaviour appears to be a problem for David, and he complains at line 705. He had stated that as soon as his parents noticed that he was sick, they went straight to the doctor. He followed this with, 'that's the thing about it, but I don't want mum to like- that's what I mean, you know, they're always there, they're always ready to help you' (lines 705-707). Here, David has difficulty in voicing the problem that he has with his parents, rendering the complaint slightly ambiguous. He may be complaining that his parents tended to take control of his problem. David had singled out his mother, even though he often said 'they', referring to both parents. He spoke of his parents' constant vigilance in watching him and wondering whether he was alright (line 710). David had conveyed



earlier that his parents were behaving as people belonging to the category of 'parents' should (see Sacks, 1992), showing their care for him (their son) and helping him when he had problems. Yet, it may also be a complaint about relationship; that his parents' relationship is primarily with his diagnosis rather than with him as a person. That is, David's relationship with his parents had become completely characterised by their responding to the problem of his mental illness.

He started to continue with this line of talk - 'my parents always' (line 711) - but then changed direction, saying 'they don't mind. They don't mind, I think they're over the worst of it, you know, the shock' (line 713-714). This assertion accomplished a number of tasks. The change of direction suggests that David had become aware that he was complaining, thus redirecting his discourse to show awareness of others' perspectives (i.e. his parents). This positioned David as a caring son, worried about his parents' well-being. It also tended to water down the complaint, and again classified his parents' behaviour as category bound, as something that parents do, but something that parents do when they have to (i.e. when it is required by illness in their children). The idea that his parents 'don't mind' implies that they did mind, but that it was something that they had to work through - 'they're over the worst of it'. It also suggested that his emotional problems had diminished, and the intensity of his parents constantly watching him had decreased. There is also a sense of resignation here in that both David and his parents may have accepted what David's emotional problems mean for their relationship. David finishes this talk with a statement regarding his sister - 'my sister, I don't even think she cares' (line 714). For David then, the intense, watchful relationship that he had with his

parents was indicative of a certain amount of care, and this was preferable to no care at all.

David's account implied that his parents saw him as a child who needs to be cared for. In these two extracts he strove to assert his independence from his parents. Yet, he maintained that his parents were typical of other parents, wanting to care for their children. Despite a complaining about the kind of relationship that had developed between himself and his parents, David conveyed that this kind of care was preferable to no care at all.

## **Conclusion**

Problems in relationship were evident in participants' descriptions of their families' perceptions of them, with accounts orienting toward the issues of understanding and care. Complaints of problematic familial interaction appeared to stem from misunderstandings of the person's self, highlighting communication difficulties between the person and their family members. For example, Deb conveyed past communication difficulties between herself and her parents, suggesting that as this had improved, so had their views of her. Karen spoke of feelings of frustration, and claimed that her family were 'still not really listening' (Karen/CS6/L314).

A second issue generated from the interviews was that of care, ranging from inferences of neglect to that of dependence. Rick managed accountability and disappointment as he conveyed that his family did not care about him. Carol initially echoed this claim, but later positioned family members as not making their care for her apparent. This links back to the previous issue of misunderstandings in that the behaviour of family

members may be interpreted as uncaring due to a lack of overt affection and possible miscommunication. In an area such as mental health, observable behaviours, along with what is said and left unsaid are open to diagnosis. In this case, as primary participants have had their words and behaviours subjected to 'professional' scrutiny, it may be assumed that the words and behaviours of family members and 'others' must also be subjected to that same scrutiny. Like Carol, David also suggested that his family did care about him. Concerns here dealt with his over-reliance on that care, his dependence upon his parents.

Versions of how staff members might see the person were oriented toward the monitoring of their behaviour. Most participants presented a socially acceptable, non-symptomatic self, perhaps the kind of self that would be expected of people in the process of recovery. Carol gave a version of self that oriented toward intellectual capabilities, whereas Deb focused on a responsible self as she had been given the task of managing the volunteer library. The much publicised link between psychoticism and dangerousness was raised by David and Carl. David proposed that staff members understood him as they were not afraid of him, suggesting that fear of the unknown (the unwell person and their behaviour) was at the heart of stigma and stereotypes about mental illness, rather than a legitimate response to his behaviour. Carl also introduced the notion of dangerousness, stating that it was the sole source of staff members' interest in him, inferring that staff members were merely looking out for themselves.

Hence, problems in relationship were apparent in primary participant accounts of how family members might see them. To a lesser degree, these

problems were also evident in versions of staff members' perceptions of the person's self. The differing roles that family and staff members played in the lives of primary participants worked to prompt expected category bound behaviours. People fitting the membership category of family were expected to show care and understanding, whereas people fitting the membership category of staff were expected to monitor the behaviour of consumers. Care and understanding were still expected of staff members, but perhaps not to the same degree as with family members. The suggestion here is that improved communication between the person and their immediate others may engender a better understanding of the person and their problems.

## CHAPTER 6 – Problems of Relationship: Emotional Support and Social Validation

Shared understandings of a given phenomenon are negotiated between the self and others over time through dialogue (Garfinkel, 1967). In this way, a sense of self exists in social relationships, as with others, people create an idea of who they are. This process of negotiating and renegotiating the self is continual. Over time, more information is brought into this dialogue or information changes. A discursive, relational perspective of the self then, will necessarily take on board accounts given of others.

*“My subjectivity is accessible to me in a way his can never be, no matter how ‘close’ our relationship. My past is available to me in memory in a fullness with which I can never reconstruct his, however much he may tell me about it. But this ‘better knowledge’ of myself requires reflection... To make it available requires that I stop, arrest the continuous spontaneity of my experience, and deliberately turn my attention back upon myself. What is more, such reflection about myself is typically occasioned by the attitude towards me that the other exhibits. It is typically a ‘mirror’ response to attitudes of the other”.*

*(Berger & Luckman, 1966, p.44)*

In this chapter, accounts of others came through talk about themselves and how participants perceived that significant others would see them. In many instances I did not ask this question directly. In negotiating these accounts of self, the impact of a label and its associated characteristics

cannot be downplayed as it can have a major influence on the perceptions and interactions a diagnosed person has with others. Fundamentally, the label in itself suggests an unstable or unpredictable self. As Scheff (1999) explains, to be able to predict the behaviour of others is the cornerstone of social order. Unpredictable behaviour, normative violations or deviance, give way to fear and anger as social transactions halt. This results in a process of labelling, segregation, and stigmatisation. For example, the person receives a label such as schizophrenic, which then encourages social segregation (perhaps institutionalisation). The label carries with it an abundance of associated behaviours regardless of whether others observe these behaviours or not, such as the linking of schizophrenia and violence. This in turn, encourages further segregation, stigmatisation and labels.

Through the inclusion of accounts of others, this chapter explores the way in which a mental health label plays out in a relational sense; it examines the effect a mental health label has on a person's conception of themselves. If the person is already known to others (i.e. family), a sense of self has already been established before a mental health label was given. Here, the self must be renegotiated or reinterpreted to incorporate the behaviours and responses associated with that label. In other relationships (i.e. with mental health workers), the label is known first and the person is then intertwined with characteristics associated with the label. As in the previous chapter, different issues emerged for participants depending upon the group of people they were referring to.

## **Fitting a Label to the Self**

Family members are more likely to hold knowledge of participants' past experiences and behaviour. A notion of self has already been established between the person and their significant others before clinical labels are applied. The accounts given of familial interaction then can be revealing in the sense that they indicate the reciprocal impact of problems. Participants' reflections of the past convey versions of themselves and events that highlight problems with family members which may still be relevant for them in the present. Reflections of the present take on board unresolved conflict, but here participants also look to allies within the family that they relate to more easily.

### **Reflections of the Past**

Past reflections on familial interaction predominantly dealt with conflict and a lack of communication. Primary participants spoke of either not talking about personal issues with their family, or of exchanging angry words, usually with their parents. Some participants highlighted personal affronts, with two people focusing on a specific event that had taken place as evidence of their discontent with these relationships.

### **Silence**

Reports of antagonism between the person and their family ranged from an uncomfortable, familial silence, where issues remain unspoken, to heated exchanges. Carol's account of past interactions with her family centred on the issue of silence. She said that she felt that she had 'never been understood' by her family, presenting understanding as something that could only be the result of shared experience. She introduced possible

similarities between herself and her father, recounting physical problems that he had later in his life, such as arthritis. Extract 41 outlines a complaining, where Carol protested her lack of knowledge about her father and her family's suppression of intimate discussion.

*Extract 41 (Carol-Sue/CS5/L381-402)*

- 381 C: but then I've never been understood by my family  
 382 S: mmm?  
 383 C: well that's how I felt anyway (1.0) but they haven't had to  
 384 live with the pain the only one who had any similarities was  
 385 dad but then h↑e copped it when he was o↑lder I↑ copped it  
 386 from b↑irth  
 387 S: mmm  
 388 C: and uhh (2.0)  
 389 S: so he sort of had similar problems to what you had?  
 390 C: well he did have yeah  
 391 S: yeah  
 392 C: he's dead now (.) has been for a while  
 393 S: mhm  
 394 C: but he copped his through arthritis and stuff like that more  
 395 than anything (1.0) so (0.5)  
 396 S: yeah  
 397 C: I dunno (2.0) I mean he may have had problems when he  
 398 was younger but (0.5) I dunno  
 399 S: mmm  
 400 C: we never talked about things (.) our family just don't talk  
 401 about things you (.) put- sort of put- really personal or  
 402 intimate sort of thing

Talk of what was known to Carol regarding her father's problems conveyed a sense of interest and disappointment. Trying to find similarities in problems between herself and her father, Carol said 'h↑e copped it when he was o↑lder I↑ copped it from b↑irth' (lines\_385-386). The use of the



phrase ‘copped it’ inferred problems inflicted from an outside source, whether deserved or not. This positioned them both as victims to an extent, although Carol immediately drew attention to the differences in the nature of their suffering; differences which precluded understanding.

Carol then reflected on the limits of her knowledge of her father, ‘I dunno (2.0) I mean he may have had problems when he was younger but (0.5) I dunno’ (lines 397-398). Used as a precursor, Carol's claim of not knowing worked to lead into the basis of her complaint – ‘we never talked about things’ (line 400). The emphasis on the term ‘talked’ placed this lack of familial communication into the past, perhaps to a time when her father was still alive. As her family did not talk about ‘things’ back then, Carol did not know whether her father (or any other family member) had endured similar problems in his younger days. Carol then brought this past behaviour into the present, continuing with ‘our family just don't talk about things’ (lines 400-401), generalising the specific (past) lack of knowledge about her father's health into a more global issue of personal communication, intimacy and understanding. Carol's account thus positioned her family as silent on personal matters. Despite her desire to understand them (and have them understand her) by drawing on linkages between herself and family, she conveyed frustration and disappointment at her lack of background knowledge of her family.

### **Antagonism**

This is not to say that the act of communication in itself was always beneficial for primary participants. Accounts of antagonism between family members emerged in the talk of three participants. For example, Brenda

spoke of having 'words' with her mother (Brenda/CS2/L182), whereas Deb and David talked of fighting with their parents. All three accounts, however, conveyed a change in this kind of interaction over time. Two people explained how they dealt with this antagonism.

Brenda had been talking of how she no longer lost her temper as quickly as she used to. I asked her what she thought was responsible for this change in herself. In Extract 42, Brenda gave an account of past behaviour and conflict with her mother, explaining that the provocation from her mother had not abated, but that she now dealt with it in a different manner.

*Extract 42 (Sue-Brenda/CS2/L177-194)*

- 177 S: mhm (.) and what do >what do you think< might be  
 178 responsible for that?  
 179 B: ↑I don't really kn↓ow (.) I think living at mum's I'm not  
 180 able- you know you had to be careful how you let off steam  
 181 S: mmm  
 182 B: yeah (1.0) cause we had words but (0.5) I've sort of just  
 183 walked away and let her have (mumbled) ◦way◦  
 184 S: y↑eah?  
 185 B: I just walk ◦↓away now◦ (0.5)  
 186 S: [so]  
 187 B: [I d]on't (.) I DON'T (0.5) umm (1.0) I don't retaliate like ◦I  
 188 used to◦  
 189 S: yeah?  
 190 B: no I just sort of walk away (0.5)  
 191 S: yeah found another way to deal with it=  
 192 B: mmm  
 193 S: =I spose  
 194 B: yeah (1.0)

In Extract 42, Brenda positions herself in relation to her mother. Antagonism of the past may still be relevant to the present, yet Brenda conveys an alternative means of dealing with her mother. In reply to my question of a change in her temperament, Brenda started with ‘↑I don't really kn↓ow...’ (line 179). This conveyed uncertainty or perhaps an unwillingness to give a definitive answer. Yet, as with Carol's account, Brenda's claim had managed to play down her interest or stake (see Potter, 1998) in the issue at hand. She implied that she was unsure, and this acted to counter other possible rhetorical alternatives to her ensuing response. Brenda had minimised self interest in the outcome of the question by claiming that she did not know, yet went on to respond with what she impressed as a logical, commonsense perspective.

Brenda's account of her relationship with her mother implied that there was a good deal of tension between them. A linguistic switch occurred in lines 179 to 180, where Brenda said ‘I'm not able-’, starting out in present tense, and then switched to past tense – ‘you know you had to...’. This revealed a change in reference to herself, where the term ‘I'm’ was changed to the term ‘you’. Wooffitt (2001) suggests that the latter type of talk (‘you’) is a speaker's appeal to normalise the behaviour at issue. That is, Brenda's use of the term ‘you’ here conveyed that the decision to take care when deciding upon a means to ‘let off steam’ was something that everybody would do in that situation. The switch from present to past was also suggestive that tension may still be current.

Brenda's suggestion that she takes care in this matter allows her to show insight into the effects of her behaviour upon others, in this case her mother. Her use of the idiom to ‘let off steam’ worked to minimise the

behaviour that might have otherwise been interpreted as aggressive. Drew and Holt (1988) suggest that idiomatic expressions are drawn upon to formulate complaints, particularly when the recipient's affiliation is in doubt. The entirety of the statement oriented toward a complaint, with Brenda protesting the need to be careful around her mother. The playing down of her arguments with her mother lent itself to possible doubt regarding my response (the recipient) to this knowledge. An issue faced by many people with a diagnosis of mental illness is ensuring that their behaviour is not seen as symptomatic. Doubt was also apparent when Brenda further explained 'cause we had words' (line 182). Letting 'off steam' and having 'words' are softer alternatives to saying that they argued.

Rather than revealing the essence of these arguments, Brenda went on to explain how she dealt with the situation. Three times she assured 'I've sort of just walked away' (lines 182-183, 185, & 190). Each time she stated this, Brenda inserted the word 'just', inferring that she did nothing more. She said 'I don't retaliate like I used to' (lines 187-188). Although her current strategy of walking away was presented as an improvement over her past retaliation, the use of the word 'retaliate' nonetheless implied that her past behaviour was not unprovoked, that her mother was the instigator of their arguments rather than herself. However, the phrase 'I used to', quietly spoken and added to the end of the utterance, suggested that the appropriateness of her own behaviour may have been questioned in this instance. In effect, this statement conveyed that Brenda was now in much greater control of her own behaviour, to the point of walking away from antagonistic situations rather than arguing.

Deb and David both spoke of arguing with their parents. Explanations were given to show the reason for this antagonism, and both people sought to convey methods that they had used to overcome such conflict. Deb cited communication difficulties as being the key to their problems with their family (see Extract 43).

*Extract 43 (Deb-Sue/CS9/L148-156)*

- 148 D: u::m my family (.) and I now get along (.) a lot bett↑er  
 149 S: yeah?  
 150 D: u:m we- we were (.) always fighting (.) before (.) cause  
 151 u:mm (.) now they understand (.) why (.) I was l↑ike that  
 152 (.) they understand the probl↑em  
 153 S: yeah  
 154 D: and (0.5) I can tell mum things n↑ow like before I couldn't  
 155 (.) really say how I was feeling (.) and I can- even my dad  
 156 n↑ow (.) now I've got a good communication thing go↑ing

Deb's account explains past and present interaction with her parents, and refers to communication as the key. In line 150, Deb utilised the extreme case formulation (Pommerantz, 1986) of 'always fighting' to explain familial interaction in the past. Placing this behaviour at an extreme enabled a contrast with current relationships. She said 'now they understand (.) why (.) I was l↑ike that (.) they understand the probl↑em' (lines 151-152). This implied that in the past, a lack of understanding of 'the probl↑em' by her parents was the reason for their constant arguments.

Deb spoke of not being able to say how she was feeling before, but that now she could talk to both of her parents about such personal matters – 'now I've got a good communication thing go↑ing' (line 156). Here, rather than saying 'we' have a good communication thing going, Deb said 'I'. That is, although acknowledging her parents' increased understanding of

her, Deb's account nonetheless also subtly emphasised her own role in producing the improvements in their relationship.

This was also reflected in a section of David's interview where he talked of his time in Heathcote Hospital, and how his parents described him when he was there (see Extract 44). He said that they saw him as very angry, and that this anger was something that he had to sort out.

*Extract 44 (David-Sue/CS4/L416-430)*

- 416 S: yeah do you fi↑nd that mu↑ch that sometimes people are  
417 afraid?
- 418 D: uhh >when I was-< when I used to get like (.) when I was  
419 like 20 (.) 21 I was in Heathcote and I w- you kno- my  
420 parents used to say I'd get very angry (1.0) but like (0.5)  
421 you know I thought (0.5) that's something I have to sort of  
422 u:mm (1.0) (swallow) you know >figure out< n an u:mm  
423 (0.5) you know keep calm and don't lose your (.) temper
- 424 S: mmm
- 425 D: because u:mm (1.5) they jus- >the more you lose your  
426 temper the less people that understan ya<
- 427 S: yeah
- 428 D: you know what I me↑an?
- 429 S: ◦mhm◦
- 430 D: they don't understand you don't get anywhere

In Extract 44, David, like Brenda, spoke of losing his temper. Like Deb, he talked of understanding. Marrying the two together, David said '>the more you lose your temper the less people that understan ya<' (lines 425-426). The use of the normalising pronoun of 'you' (Wooffitt, 2001) throughout this section of talk worked to make this reasoning unremarkable. Embedded within this talk is the issue of control: to be understood by others, the self must be controlled. The perspective that David conveyed

here was that a person is responsible for making themselves understandable to others, rather than the onus being upon others to understand the person or understanding as a joint process.

### **Personal Affronts**

Several accounts of past familial interaction invoked examples of personal affronts. These negative exchanges with family members were drawn upon to outline difficulties the participants had with specific people. For example, Scott was offended by the manner in which his cousins spoke to him - ‘they- they d↑id talk to me but not very nicely’ (Scott/CS7/L156). Ken also talked of negative interactions with family members, outlining the impact that this had on him. When talking of how friends and family might have influenced how he saw himself, Ken said, ‘when my dad was alive he was always putting me down and stuff and I used to put myself down pretty badly’ (Ken/CS1/L220-222). Ken’s talk about his father’s behaviour towards him emphasised the depth of the negative effect it had on him. Not only did his father put him down, but Ken manages his account to suggest that this is the reason that he (Ken) was also so hard on himself. In addition to this verbal degradation, Ken added ‘and stuff’ suggesting that there was more to it than he was saying.

Rick and I had been talking about working, and the regular drug tests he had to have. When I asked him how he felt about himself now, he spoke of his family, complaining of the stigma he experienced from them. In particular, his account focused on his brother, a health professional (see Extract 45).

*Extract 45 (Rick-Sue/CS8/L86-112)*

- 86 S: yeah (1.0) yeah okay (0.5) so (.) how (0.5) how do you sort  
 87 of generally feel about yourself now? (0.5)
- 88 R: u::m (0.5) o:h I still- I still have to put up with the stigma  
 89 of mental illness even from my own family
- 90 S: yeah?
- 91 R: it's just my- m↓y family's told me straight out in front of  
 92 people I'm a burnt ↑unit (.) that I don't really (.) b↑other
- 93 S: mhm (.) and how do you fe[el about that?
- 94 R: [what's the poi]nt?
- 95 S: mmm
- 96 R: what do you d↑o?
- 97 S: yeah
- 98 R: what are you sposed to do? (0.5) how are- how are you as  
 99 one person gonna change their (.) their thinking?
- 100 S: [mhm]
- 101 R: [you j]ust can't do it (.) you're wasting your t↑ime (0.5)
- 102 S: yeah (1.0) and sort of saying it in front of[ pe]ople as we:ll
- 103 R: [yep]
- 104 well my nurse (.) my my brother is actually (.) a nurse (.) so  
 105 he should (.) have some insight he's done the mental health  
 106 shit
- 107 S: mmm
- 108 R: he should have some sort of insight into mental illn↑ess and  
 109 he said straight out I'm a burnt ↑unit
- 110 S: yeah
- 111 R: so yeah (.) ever since then I just (0.5) have very little to do  
 112 with my family at a↑ll

This complaint started out with a general blaming, but became more specific, focusing on his brother. In lines 91 to 92, Rick claimed that his family had publicly declared him ‘...a burnt ↑unit ...’. Later in the extract, Rick became more specific, singling out his brother as the person who insulted him (line 109). In both instances, the words ‘straight out’ were



emphasised, seeming to remove the possibility that he (Rick) had somehow misinterpreted his brother's meaning, and had been overly sensitive.

The phrase, 'a burnt ↑unit' (lines 92 & 109), expressed the notion of an entity that was beyond repair, a person beyond recovery. The insult evoked a retaliatory response of criticising his brother for showing a lack of insight (lines 105-106). The suggestion of insight here could be oriented towards many possibilities. For example, Rick may be aligning to a belief that people with a mental health concern are not beyond repair, and that his brother (a nurse) should have been aware of this. It is equally possible that Rick had sided with the notion that if a health professional believed there was little hope of recovery for a person with a mental health issue, the person in question should not be informed of this. Whatever the implication that Rick had oriented to, his critical following remark of 'mental health shit' implied that Rick did not personally believe it.

The issue for Rick here was one of betrayal. His account conveyed personal insult from family members, specifically his brother. Of these family members, the person that Rick saw as best being able to understand his problems was the very person who had publicly insulted him. For Rick then, his brother had betrayed his trust, and given him little reason to pursue a closer relationship with his family.

Finally, Karen also spoke of conflict, personal insult, and problems of trust. When talking of whether her family had noticed a possible change in herself over time, she introduced what she saw as a contentious event that she still had an issue with (see Extract 46).

*Extract 46 (Karen-Sue/CS6/L331-338)*

- 331 K: u::mm (1.0) they could pick up on different things that were  
 332 wrong when I was sick
- 333 S: mmm
- 334 K: the- cause they're the ones that put me into the mental  
 335 institution anyway against my will
- 336 S: °yeah°
- 337 K: u::m ((voice quavering)) (1.0) sometimes I'm not- I don't  
 338 feel very happy about tha↑t

For Karen, an issue of trust in family members emerged. Karen started out by acknowledging their awareness of her problems, even granting that they may have had a clearer perception of ‘things that were wrong’ (line 331-332) as a result of her illness than she did herself. This awareness of her illness was quickly portrayed as problematic though, as Karen explained that her family had her institutionalised ‘against’ her ‘will’ (line 335). This was taken a step further when Karen revealed her unhappiness with their decision. The use of the word ‘sometimes’ (line 337), and may have been used as a softener, indicating that she was unsure of her ground. Karen’s references at other points in the interview to the positive changes in her brought about through medication and her accounts of the differences in her pre- and post-diagnostic self suggests that she may believe that she lacked insight into her own behaviour, and needed intervention from others. However, her ambivalence is expressed clearly in her statement that ‘sometimes I'm not- I don't feel very happy about tha↑t’ (lines 337-338).

## **Perceptions of the Present**

Participants' current perceptions of their family members dealt with unresolved conflict from incidents occurring in the past, how people dealt with (or were dealing with) this conflict, and specific family members that people saw as allies. These latter family members gave comfort, reassurance and understanding, allowing the person a sense of security in the knowledge that they were not alone. For the majority of relationships then, an agreed upon sense of self appeared to be in dispute yet for some relationships it appeared to have been successfully renegotiated.

## **Unresolved Conflict**

Karen suggested unresolved issues when she talked of her frustration with her family. When speaking of her sister's possible mental health problems, Karen said 'so I ge- I get a little bit frustrated >with my family when I try to explain to them what< mental illness is all about and they're still not really (.) listening' (Karen/CS6/L312-314). Karen tempered her statement by saying that she was 'a little bit frustrated'. Softeners such as this promote the speaker as reasonable, as not making an excessive claim (Edwards, 2000). This enabled Karen to avoid accusations of extremism, which may have been oriented toward symptomatic diagnoses, yet still make the claim of feeling frustrated with her family. That Karen would 'try to explain' to her family the issues surrounding 'mental illness' implied that either her explanations were inadequate, or that she was hampered in her efforts in some way. That is, to 'try' is to attempt but not necessarily to succeed. Karen alluded to this when she concluded her statement with 'they're still not really (.) listening'. The use of the term 'still' suggests that

this was an ongoing problem which she had attempted to address repeatedly, and once again, a modifier or softener prevented the assumption of extremes. The issue for Karen here was that her family did not listen to her. As with her account of past experiences, Karen had conveyed that nothing had changed in her interactions with her family.

When asked of familial change over time, Carol said ‘a little bit but not enough to really understand or to support properly’ (Carol/CS5/L602-604). Carol had talked earlier of the silence within her family, of their unwillingness to discuss personal matters. Her claim of ‘a little bit’ of a change in her family's behaviour over time was a show of concession that managed to avoid extremes, thus implying that she was being reasonable about the issue. The word ‘but’ placed after this concession worked to downplay the moderator, in effect impressing that the change was very small. Carol believed that her family had not changed enough to ‘really understand’ or ‘support’ her ‘properly’. This proposes that familial understanding was superficial, and did not have any depth.

### **Dealing with Conflict**

Other primary participants spoke of methods that they used to deal with familial conflict. Unresolved conflict was evident in the account given by Rick, where his brother had insulted him. Extract 47 was a continuation of this talk, where Rick spoke of disengaging himself from family.

*Extract 47 (Rick-Sue/CS8/L111-119)*

- 111 R: so yeah (.) ever since then I just (0.5) have very little to do  
 112 with my family at a↑ll  
 113 S: yeah (.) so how how do you think they would describe  
 114 [you?]

- 115 R: [I don]'t know (.) my mother sort of walks in and walks out  
 116 of my life when she feels like it (0.5) [and I]'m not willing=  
 117 S: [mhm]  
 118 R: =to put up with that so I would r↓ather (.) if she can't be in  
 119 my life fulltime well (.) don't bother (1.5)

Rick's account of unresolved conflict managed separation of himself from his family by implying a lack of understanding, commitment and support. I asked Rick how his family would describe him, and he replied ' [I don]'t know' (line 115). This worked to minimise Rick's interest in the matter (see Potter, 1998), giving the impression that he cared little about his family's view of him. He spoke of his mother coming and going in his life, suggesting that he wanted a more consistent interest and involvement from her. In addition to the personal affront from his brother, his mother's inconsistent behaviour gave further impetus for Rick to distance himself from his family. According to Rick's account, his family were a source of betrayal and disappointment, and despite his desire for them to understand and care more, it was not in his interests to continue to hope for better from them.

Like Rick, David had also separated himself from his family as a way of managing familial conflict brought about by his over-reliance on his parents. Early in the interview, David had talked about how he had decided not to have much to do with his parents once he moved into his own house. Later, David had spoken of how his mother had taken control of his emotional problems. He said that although it was nice of her to do that, it was his problem. Extract 48 furthers this by dealing with David's need for independence.

*Extract 48 (David-Sue/CS4/L877-882)*

- 877 D: I know- >I gotta know how to deal with it I gotta know<  
 878 (0.5) you know umm (1.0) I gotta- I've gotta do everything  
 879 myself now you know I'm 28  
 880 S: mhm  
 881 D: it's not one of those ages where you can run back and forth  
 882 to your mum all the time you know what I mean

In Extract 48, David provides a justification for wanting his independence. His need to deal with his emotional problems was apparent in his repeated use of the phrase 'I gotta know' (line 877). It also implied that at present, he did not know. His justification comes in line 879 where he declares his adult status, and goes on to give an explanation of the difference between an adult and a child in terms of decision making. That a man of 28 years of age would need to provide a rationale to justify wanting to control his own emotional problems was suggestive that in the past, others had made his decisions for him. In this sense then, independence would allow a separation from his parents.

### **Allies within the Family**

Several participants impressed the idea of having an ally within their family. Here there appeared to be more ease with the renegotiation of self. The ally was a family member that they could talk to and confide in, someone they believed understood them better than other family members did. The person was usually a parent, sibling, or spouse. David, Carl and Scott did not appear to align to any particular person, and although Brenda impressed devotion and pride in her son, she did not convey him as a confidant.

One person to give a positive current account of her parents was Deb. Deb had spoken of how she and her family got along better now than they had in the past (see Extract 49).

*Extract 49 (Deb/CS9/L154-156)*

154 D: and (0.5) I can tell mum things n↑ow like before I couldn't  
 155 (.) really say how I was feeling (.) and I can- even my dad  
 156 n↑ow (.) now I've got a good communication thing go↑ing

In this extract the emphasis on 'now' assisted in drawing a distinction between the past and the present. To be able to tell her mother 'things' and talk about how she was 'feeling' conveyed a sense of understanding between her and her parents. Thus, Deb 'now' viewed her parents as knowledgeable and sympathetic to her needs, as compared to the past.

Siblings were oriented to as allies by Rick and Ken, who spoke of their sisters, and Carol who spoke of her brother. Rick and I had been talking about how members of his family might see him. Here, Rick spoke of his sister (see Extract 50).

*Extract 50 (Rick/CS8/L123-126)*

123 R: [no (.) my sister I ]don't really know what my sister thinks  
 124 but (1.0) I've ou- I've asked her once (.) and everybody  
 125 reckons that me as a brother even though I'm different (.) is  
 126 like 'I don't care I love you you're my brother'

Extract 50 is slightly ambiguous, as Rick positions himself as loved despite his problems. Rick started out by saying that he did not know what his sister thought of him, and then revealed that he had 'asked her once'. That he had asked his sister suggested that her opinion of him was important

to him. He did not reveal her response though, instead switching his talk from his sister to ‘everybody’.

Rick identified himself in broad category terms as a ‘brother’ (line 125). This category was then used to trump the effect of his being ‘different’ and to render difference as something that siblings ‘don’t care’ (line 126) about and that doesn’t prevent him from being loved. Rick also changed the direction of talk from his sister’s opinion of him to a generalisation of ‘everybody’ (line 124). This managed the impression that everyone agreed that Rick was loved as a brother.

At stake here was whether anyone actually cared for Rick. In the talk preceding this extract Rick had spoken of how his brother, mother and step-father had held negative perceptions of him. Here, Rick appeared to go to the other extreme, conveying that everyone believed that his sister loved him. Portraying this knowledge as held by everyone can be understood as an attempt to render it irrefutable. Therefore, Rick had conveyed that belonging to the membership category of ‘brother’ should necessarily bring with it the benefit of being loved despite being ‘different’.

Ken also spoke about his sisters, in particular, his eldest sister. We had been talking about a possible change in the behaviour of friends and family since his problems had begun, and in Extract 51, Ken talked of how a problem in common had brought him closer to his eldest sister.

*Extract 51 (Ken-Sue/CS1/L268-278)*

- 268 K: (1.5) oh I think my two sisters are pretty understanding  
 269 S: yeah?  
 270 K: (mumbled) (4.0)  
 271 S: so you've sort of lost some people along the way but you've  
 272 kept [som]e other people?



- 273 K: [yep] I think I've gotten along better  
 274 with my oldest sister because (1.0) I was pretty uh mean to  
 275 her when she was feeling sick (0.5) and now I know what it  
 276 feels like to be mentally ↑ill  
 277 S: yeah  
 278 K: now I understand her problems

Here, Ken conveys closeness to one of his sisters through a commonality – being ‘sick’ (line 275) or ‘mentally ↑ill’ (line 276). Ken appears to align himself with his eldest sister (lines 273-274), and the reason for this came in the form of a confession, where Ken was ‘mean’ toward her ‘when she was feeling sick’ (line 275). To feel sick may be indicative of a physical or psychological illness, but it is non-specific with regard to both the type of illness and its severity. Ken then indicated that he had experienced the same kind of illness, this time using the term ‘mentally ↑ill’ (line 276), perhaps implying that Ken's sister also had a mental illness. Yet, he had played down her problems in describing them as ‘feeling sick’, as compared to his problems of being ‘mentally ill’. This talk positioned Ken's emotional problems as potentially more important, or more severe than his sister's, despite empathising with his sister in saying that he now understood what she had gone through. For Ken, this understanding had brought them closer together.

Carol's account conveyed that after a ‘good talk’ with her brother, she too, felt closer to her sibling. We had been speaking of a possible change in her family's behaviour over time, and she claimed that this talk had ‘... sort of se- opened his eyes a little bit’ (Carol/CS5/L613-614). For Carol, speaking openly about personal issues was important, as she had said that her family generally avoided such matters. The emphasis on ‘his’

implied that others in her family were either unaware of the issues that they had discussed, or had been less understanding than he had been, whereas the phrase ‘a little bit’ acted to moderate this understanding. This suggested that there may still be more that she wanted to say to her brother, or that his understanding of her was not as complete as she would like it to be.

### **Before and After a Label**

Accounts of relationships with non-familial others described the behaviours of friends in the past and present. This tended to be very general - no names were mentioned. As with families, the retention of friends after a diagnosis had been made would incorporate a renegotiation of self within those relationships. Some people did not mention friends at all, and others tended to distance themselves, indicating loneliness. It is possible that some people had few friends before their diagnosis. For those who did, a self with a mental health label is not as socially acceptable or predictable as a self without the label, and some friends may part company. New friends made after their diagnosis would incorporate both the person and the behaviours associated with that person’s label in forming their perception of that person. Several primary participants showed camaraderie through association, where people aligned themselves with fellow consumers, demonstrating problems in common. Only a couple of women spoke of close friends and the importance of emotional support.

### **Loneliness**

For most primary participants, loneliness appeared to be an underlying issue. Karen did not speak of friends at all, with the majority of her socialisation activities arranged through mental health support services.

Prior to Extract 52, Karen and I had been talking about her future. She said that she was not sure what the future would bring, taking one day at a time, and she tended to keep her thoughts to herself.

*Extract 52 (Sue-Karen/CS6/L194-207)*

- 194 S: yeah (.) ↑ok↓ay (1.0) mhm (.) umm do you think that there  
 195 are any things (.) say maybe that you do now that you  
 196 never used to?  
 197 K: ((deep breath)) I soc- I'm sociali:si:ng a lot mo:re than  
 198 what I u↓sed t↑o  
 199 S: yeah?  
 200 K: umm like (.) I have a couple of organisations that come out  
 201 to see me and (.) we go out for coffee or go for walks o::r  
 202 just someone that I can talk to  
 203 S: yeah  
 204 K: if I wasn't coming to these organisations like ((service  
 205 provider's name)) I would just be sitting at home by myself  
 206 S: mmm  
 207 K: u:m feeling pretty sa:d

In this extract Karen conveyed her loneliness and her dependence on mental health services for company. Here she positioned organisations as taking the place of friends in her life. In lines 200 to 202, Karen stated that organisations rather than people from those organisations went to see her. This kind of distancing lends itself to categorisation devices (see Sacks, 1992), in that the people working for those organisations are objectified and classified as being a part of the organisation. The human interaction that occurred could be portrayed as typical for those organisations. That is, going for coffee or walks with people with mental health concerns were activities that these people did for a living, not activities that they chose to do with her. In addition, the behaviours she described such as having

coffee, taking walks, and chatting to people are the types of behaviours a person would engage in with a friend. For Karen then, the organisations appeared to act as substitute friends. Although Karen began the extract presenting herself as a passive recipient of these services, by the end she had provided a more active role for herself by emphasising her voluntary participation in ‘coming to these organisations’ (line 204).

Karen finished her account by concluding, ‘I would just be sitting at home by myself u:m feeling pretty sa:d’ (lines 205-207). This conveyed that Karen didn’t see herself as having other viable options for social contact, and that without the support of agencies she would be alone. Karen’s account started on a positive note, with talk of increasing social contact compared to her own past. However, the framing of her improved social engagement as being dependent on support services suggested that her access to social life and social support was tenuous and fragile, and that the possibility of loneliness and social isolation was very salient for Karen.

Scott spoke of a past friend, and his loneliness was apparent. I had asked Scott if he thought that family and friends influenced the way that he felt about himself. At first, he did not understand the question. I rephrased what I had said, and Scott spoke of his best friend (see Extract 53).

*Extract 53 (Scott-Sue/CS7/L175-222)*

- 175 S: (1.5) okay (.) umm (1.0) do you think maybe umm other  
 176 people sort of like friends and family sort of influence the  
 177 way that you feel?  
 178 Sc: (1.0) >what do you mean< what  
 179 S: so do you think they (.) maybe some of the things that they  
 180 say (.) might (.) umm affect the way that you feel  
 181 [about yourself]  
 182 Sc: [well there is a] friend that devastated me

- 183 S: mmm
- 184 Sc: he stole money off my mum (0.5) and took off you kn↑ow
- 185 S: oh no
- 186 Sc: so that that's o↓ne th↑ing
- 187 S: yeah
- 188 Sc: I still- he's still like a brother to me
- 189 S: mmm
- 190 Sc: yeah I know he devastated me but (0.5) if they catch him
- 191 and put him in gaol he'd pay his d↑ebt
- 192 S: yeah
- 193 Sc: you kn↑ow I'd still be a friend to him
- 194 S: mmm (0.5) so because he's made a mistake
- 195 Sc: yeah (0.5) my mum doesn't tr↓ust him anym↑ore but you
- 196 kn↑ow

In Extract 53, Scott positions himself as a loyal friend. His account centred on his best friend who stole money from Scott's mother, and then ran away. While clearly establishing his friend's culpability, Scott's emphasis in this exchange is on presenting himself as being willing to forgive his friend. His forgiveness is produced as particularly noteworthy by contrasting it with his mother's lack of trust. Although Scott does state some conditions for his forgiveness ('if they catch him and put him in gaol he'd pay his d↑ebt' (lines 190-191), the overall impression Scott creates is of a loyal and forgiving friend even in the face of extreme provocation, whose lack of friends cannot be attributed to his disregard for friendship.

The interview continued with my asking Scott about any major events that had happened in his life (see Extract 54). After a two second pause, I attempted to simplify the question. Again, there was a pause, and I simplified further, asking for 'big things' (line 200) that might have happened. Scott immediately responded that nothing big had happened to

him. I questioned 'no?' (line 202), and Scott repeated 'no' (line 203). As this avenue of talk did not appear to be going anywhere, I drew Scott back to the topic that he had previously been speaking of, his friend.

*Extract 54 (Scott-Sue/CS7/L182-222)*

- 197 S: mmm (0.5) yeah (0.5) are there any >sort of like< (.)  
 198 major things that have happened in your life that sort of  
 199 re:ally stand out? (2.0) that you can re:ally sort of think of  
 200 straight away (1.5) sort of big things  
 201 Sc: no nothing big happened to me  
 202 S: no?  
 203 Sc: no  
 204 S: °no° (1.0) just (.) this friend [who]  
 205 Sc: [he's] the only best friend I've  
 206 got (.) you kn↑ow  
 207 S: yeah  
 208 Sc: I used to have more friends at school but you know what  
 209 happens  
 210 S: mm  
 211 Sc: one- you know they just go  
 212 S: you sort of lose touch with people  
 213 Sc: yeah (.) yeah  
 214 S: yeah (.) and so but now I spose you've made (.) different  
 215 friends?  
 216 Sc: yeah well I've made friends here but then they're not  
 217 exactly (.) friends  
 218 S: mmm (1.5) you sort of (.) don't socialise with them outside  
 219 Sc: well I should ask them if they wanna go see a movie or (.)  
 220 go to speedway or something  
 221 S: yeah  
 222 Sc: you kn↑ow

Underlying Extracts 53 and 54 is the suggestion that for Scott, having a friend who stole money from his mother was better than not having

a friend at all. In Extract 46, Scott infers difficulty in making friends, and a show concession (see Antaki & Wetherell, 1999) works to establish his loneliness. Loneliness is immediately apparent in lines 205 to 206, where Scott states; '[he's] the only best friend I've got (.) you kn↑ow'. This sets the scene for the following explanation of a scarcity of close friends.

Antaki and Wetherell (1999) explain that the three-part structure of a show concession works to strengthen the speaker's initial assertion. To begin, a proposition is made that is open to challenge. Acknowledgement of challenge comes through a concession made by the speaker, which is then followed by a reprise where a version of the original proposition is restated. This management of counter-argument moves to fortify the initial claim. Scott's proposition in lines 208 to 211 of 'I used to have more friends at school but you know what happens ...one- you know they just go' again expressed his loneliness. In this interactional sequence, I provided a challenge to his statement in lines 214 to 215, suggesting that he had made other friends since school. Scott then conceded 'yeah well I've made friends here...', following this with a reprise; '...but then they're not exactly (.) friends' (lines 216-217). To be 'friends' but not 'exactly (.) friends' suggests a technical, perhaps superficial meaning to the term. This may be indicative of a group of people who had problems in common, people who had been placed together due to their experiences of emotional problems. This conveyed that Scott's 'friends' were merely acquaintances. I asked for clarification of this with what could be deemed a second challenge and Scott again conceded 'well I should ask them if they wanna go see a movie or (.) go to speedway or something' (lines 219-220). This second concession was not followed by a reprise, and managed that perhaps some of the fault might

lie with Scott himself. It also suggests that although shared category membership did not itself constitute friendship, it could be a basis from which friendships might develop.

Loneliness was also apparent in Ken's descriptors of himself. I had asked Ken how he saw himself, and he mentioned that he liked 'talking to people better' (Ken/CS1/L24), but also said that he was 'probably pretty lonely...' (Ken/CS1/L61). Ken rarely spoke of friends in the interview. In Extract 55 Ken outlined the reactions of his Army friends to his problems, and in Extract 56 Ken noted that community ignorance about mental illness produced a lot of problems for him and other mental health consumers.

*Extract 55 (Sue-Ken/CS1/L262-266)*

- 262 S: okay umm (2.5) do you think maybe say that your family  
 263 and friends and that might have changed since you started  
 264 having problems?  
 265 K: ye:ah like all my friends from the army (.) they'd (0.5) just  
 266 never understand it so (mumbled)

The first occasion that Ken had mentioned friends was when I asked him about any changes in the behaviour of family and friends. Lines 265 to 266, where Ken states '... they'd (0.5) just never understand it...' suggests that being able to understand mental illness is an essential requirement in any friend of a person with a diagnosis of schizophrenia. The use of the conditional 'would' ('they'd') indicates that Ken had not told any of these friends about his mental illness, but that he could confidently anticipate their lack of understanding. Keeping in mind that Ken's narrative (refer to Chapter 4) indicated that he was experiencing severe emotional distress when he left the Army, this attributed lack of understanding may be based



upon direct experience or on expectations that Ken may have of his Army friends.

Ken had gone on to talk of his sister and how he now identified with the mental health problems that she had (refer to section Allies Within the Family). He then spoke of the need for others to understand these problems (see Extract 56).

*Extract 56 (Ken-Sue/CS1/L280-284)*

- 280 K: there's definitely a lot of ignorance out there in the  
 281 comm(h)unity  
 282 S: yeah (.) for sure  
 283 K: specially with uh what's happening to ↑me and ◦uh (.) my  
 284 mates (0.5) it would definitely help things out a lot more◦

Extract 56 was revealing in terms of how Ken saw other mental health consumers. After a claim of community ignorance, Ken furthered this by saying, ‘specially with uh what's happening to ↑me and ◦uh (.) my mates (0.5) ...’ (lines 283-284). When talking of his self, Ken’s voice was at a regular pitch, yet his voice lowered and he appeared to hesitate – ‘◦uh (.)’ – before saying ‘my mates’. This pausing around the phrase ‘my mates’ suggested that Ken was not sure how to refer to other consumers within the mental health system. They could indeed have been friends, as the term ‘mates’ is indicative of friendship, although the hesitation in choosing this word belied such friendship. As in Scott’s interview, Ken seemed uncertain about how to characterise the relationship between himself and other people at the centre: the shared category membership and time spent together does not seem quite enough to easily be called friendship, but the hesitant choice of ‘mates’ suggests that perhaps it could provide a basis for friendship.

## Problems in Common

Having problems in common could act as a connective device, linking consumers to each other as they have all experienced severe emotional distress and the problems stemming from a diagnosis of schizophrenia. Carl stated ‘well I haven't got too many friends’ (Carl/CS3/L272), and although this was the only time he spoke of friends, the implied loneliness did not seem to be a concern for him. Like Ken, a sense of camaraderie with other people experiencing mental health concerns emerged, particularly through his referral to a fellow patient during institutionalisation as ‘me (0.5) uhh inmate’ (Carl/CS3/L211) – Ken did state that he used the term loosely.

Deb took this a step further, categorising fellow consumers at the service centre that she attended as friends. Throughout her interview, Deb had given me the impression of a bubbly, vibrant woman, a woman who would have many friends, yet this was an issue that she did not really speak of. However, an idea of friends did emerge in her talk of her unhappiness regarding her pending discharge from the service centre (see Extract 57).

### *Extract 57 (Deb-Sue/CS9/L209-221)*

- 209 D: umm (.) which I did last year >haven't done so much this  
 210 year cause I< (.) try not to go in there so m↑uch cause they  
 211 wanna dis-charge me from there n↑ow  
 212 S: oh r↑ight  
 213 D: u:m but- nah- I've- every- I've got lots of friends there's  
 214 only a couple there that I totally (.) have got no time f↑or  
 215 (0.5) but (.) the majority of the group there is really g↑ood  
 216 (.) and I get along really well with Mel=  
 217 S: yeah?  
 218 D: =and Viv and- actually I get along really well with all of



- 242 D: yeah so no I'm- I'll miss i↑t cause umm (.) well when I first  
 243 got there I I used to go in there for about five minutes (.)  
 244 and (.) umm (.) I'd just say- I'd panic and I'd just le↑ave  
 245 ((laughing))  
 246 S: yeah?  
 247 D: yeah but now I stay- can stay there for nearly a whole day  
 248 so

Here, Deb produces another account in which understanding ('they don't judge y↑a – line 236) is a central feature of friendship. When asked how she felt about leaving the centre she answered - 'depressed' (line 229), and then worked to list reasons as to why her leaving the centre would not be a good idea. She first spoke of a feeling of belonging at the centre, and how she had never experienced this before (lines 231-234). Deb started with 'I'm finally', and then changed tact emphasising the seriousness of the issue through extreme case formulations (see Pomerantz, 1986), restarting her talk with 'all my life'. This 'upping the ante' by choosing a stronger approach allowed the importance of belonging for Deb to be conveyed. She had claimed that the environment of the service centre gave her a sense of belonging, and that this was something that she had not experienced before.

In addition to the emotional benefits of feeling understood, Deb also emphasised the behavioural freedom provided by an understanding environment. Deb conveyed that to sit with a friend and 'have a good ole whinge' to make you 'feel better' was an activity that perhaps many people took for granted. For a person with a mental health diagnosis, such an activity might be heavily laden with connotations of re-emerging symptomology. The inference here was that chatting with friends without having to censor herself was important to Deb, and something she could

only do in an understanding environment where her behaviour was not judged.

Deb concluded with an example of her emotional progress. She stated that when she first started attending the service centre she would 'panic' and 'leave' after 'about five minutes' (lines 243-244), but that 'now I stay- can stay there for nearly a whole day' (line 247). The distinction drawn between 'five minutes' and 'nearly a whole day' worked to show how far she had come, yet also showed that it took a while for her to adjust and be able to relax in this environment. Both distinctions conveyed that it would be difficult for her to find something to replace the role of the service centre in her life.

The presence of friends and the understanding attitude of the service centre toward mental health issues had allowed Deb to perhaps feel safe in this environment, giving her a feeling of belonging, and contributing to her overall emotional well-being. That she would soon be alienated from this environment, from these friends and this sense of belonging was of concern for Deb. It also suggested that perhaps Deb did not socialise with these friends outside of the service centre; that the 'lots of friends' (Extract 47, line 213) that she had were restricted to this setting, due to problems that they had in common and the understanding they therefore shared.

David brought up the topic of making friends with people who had similar problems when I asked him if he thought that his friends and family had seen a change in him. He spoke first of withdrawing from others (see Extract 59), but then finding that some of the people he went to school with had also developed mental health concerns (see Extract 60).

*Extract 59 (Sue-David/CS4/L661-672)*

- 661 S: so yeah do you think maybe your friends and family sort of  
 662 (0.5) umm see that you've changed?
- 663 D: well (.)
- 664 S: over time
- 665 D: ys-you see when I got umm (.) m-mentally ill I stopped  
 666 seeing a lot of people that I kne:w
- 667 S: mmm
- 668 D: they had jobs and (.) all that and they all [move]d=  
 669 S: [yeah]
- 670 D: =and (0.5) like it was like a really quick decision not to umm  
 671 (0.5) go round there any [more ] (0.5)
- 672 S: [mmm]

David responded to the question of change in his relationships by emphasising his loss of contact with people who knew him before he ‘got umm (.) m-mentally ill’ (line 665). This sets up ‘mental illness’ as an event that caused the shift in contact, but it is really not clear what aspect of being ‘mentally ill’ is held responsible for the change. David gave an explanation of ‘they had jobs and (.) all that and they all [move]d=’ (line 668), which began to imply that the people he knew were not there for him when he started having problems. However, David immediately assigned himself a more active role, describing himself as having made a ‘... really quick decision not to umm (0.5) go round there any [more ] (0.5)’ (lines 670-671). Here, David claimed responsibility for the decision to end his relationship with his former friends. Yet, some accountability also remained with ‘them’ as ‘they’ were no longer there. ‘They’ were busy with work and had moved away from him when his problems had begun. Thus, David’s account highlights others behaviour, yet attempts to maintain agency for the

loss of contact. Extract 60 gave a clearer picture of David's perspective of earlier relationships with friends.

*Extract 60 (David-Sue/CS4/L673-692)*

- 673 D: it's like I (.) used to ride around the (.) the block and stuff  
 674 (.) and they blokes (.) still sort of say giddyay (.) to some of  
 675 em an (.) an some of em are even in here now  
 676 S: yeah  
 677 D: know what I mean (.) like kids I went to school with an (.)  
 678 kids that umm (0.5) used to be the big fellas at school an (.)  
 679 all this an I thought I won't hang around em (0.5) I start  
 680 comin here an doin my own thing  
 681 S: yeah  
 682 D: and now sort of these are the blokes that I know these are  
 683 the blokes that I hang around sorta and (0.5) like (.) the  
 684 people I met at school some of them like three four of them  
 685 I've noticed are in here now (.) coupla girls (.) =  
 686 S: mmm  
 687 D: =that I met in hospital w-w-were there when I was at  
 688 school I catch up with them they (.) sometimes they're here  
 689 sometimes I just catch up with them down the shops you  
 690 know how a:re ya  
 691 S: yeah  
 692 D: how's ya medication are you getting better

In this extract, David highlights the impact of shared mental health status, of a shared label, on relationships; people with whom he attended school but chose not to associate with (and who were more popular than him) are now, and by virtue of sharing a mental illness diagnosis – ‘the blokes that I know’ (line 682), ‘the blokes that I hang around’ (line 683). That David chose not to ‘hang around em’ (line 679) inferred that David had a choice in this, that he too could have been a popular student through association, yet chose not to: David presents himself as agentic rather than

a passive recipient of hierarchical schoolyard selection processes. The dramatic change in his relationship with these people since they were in school is presented as entirely premised on their shared circumstances, and David's reports of the kinds of exchanges that occur when they 'catch up' (line 689) are centred on this shared category membership ('how's ya medication' – line 692). The use of the terms 'sort of/sorta' here revealed the nature of David's relationships with these people today. The terms work to suggest that the relationships were not close and circumvents any possible challenge by keeping the claims vague.

David's account manages that he doesn't have many friends, and that he is concerned to present this as arising from his agency and/or external circumstances, and not from other people's rejection of him. There is concern that his friendless state not be attributed to a lack of opportunity or choice on his part, thus agency is apparent throughout his discourse.

Rick spoke of the difficulties he encountered with friends, enticing him back to a way of life that he would rather leave behind (see Extract 61). This came about through my question on how his family and friends might have changed over time, focusing specifically on people that he did not get along with anymore. This narrowing of focus may have instigated the complaint that followed, where Rick conveyed his unhappiness at having few friends.

*Extract 61 (Sue-Rick/CS8/L269-292)*

- 269 S: yeah (.) yeah (.) do you do you think maybe your family and  
 270 friends might have changed?
- 271 R: oh (.) some of them have some of them haven't
- 272 S: yeah (.) sort of depends on the person?
- 273 R: yeah



- 274 S: really (.) yeah (.) are there any people in particular sort of  
 275 who (.) say you might have used to get along with but you  
 276 don't get along with anymore?
- 277 R: a few (.) °yeh yeh° (.) oh (.) then again I don't really wanna  
 278 see a lot of em a↑nyw↓ay
- 279 S: mmm (1.0) okay
- 280 R: I only keep ones that sort of still- like I'd like to keep as  
 281 friends but you know (.) what can you d↑o (1.0) they're  
 282 smackin a needle up their arm 24 hours a day
- 283 S: mmm
- 284 R: but (.) I don't need th↓at (.) too much of a tempt↑at↓ion
- 285 S: yeah
- 286 R: not not in the needle aspect but the drugs (0.5) you can  
 287 snort cocaine as well as you can snort heroin
- 288 S: mmm (1.0) yeah (0.5) and so its yeah its not really  
 289 something that you want to do really
- 290 R: nuh
- 291 S: so
- 292 R: too much temptation

Like David, Rick's talk of friends also clearly produced him as having agency in his friendships. However, Rick's account explained his loss of friends as a step forward in his recovery. In lines 277 to 288, Rick expanded upon his initial response of still seeing 'a few' friends with 'oh (.) then again', working to show a reconsideration of the matter. He finished his claim of not wanting to see the majority of these people with the term 'a↑nyw↓ay', implying that this was through choice. In lines 280 to 281, he started to detail how he selected his friends – 'I only keep...' – but then altered this approach, positioning himself as having a lesser choice in the matter – 'I'd like to keep...'. The focus on agency managed accountability

and blame for the loss of friends, as Rick strove to show that he was not at fault.

Rick continued with an appeal for understanding and agreement of ‘but you know’, which was followed with the deployment of a rhetorical question – ‘(.) what can you d↑o (1.0)’ (line 281). Through the use of this idiomatic expression (see Drew & Holt, 1988), Rick had conveyed that he had no control over his friends' behaviour, and that this behaviour was the reason for the loss of contact. Thus, Rick delicately managed the issue of control and accountability, positioning himself as helpless in controlling his friends' behaviour, but responding to the occurrence of this behaviour by choosing to sever contact.

An unsympathetic audience might view Rick as hypocritical and lacking in understanding for what his friends might be going through, particularly as Rick had spoken earlier in the interview of his own drug addiction. Having described his friends' behaviour, Rick then went on to detail how this behaviour might affect him, countering any possible criticism for his stance of not wanting to see these friends. He said, ‘but (.) I don't need th↓at (.) too much of a tempt↑at↓ion’ (line 284). The temptation of being drawn back into a life of drug abuse by associating with friends who still used drugs conveyed insight into his own behaviours. He finished off the account by reiterating the notion of temptation. Temptation worked as a justification for Rick no longer wanting to associate with these friends, and suggested that Rick recognised that he was still vulnerable and portrayed his decision about his friends as pragmatic rather than judgemental. Portraying himself as responsible for avoiding drug use also works to present as a sacrifice the efforts that Rick has made toward

recovery. That is, there are friends that he has lost that he would like to keep, but the temptation means that he cannot.

### **‘Select’ Friends**

Emotional support from friends was a rare occurrence for primary participants. Brenda addressed the topic of friends when I asked her if the behaviour of friends and family members toward her had changed over time. In Extract 62, she drew the distinction between close friends and acquaintances, both at the service centre and in the general community.

*Extract 62 (Sue-Brenda/CS2/L444-463)*

- 444 S: yeah (2.0) okay umm (1.0) do you th↑ink that maybe sa:y  
 445 some of the people that you know ((cough)) like friends and  
 446 family do you think that their behaviour toward you might  
 447 have changed? say now as compared to bef↑ore?
- 448 B: I have made a few friends here (0.5) I so:rt of see one  
 449 person on a regular basis
- 450 S: mhm
- 451 B: oh a couple on a regular basis but not a lot of them no
- 452 S: mmm
- 453 B: no I sort of keep to myself in that area (1.0) if I do see  
 454 them I say hello to them if I see them up the street I have a  
 455 chat with them and that (0.5) but other than that I only go  
 456 to a co↓uple of places and that's i↑t
- 457 S: alright so (.) so maybe there isn't any sort of friends that  
 458 you might have had in the past that you still have now?
- 459 B: yeah I have got an old friend that was a neighbour (.) she  
 460 keeps telling me to come round but I sort of didn't get the  
 461 time over Christmas to catch up with her
- 462 S: yeah? but you still see her every now and then?
- 463 B: >yeah< (2.5)

Brenda spoke of making ‘a few friends’ (line 448) at the service centre. She drew a distinction between the ‘few’ friends she had made at the centre, and other people who were not in the category of ‘friends’ were oriented to as ‘them’ (lines 451-455). Like David, the categorisation of fellow consumers as ‘them’ relegated these people to acquaintance status, as Brenda tended to keep to herself.

I drew the conversation back to the issue of change over time. Based on Brenda's statement that she had made a few friends at the service centre and the absence of talk regarding friends outside the centre, I questioningly stated that perhaps she did not have any friends from the past that she still associated with in the present. Brenda said that she did have ‘an old friend that was a neighbour’ (line 459), but inferred that this friendship was not close because she herself had not had time to catch up. Once again, Brenda positioned herself as the one who had not kept in contact with her old friend, forestalling any possible suggestion that she had been rejected or abandoned by former friends.

Carol and I had been talking of her family's move to Western Australia from Victoria. I had commented on her not knowing anyone, and how difficult it would have been for her to adjust to a new environment. Carol's talk of friends took the form of a complaint; contrasting friends and family on issues of assistance and personal support (see Extract 63).

*Extract 63 (Carol-Sue/CS5/L571-597)*

- 571 C: oh like I said I've had it hard all me life Sue  
 572 S: mmm  
 573 C: make friends all over the place (.) mainly acquaintances all  
 574 over the place I've got very few select friends (1.5) and I'll  
 575 stick with them for the time being

- 576 S: it's usually the way you have a lot of acquaintances a lot of  
 577 friends or people that you chat to but you only have a few  
 578 close friends
- 579 C: mhm
- 580 S: they're the ones that really matter to you
- 581 C: well they're the ones who've helped me and supported me  
 582 when me own family can't [do it ] (0.5) or won't do it
- 583 S: [mmm] yeah
- 584 C: even in the last- well more so in the last si-fou-four years  
 585 (0.5) three or four years in particular
- 586 S: well is spose its good that you've got them there that  
 587 they're there for you (1.5) yeah (0.5)
- 588 C: mhm
- 589 S: cause I spose it would be very very difficult if
- 590 C: well I didn't have anyone when I first had Sally when  
 591 she was a baby
- 592 S: mmm
- 593 C: cause I'd moved to another area (2.0) and uh (0.5) the time  
 594 I spent with him I sort of lost all of the friends I had and  
 595 (1.0) that sort of th↑ing so
- 596 S: yeah
- 597 C: like I said I've had it hard (laughing)

Carol started out with a general complaint of having a hard life, conveying that difficulties were apparent on the topic of friends and family. To explain this, Carol first presented a sociable self, claiming that she made 'friends all over the place' (line 573), and then changed the term 'friends' to 'acquaintances'. Stating that she had 'very few select friends' (line 574), she emphasised the support provided by these friends when her '...own family can't ...(0.5) or won't...' (line 582). Carol's 'select' friends had differentiated themselves from her acquaintances (and family) by providing help and support over a period of many years.

In this extract, Carol also gave an example of previous difficulties she had with keeping friends, and this seemed to fit with the general themes of friends and of a 'hard life'. Blame was again deployed here, as Carol saw moving house and the man that she was with at the time as the cause of her friendless state – '...I sort of lost all of the friends I had...' (line 594). Carol then wrapped up this account of her difficulties by restating her initial claim of having it hard, although the laughter that accompanied this statement suggested a somewhat ironic orientation to the self-pity expressed.

### **Fitting the Self to a Label**

Accounts given about staff members at the service centre were reflective of relationships that participants had with these people. Here, the label was known first, before staff members got to know the person. In this sense, staff members were already expectant of certain behaviours and characteristics to be displayed by primary participants. Scott was the only primary participant who did not speak of the support workers he dealt with. General themes surrounded the amount of personal interest that support staff showed towards primary participants and the blended, easy going environment that staff members provided.

### **A Lack of Interest**

Two people gave reserved accounts of staff members. Their talk suggested that staff members showed little interest in them. Carl and I had been talking about how others might see him, and in Extract 64, he spoke of staff.

*Extract 64 (Sue-Carl/CS3/L114-122)*

- 114 S: yeah? (1.5) okay (0.5) what about say the support staff  
 115 here?  
 116 C: mm?  
 117 S: how do you think they might see you?  
 118 C: tell you the truth I d↓on't really c↑a::re  
 119 S: yeah? (1.5) okay (1.0) do [you think]  
 120 C: [underling]s worry  
 121 about superiors superiors don't worry about underlings  
 122 ((smiling voice))

Carl gave an ambiguous response to the question of how staff members might view him. In line 118, Carl positions himself as honest, impressing that he had no interest in support staff. His following statement about '[underling]s' and 'superiors' (lines 120-122) was indistinct in that it might impress a hierarchy at the centre, where the staff may have viewed themselves as superior to consumers. Alternatively, it may have been Carl who viewed himself as superior, and had conveyed that staff members did not warrant his attention.

Later in the interview, I had asked Carl whether support staff influenced the way that he saw himself (see Extract 65). Carl's response gave further indication of his current stance toward staff members.

*Extract 65 (Carl/CS3/L251-253)*

- 251 C: (4.0) ahhh (0.5) I'd say they've got a (2.0) mildly interested  
 252 (1.5) perception o-o-o-of my behaviour (.) so they don't  
 253 have to call the police

A 'mildly interested (1.5) perception' (lines 251-252) suggested that staff members may be watching Carl for a particular reason. The one and a half second pause worked to emphasise or give effect to what would come

next. Carl's mention of calling the police inferred dangerousness. Hence, Carl saw staff members as having little interest in him, and only when it concerned their own safety. This account, coupled with earlier talk of staff members (Extract 68), implied that Carl may see support staff as perceiving themselves to be above consumers, and that they saw him as potentially dangerous.

Another negative view of staff came from Rick, who had talked earlier of having a 'run in with Mike long long time ago and yeah I got over that (laughing)' (Rick/CS8/L139-142). A 'run in' was suggestive of some kind of disagreement, one that Rick claimed he had resolved. He also spoke of having worked 'with Luke many years ago in the (.) in the old (.) industrial (.) organisation that used to get run by mental health' (Rick/CS8/L144-148). I had asked Rick whether he got along with staff members. His reply in extract 66 conveyed that he had little to do with staff.

*Extract 66 (Sue-Rick/CS8/L157-162)*

- 157 S: mmm (.) oh right (0.5) so (.) you get on (.) ok↑ay?  
 158 R: yeah most of em (.) I don't see a lot of em ↑anyw↓ay  
 159 ((laughing)) I only have contact with a few members of staff  
 160 basically ↑anyw↓ay  
 161 S: mmm  
 162 R: the rest is too busy stuck in offices (0.5)

Like Carl, Rick's account implied that staff members had little concern for consumers. Rick said that he got along with 'most' staff members (line 158), suggesting that he did not get along with some people. His comment that his contact with staff was minimal and confined to only a few people could be interpreted in at least two different ways. It may imply



that staff members were run off their feet with work, and had no time to converse with Rick. On the other hand, Rick may have been having a dig at staff, inferring that they could not be bothered talking with him.

### **Blending In**

Some participants saw staff members as merging with consumers in a friendly, helpful manner. David and I had been talking about his relationship with his parents, and this led to his relationship with staff. He said that he enjoyed their company, and found it easy to relax around staff (see Extract 67). Here, he conveyed a possible difference in the way that staff at the service centre related to him, as compared with staff at other mental health services.

#### *Extract 67 (Sue-David/CS4/L390-406)*

- 390 S: yeah (0.5) ho-how do you sort of find the umm say the staff  
 391 here?  
 392 D: pretty good  
 393 S: yeah?  
 394 D: helpful (1.0) you know u::mm (0.5) the-there's usually like  
 395 a couple a staff like- been quite a lot since I been here but  
 396 (0.5) while they're here they're very u::m (.) helpful (.) and  
 397 not just like (.) I'm here to do a job (.) sit in the office do  
 398 paperwork they're a:lways=  
 399 S: yeah  
 400 D: >always always< there f- you know (0.5) sit down have  
 401 lunch with you:: everybody would enjoy their company::  
 402 (0.5) u:h like yourself you kno↑w (.) I enjoyed your  
 403 company even though I didn't know who you were at first  
 404 S: ye(h)ah  
 405 D: you know sort of didn't worry about being round ya sort of  
 406 you kno↑w

David suggested a sense of ease with staff members, commenting that they did not merely do their job, but interacted with consumers on a more personable level. He started out describing support staff as ‘pretty good’ and ‘helpful’ (lines 392 & 394), but then touched on the issue of staff turnover, claiming that there had been quite a few members of staff in the time that he had attended the service. This mention of turnover may be seen to imply a sense of impermanence in the relationships, and suggests that consumers should not come to rely on particular staff members too much. However, despite their impermanence (‘while they’re here’ – line 396), David portrays the staff as friendly and helpful. Unlike Rick’s account in which staff stayed in their office dealing with paperwork, David stated the opposite (lines 397-398). David implied that the role these people played at the service centre was more than an office job. He talked of staff sitting down and having lunch with consumers, mixing in with consumers, where their role was more of companionship than that of an authority figure. Here, David had conveyed that staff members at the service centre did not adopt typical category bound behaviour (e.g. staying in offices and doing paperwork).

Ken reiterated David’s view of the staff as he spoke of how staff members tended to blend in with consumers (see Extract 68). Ken and I had been talking of how his family might see him, and the conversation changed direction to how he saw support staff.

*Extract 68 (Sue-Ken/CS1/L156-168)*

- 156 S: okay (0.5) umm what about the-the staff (.) here (.) in  
 157 general?  
 158 K: oh they're really g↑ood  
 159 S: mhm?

- 160 K: they're very straight forward (0.5)  
 161 S: yeah?  
 162 K: and ummm (0.5) instead of acting like a staff they're just  
 163 (mumbled) (0.5) they're part of the (0.5) people that are  
 164 h↑ere  
 165 S: mm  
 166 K: they just run the place (mumbled)  
 167 S: mm  
 168 K: they they they just stay close and (.) in tune with the people

Like David, Ken also drew upon the membership category of 'staff'. He pointed out how staff members at the service centre, although aligning to this category, did not adhere to category-bound behaviour. Ken explicitly contrasted the staff of the centre with 'a staff' (line 162) in general, suggesting that typical mental health 'staff' were not close to consumers, and did not have a good idea of how they might be feeling. Ken too, could have been comparing staff members at the service centre to support staff at other mental health services that he had attended.

Karen also reinforced the idea that staff were 'in tune' with consumers, stating 'they tend to no- take notice of (0.5) or when (.) you're not (.) yourself (.) yeah' (Karen/CS6/L257-258). This implied that staff members took the time to get to know consumers, and that they were able to notice when a person's behaviour was not consistent with the typical behaviour they displayed. This noticing was portrayed in benign terms as the caring behaviour of staff members with an interest in the welfare of consumers rather than a more sinister monitoring of behaviour for signs of relapse. It did suggest though, that a particular 'self' was expected for each person at the service centre.

## Easy Going

Many people gave accounts impressing that staff members were easy going and relaxed in their approach toward consumers. This kind of atmosphere had the propensity to place consumers at ease. Here too, a comparison of the behaviour and attitudes of staff at different service centres was apparent. Although the accounts generally outlined harmonious relationships, many were quite brief and left a lot unsaid.

For example, in her interview, Brenda spoke little of staff members. When I asked her how support staff might see her, Brenda complained that she was not listened to when she spoke of grievances to staff members, and that she was often told to ‘...g]et on with it’ (Brenda/CS2/L230). Although this was said in a jovial manner, it painted a picture of support staff not taking her seriously, and that Brenda did not bother anymore. When I asked how she saw them, Brenda replied; ‘good yeah yeah they're [really] good’ (Brenda/CS2/L239 & 241). She did not expand upon this. Taken on its own, this latter comment may convey satisfaction in her relationships with staff members. Yet coupled with her earlier claims, it conveys perhaps a stock, standard response that Brenda gave to deflect the introduction of issues that might be contentious.

Carol also only gave brief comments regarding staff members. When I asked how she felt about the staff at the service centre, she said ‘relaxed (0.5) glad they're there’ (Carol/CS5/L685). The idea that she felt ‘relaxed’ was suggestive that she felt no pressure from staff, that the environment was calm and stress free. To say that she was ‘glad’ that they were ‘there’ implied security for Carol. She felt comfortable around staff members and perhaps utilised them as a back-up in case things went wrong

in her life. Carol seemed to consider the staff more as a kind of ‘safety net’ against problems that might emerge, rather than an everyday source of help.

Deb also talked of feeling at ease with members of staff at the service centre. In Extract 69, I had asked Deb how she saw the staff members that she dealt with. Here, she made a comparison between the current centre she attended and one that she had attended in the past.

*Extract 69 (Deb-Sue/CS9/L503-527)*

503 D: yeah u::m (.) yeah no they're really great it took me a while

504 to get to know them all (0.5) [yeah]

505 S: [yeah]

506 D: yeah they're like (.) pretty much down to earth

507 S: mhm

508 D: I used to go to on- to the one in Fremantle (.) a:nd (.) I was

509 there for quite a while cause I used to live in Freo (0.5)

510 u::m (.) and when I went- you couldn't have like the (.) you

511 know (.) you can't- couldn't have the (.) jus the

512 conversations that you do n↑ow

513 S: yeah?

514 D: yeah so (1.0)

515 S: so do you think that had to do with umm (.) the way that (.)

516 say the service was set u↑p or

517 D: yeah

518 S: do you think it had more to do with the people that were

519 th↑ere?

520 D: I think umm the people down here are more easy going than

521 up in Fremantle and all that up that way anyway so

522 S: yeah? so

523 D: yep

524 S: in- easy going in what way?

525 D: u::m (.) they don't (.) worry t- I mean (.) they're pretty laid

526 back they probly worry but they're like laid back sort of

527 peop↑le

In drawing a comparison between the service centre she currently attended and one she had attended in the past (Fremantle), Deb highlighted the easy going demeanour of current staff, and the freedom and relaxation that this allowed her. Her main issue with Fremantle was the implication that she had to be careful with what she said when she was attending the centre. In lines 510 to 511, Deb switched from past tense to present tense, and then back to past tense – e.g. ‘you couldn’t...’, ‘you can’t- couldn’t’. This difficulty impressed that situation at the centre had not changed. That she had to watch what she said inferred that there may have been ramifications to her talk, that perhaps staff members may have been over vigilant in their care for consumers. Deb appeared to base her preference for the service centre she was currently attending on her perceptions of the behaviour of staff. At the current centre, staff members were ‘down to earth’ (line 506), and ‘laid back’ (lines 525-527). Deb did not have to carefully monitor what she said to staff members, implying that she could also relax. Staff were presented as caring and responsible (‘they probly worry’ – line 526), but not as likely to overreact to behaviour from consumers at the centre.

## **Conclusion**

Accounts given of others tended to elicit problems in relationship, and all issues brought up by primary participants appeared to revolve around the general themes of emotional support and social validation. People drew upon different methods to negotiate a sense of themselves, often positioning themselves as agentic, as having some control over situations. The self appeared to be in contention. Versions of past

interactions quite often dealt with issues that had occurred before their diagnosis, before a label of mentally ill had been placed upon them. For some people, their families showed an unwillingness to talk of personal matters, evoking complaints of a lack of understanding. For others, antagonism within the family centred on participants controlling their temper in the face of provocation. Many of these past issues appeared to be relevant to the present. Once a label had been placed upon the person, the task of renegotiating a sense of self was highly contentious for some people. Dealing with unresolved conflict brought about issues such as frustration and a lack of familial support. In order to deal with this conflict one participant spoke of walking away from arguments or distancing themselves from family members. A few people spoke of having an ally within the family, a person they could talk to and confide in, and whom they believed understood them.

A renegotiation of self may also be needed with friends, dependent upon whether the friend knew the person before or after diagnosis. Talk of friends revealed the desire for companionship and avoidance of solitude. This drew out issues such as loneliness, camaraderie where the problems that consumers had in common worked to unite them, and the need for close friends. Two people who mentioned friends pre-diagnosis conveyed that they no longer had contact with them through choice. Another spoke of becoming friends with known acquaintances after diagnosis as they had similar mental health concerns. As new ideas and concepts are brought into a person's notion of self and behaviours and ideas are discarded, the social acceptance of this newly emerging self takes on greater importance in regard to friendships as there is no familial bond to keep people together.

In the setting of a mental health support service staff members would know of a label before they got to know the person. People attending the service centre showed awareness of how they might be perceived by staff members through the mention of notions of fear and dangerousness. Most apparent in these accounts were comparisons made between staff members at the service centre and other mental health services that primary participants had attended. Issues such as open communication and to feel at ease emerged. Thus, primary participant accounts revealed an overall need of not being seen to be helpless and totally reliant upon others for their own well-being, yet managed the exploration of different avenues taken to look for emotional support.



## CHAPTER 7 – Troubled Selves

*“Now, our view of the other depends on our willingness to enlist all the powers of every aspect of ourselves in the act of comprehension. It seems also that we require to orientate ourselves to this person in such a way as to leave open to us the possibility of understanding him [sic]. The art of understanding those aspects of an individual’s being which we can observe, as expressive of his mode of being-in-the-world, requires us to relate his actions to his way of experiencing the situation he is in with us”.*

*(Laing, 1990, p.32).*

The incorporation of accounts of the person from others allows for a broader, relational perspective of self. As the self is continually defined and redefined through relationship (Gergen, 1997), people tend to view others in one way or another, placing their interpretations or constructions upon behaviour from the very beginning of that relationship (Laing, 1990). The versions under analysis then, are situated and occasioned, and Potter (1996) argues that problematic or negative identities may encourage factual or descriptive discourse. In an institutional setting such as the service centre, accounts given of participants tend to align with popular theory of the time. This is a setting where the participants of this study engage in much of their social interaction, and the influence of support staff in defining a person’s sense of self holds much power.

*“To look and to listen to a patient and to see ‘signs’ of schizophrenia (as a ‘disease’) and to look and to listen to him [sic] simply as a human being are to see and to hear in as radically different ways as when one sees, first the vase, then the faces in the ambiguous picture”*

*(Laing, 1990, p.33).*

Previous chapters examine what it is like to be under the gaze of others. This chapter deals with actual perceptions of others; the initial versions that support workers gave of primary participants when I first asked them to describe each person. That is, the sections of transcript used in this analysis reflect the first instance of talk about each primary participant given by each of the support workers. The major sections of the chapter incorporate the perspectives of all four support workers when asked about each of the primary participants, incorporating common features picked up by each person. During the interviews, issues of consumer confidentiality were adhered to, and this may have affected the extent of the information that support staff were willing to discuss.

### **Ken: Nature/Nurture**

All support workers saw Ken as a man dealing with serious emotional problems. Accounts of Ken tended to orient toward either a biological/genetic or a socio-cultural perspective. Biological/genetic perspectives offered little hope for the future, whereas socio-cultural perspectives saw the possibility of Ken resolving his emotional problems. The absence or presence of hope emerged through explanations of causality of Ken's emotional problems.

## An Unfortunate Man with a Risk of Snapping

I had asked Mel to describe Ken as a person, and initially there was some confusion behind the meaning of ‘as a person’. Once clarified, Mel went on to outline a man she saw as ‘unfortunate’ (see Extract 70).

*Extract 70 (Mel-Sue/SW2/L288-308)*

- 288 M: umm (.) I would descr↓ibe Ken as (0.5) umm (0.5) yeah  
 289 (2.5) as a g↓uy whose had a very unfortunate (.) umm (1.5)  
 290 upbr↑inging umm (.) coming fr↓om (.) a family (.) with  
 291 umm (0.5) ye:ah (0.5) genetically (.) umm you kn↓ow (.)  
 292 he comes from a family where other- they also have (.)  
 293 been umm affected with mental illness you know have  
 294 mental ↑illness umm schizophrenia or something like that  
 295 as well
- 296 S: mhm
- 296 M: and umm (.) I guess he hasn't experienced a lot of a- you  
 297 know what we'd say a normal l↑ife ((laugh))
- 298 S: mm
- 299 M: umm (2.0) a:nd he: (.) really needs quite a lot of (.)  
 300 affirmat↑ion quite a lot of (.) umm (.) encouragem↑ent (.)  
 301 umm
- 302 S: mhm
- 303 M: and struggles (.) a lot (.) but really does try (.) umm (.) has  
 304 (.) yeah has interests and umm (.) really (.) noble interests  
 305 as w↑ell to (.) help the environment and recycle and stuff  
 306 like tha:t (.) I think that's (.) really really good (.) umm
- 307 S: yeah
- 308 M: ye::ah

In her description of Ken, Mel's account manages a biological/genetic explanation for the emotional problems that Ken has. Drawing upon medical discourse and membership categorisation devices, Mel works to strengthen her argument, resulting in a non-verbalised claim

of biological abnormality. Mel starts out by speaking of Ken as having ‘...a very unfortunate (.) umm (1.5) upbr↑inging’ (lines 289-290), orienting toward a socio-cultural argument, and hinting at social and environmental factors as the cause of his emotional problems. From this first impression though, the explanation takes a sudden turn with the introduction of genetic heritage in line 291. Medical discourse (the introduction of the classificatory term ‘schizophrenia’ in line 294), interspersed with lay talk, provides a more definitive explanation of causality; that of genetics. Here, rather than hinting at socio-cultural explanations (that Ken's upbringing may be at fault), Mel is more decisive and points to his genetic heritage, inferring chronicity. Membership categorisation devices are deployed to support genetic causality, and guard against counter argument as Ken and his family members are classified into the general membership category of ‘mentally ill’. More specifically, the subcategory of schizophrenia is evoked. As family concordance provides part of the evidence for bio-medical accounts of emotional problems by suggesting a genetic basis (Tsuang & Faraone, 2000; Tsuang, Gilbertson, & Faraone, 1991), Mel is evoking ‘professional’ understandings to support her claim, and giving all family members such an identity works to strengthen the genetic argument.

Mel then draws upon this genetic heritage claim to infer familial ‘abnormality’. She states that Ken had not ‘experienced ... what we'd say a normal l↑ife ((laugh))’ (lines 296-297). Here, the use of the term ‘experienced’ lends itself to environmental factors. Thus, Mel suggests that Ken, genetically tainted to begin with, did not have a typical upbringing due to this familial abnormality. To give authority to her claim, Mel draws upon the term ‘we’. This marks Mel as a member of a particular collectivity or

group, and it is possible that I have been included into this group. The orientation here is toward a professional body with the authority to make judgements to determine 'normality'. Through the claim of an absence of 'normality', Ken is placed into a category of 'abnormal'. Mel's description of Ken then is not so much an outline of the kind of person he is, but an explanation of why he has the problems that he does. Although Mel portrays Ken as suffering from chronic, irremediable problems, she does suggest that there are some social factors that can alter aspects of his experience. His willingness to 'try' and 'affirmat<sup>↑</sup>ion' and 'encouragem<sup>↑</sup>ent' seem to help him.

The first response Mike gave when speaking of Ken was his size. Ken was a 'big man' (see line 313, Extract 71). From this though, Mike reverted to clinical terminology, describing symptomology and Ken's relationship with staff members. A sense of what Ken is like as a person was absent in this account.

*Extract 71 (Sue-Mike/SW3/L312-338)*

- 312 S: okay umm how would you describe Ken (.) as a person?
- 313 M: big [[[laughs]]) umm as in um (.) you know he's a big man
- 314 S: [[[laughs]])
- 315 M: ((sigh)) umm how would I describe him (1.5) (tch) he's >I  
 316 mean I guess I would descr↓ibe him in clinical terms<  
 317 because I alw(h)ays describe him in clinical terms at  
 318 meetings (.) its that his umm you know that he (.) he umm  
 319 (.) hi::s (.) level of functioning is quite dis↓organi:sed (.)  
 320 umm (.) yeah so: (.) umm he he I guess (.) he requires (.)  
 321 quite intensive suppo:rt (0.5) umm (tch) then in terms of  
 322 his personality he's got a really nice personality he's got a  
 323 really caring personality >but I'd say there that there's a  
 324 (mumbled) there that there's a risk of him snapping< and

- 325 doing something bad (.) u::m (.) u::m (.) but you kn↓ow  
 326 I've never seen that here (.) and I think in this environment  
 327 he's got a very very caring (.) very loving relationsh↑ip (.)  
 328 umm (1.0) yeah with with the st↓aff and with just with the  
 329 service I th↑ink (.) with what we offer and he's really really  
 330 appreciative of i↑t (.) umm (.) but you know underneath  
 331 th↓at all that's kind of masked by this (.) disorganisation  
 332 ((laughs))  
 333 S: yeah?  
 334 M: yeah (0.5) [it] masks his disorganisation you kn↑ow (.)  
 335 S: [so]  
 336 M: yeah he just comes across as really (.) u::m (1.0) really (.)  
 337 caring and friendly (0.5) umm but underneath you just feel  
 338 that he's (.) you know

In Extract 71, Mike evokes his 'professional' status to manage a clinical account of Ken as a dangerous man. Mike concedes that he has not seen this, but provides a rationale as to why Ken has not lost control of himself, giving agency to support staff and the service centre. In his descriptors of Ken, Mike first draws upon his occupation to justify his preference for medical discourse, claiming that he 'alw(h)ays' used this terminology in 'meetings' (lines 317-318). This works to lend himself authority for what he is about to say, as he goes on to outline symptomatic behaviour. In clinical terms, Mike describes Ken as having a high level of disorganised functioning, as needing 'quite intensive suppo:rt' (line 321) with many aspects of his daily life. This proposal of disorganisation then allows for a more extreme claim. Mike shifts to Ken's personality, first describing him as 'nice' and 'caring', but then goes on to infer dangerousness through talk of a 'risk' of Ken 'snapping and doing something bad' (lines 322-325). This conveys more than a sudden mood

change, as the idea of mentally ‘snapping’ infers a loss of control. Here, the introduction of a risk of dangerousness tends to overshadow the kind, caring persona initially offered.

Mike concedes; ‘I’ve never seen that here’ (line 326), yet this still allows for the possibility of it occurring elsewhere. The environment at the service centre and Ken’s relationship with staff members is offered to be ‘very very caring (.) very loving’ (line 327). This formulates a rationale for Ken not ‘snapping’ at the service centre, and gives agency for self-control to support staff rather than to Ken. Mike then moves back to reinforce the idea of dangerousness, stating that on the surface Ken was a kind and caring person, yet this behaviour ‘masks his disorganisation’ (line 334). This infers that the person that others see is not Ken. Underneath the mask, Ken is a dangerous man, and not in control of himself.

### **A Confused, Invisible Man**

In his descriptors of Ken, Luke also formulated an explanation for Ken’s problems. Luke tended to orient toward circumstance, noting environmental stressors and events that had occurred in Ken’s life (see Extract 72).

*Extract 72 (Sue-Luke/SW4/L200-217)*

- 200 S: okay so the f<sup>↑</sup>irst person is Ken
- 201 L: Ken yeah
- 202 S: yeah (.) umm (.) how would you describe Ken? (.) as a
- 203 person
- 204 L: Ken is a n<sup>↑</sup>ice fella but ↓ehh (.) he’s got a lot of problems
- 205 and its due to him being (.) ehh in the arm<sup>↑</sup>y
- 206 S: mhm
- 207 L: and I feel that when he was in the army he had (.) qu<sup>↑</sup>ite a

- 208            stressful time there and had s↑ome problems with other (.)  
 209            army (.) memb↑ers (1.0) ehh I feel he's quite a str↑aight  
 210            forward fell↑a but very forgetf↓ul  
 211    S:        mm↑  
 212    L:        he quite often forgets which day it is and (.) app↓ointments  
 213            he's g↑ot and ehh (1.0)  
 214    S:        yeah  
 215    L:        so f↑orth but ehh (1.5) (tch)  
 216    S:        mhm  
 217    L:        he's quite mixed up at t↓imes put it that way.

Luke's account of Ken produces a primarily socio-cultural rationale for Ken's emotional problems. He focuses on life experiences and the influence of these experiences upon Ken's behaviour. Noticeable here is that Luke draws upon lay terms rather than clinical discourse in his descriptors of Ken; 'forgetf↓ul' and 'mixed up' compared to Mike's 'disorganised'. Luke describes Ken as a 'nice fella' (line 204), echoing the idea of 'nice' that Mike had proposed. He then goes on to talk of Ken's problems and where he believes they emanate from - '...the arm↑y' (line 205). He infers that the stress of Army life and issues with '...other (.) army (.) memb↑ers' (lines 208-209) took its toll on Ken. Luke also raised the issue of disorganisation that Mike had spoken about, yet Luke uses lay terms such as 'very forgetf↓ul' (line 210), concluding that Ken was '...quite mixed up at t↓imes' (line 217). There is no implication of dangerousness here that might come about through clinical discourse. Rather, Luke's version of Ken conveys an image of a confused man, one who needs reminders and perhaps assistance to sort out his thoughts.



Viv's account of Ken conveyed a man who did not draw attention to himself (see Extract 73). Her descriptors were brief, but to the point, and created an impression of a somewhat invisible man.

*Extract 73 (Sue-Viv/SW1/L208-220)*

- 208 S: umm (0.5) Ken
- 209 V: mhm
- 210 S: how would you describe Ken as a person?
- 211 V: (1.0) u::m fairly qu↑iet (0.5) fairly (0.5) insec↑ure (1.0)
- 212 u::m (.) tries h↑ard at everything he do↑es (1.0) u::m (0.5)
- 213 probably:: is a person who (.) doesn't attract a lot of
- 214 attent↑ion (0.5) so maybe he could do with more (0.5) u:m
- 215 (.) help than he gets (0.5) u::m
- 216 S: yeah
- 217 V: (1.0) ◦what else about Ken◦ (1.5) he's (.) a very pleasant
- 218 well mannered person (.) very easy to get along w↑ith
- 219 S: mhm yep
- 220 V: u::m (2.0)

Unlike the other three support workers, Viv does not give an explanation for Ken's emotional problems. Instead, she manages Ken as an agreeable man who is not being properly supported by the mental health system. Here, Viv lays down a complaint (see Potter & Wetherell, 1987) where the mental health system is portrayed as not doing enough to support consumers. The initial descriptors given of Ken are of a 'fairly qu↑iet (0.5) fairly (0.5) insec↑ure...' man who 'tries h↑ard at everything he do↑es' (line 211-212). The softener (Edwards, 2000) of 'fairly', used before the descriptive terms, work to minimise extremes. They position Viv as a rational, reasonable woman, who does not make excessive claims of others. This manages to give her perspective of Ken more credibility, as speaking in extremes may be common when describing people with mental health

concerns (see Smith, 1978). Viv's portrayal of a man who is quiet, insecure, and tries hard resembles some of the descriptors Mel gave of Ken. Mel had talked of Ken needing affirmation and encouragement, and also conveyed that he tried. Viv's account reinforces the idea that Ken attempts, but does not necessarily succeed at, tasks.

Viv's account also suggests the notion of Ken as an invisible man in that he does not get the attention that he perhaps needs due to his 'quiet' manner (lines 213-215). Through this complaint, Viv is challenging established practices within the mental health system, highlighting an assumption that 'quiet' equates to positive mental health.

### **Deb: Distance and Inclusion**

Deb was the second primary participant I asked support workers to describe. The four support workers varied in the degree of closeness they portrayed in their relationship with Deb. Clinical staff members tended to distance themselves from Deb, whereas non-clinical staff members were more inclusive.

### **An Anxious Woman, Almost a Friend**

After talking about Ken with Mike, our conversation moved on to Deb. His account of Deb conveyed a friendly, but anxious woman (see Extract 74), where this anxiety could only be overcome to a certain extent.

*Extract 74 (Sue-Mike/SW3/L420-440)*

- 420 S: okay (.) umm (0.5) what about Deb?
- 421 M: Deb (.) its ((participant's surname))?
- 422 S: ((participant's surname))
- 423 M: yeah (.) okay so::
- 424 S: how (.) how would you describe her?

- 425 M: how would I describe her  
 426 S: yeah  
 427 M: (2.5) re::ally really bubbly (.) umm and re:ally friendly (0.5)  
 428 and umm (1.0) you know willing to try things (0.5) umm  
 429 (0.5) but again (h) I'm looking at her needs and I always  
 430 see her as this very anxious pers↓on (.) and she's just trying  
 431 to (.) umm (0.5) maintain or you know manage that  
 432 anxiet↑y (1.0) umm (.) yeah and I think she's doing a  
 433 fantastic job at the moment (.) umm (.) yeah but I can still  
 434 see that anxiety in her  
 435 S: mhm  
 436 M: umm but you know she's- (.) she's certainly using her  
 437 personality as much as she can to (.) to overcome ↓it which  
 438 I think is the way to go  
 439 S: yeah?  
 440 M: yeah yep

In this account, Mike works an image of Deb as a woman working hard to overcome her anxiety. By drawing upon medical discourse, Mike manages a woman who will always have problems despite promising current attempts to prevail over her emotional problems. That is, Deb will always be anxious. The initial descriptors given of Deb are of a 're::ally really bubbly', 're:ally friendly' woman who shows a willingness to try new ideas (lines 427-428). Here, the injection of the extreme case formulation (see Pomerantz, 1986) of 'really' manages to emphasise these qualities, promoting them as objective claims.

From this encouraging outline of Deb's character, Mike then draws upon medical discourse (perhaps aware that his status at the service centre as a 'professional' may come into question) by balancing his descriptors with clinical representation. In this instance, evoking 'professionalism' may also be viewed as a distancing device, as it places Mike in a position of

authority. Through the justification of ‘... looking at her needs’, Mike creates an image of an ‘anxious’ woman (lines 429-430). As Mike ‘always’ sees her in this way, an inference of chronicity emerges, and the best that Deb can do is to ‘maintain’ or ‘manage’ her problem (line 431). Deb’s success in the endeavour of managing her problem is rated as ‘fantastic’, yet the follower of ‘at the moment’ (line 433) works to downplay this success and imply that this could change very quickly. (lines 436-438). In lines 436 to 437, Mike then implicitly draws upon his earlier comments of Deb’s qualities and promotes the use of personality as a tool to ‘overcome’ Deb’s problems. However, the moderating use of the phrase ‘as much as she can’ (line 437) moves to play down the possibility of permanent success with this tactic. Thus, in Mike’s account, Deb can achieve some gain, yet not a complete recovery.

Mel too, tended to distance herself from Deb. In Extract 75, Mel deferred to the circumstances of her relationship with Deb, focusing on the notion of friendship.

*Extract 75 (Sue-Viv/SW1/L208-220)*

- 365 S: okay umm (.) what about Deb?
- 366 M: Deb?
- 367 S: yeah how would you describe Deb?
- 368 M: umm I su- I think she's a really lovely person with a really
- 369 lovely personality that makes you (.) warm to h↑er makes
- 370 you (.) w↓ant to (.) chat with h↑er you kn↓ow as a fr↑iend
- 371 S: mm
- 372 M: umm I see her almost as someone that (.) yeah I would (.)
- 373 feel very very comfortable being a friend w↓ith you kn↓ow n
- 374 different circumstances and stuff like that
- 375 S: mhm
- 376 M: umm (1.5) ye::ah

In this account, Mel impresses Deb's warmth and friendliness. She conveys a forced distance between herself and Deb, due to her role at the service centre, yet it is possible to imagine that without these circumstances, she and Deb would not have been friends. Mel starts out her account with the kind of person she sees Deb to be. She draws upon extreme case formulations to promote this version (see Edwards, 2000; Pomerantz, 1986); twice claiming Deb to be a 'really lovely' woman (lines 368-369). She then goes onto to claim that it is Deb's personality that 'makes you' (lines 369-370) want to befriend her. The use of 'you' (Wooffitt, 2001) in these two excerpts works to show that Deb has this effect on most people, and that it was not specific to Mel.

From this impression of a warm and friendly person, Mel then manages an explanation for why they could not be friends. To do this, she draws upon 'circumstances' (line 374), inferring that her role at the service centre did not allow for a close association with consumers. Telling in this extract though, is the use of the term 'almost' (line 372). Mel says that under different circumstances she could 'almost' be a friend to Deb, which suggests a sense of 'not quite'; something else would prevent this friendship. That Mel mentioned her own comfort levels with this proposition suggests that other people might also not feel at ease. Thus, in order to maintain authority, Mel conveys that she had to separate herself from consumers, yet she would not quite be a friend to Deb if circumstances were different.

## Coping Well, a Woman Becoming

In their accounts of Deb, Luke and Viv tended to be more inclusive toward Deb and consumers in general. Luke did not have much knowledge of Deb, but gave a positive impression that he had gained of her (see Extract 76).

### *Extract 76 (Sue-Luke/SW4/L277-301)*

- 277 S: yeah (0.5) mhm (.) okay umm Deb  
 278 L: Deb?  
 279 S: is it Deb ↑ (participant's surname))?  
 280 L: ((participant's surname)) (.) don't know a great deal about  
 281 Deb ehh  
 282 S: yeah?  
 283 L: she doesn't come to any programmes I'm in  
 284 S: mhm  
 285 L: so she's usually with umm with Mike or Mel really  
 286 S: okay  
 287 L: but umm  
 288 S: so what (.) what would be you're impressions of her then?  
 289 L: well she's an outgoing p↓ers↑on  
 290 S: mhm  
 291 L: she seems qu↑ite capable I feel of (.) holding down a j↑ob  
 292 S: °yeah°  
 293 L: I think she's going through a change of ehh house just now  
 294 she's moving house at the mom↑ent (.) and I feel once she  
 295 moves in and she settles in I f↑eel she could get a part-time  
 296 j↑ob  
 297 S: yeah  
 298 L: I just feel she comes (.) here and she's qu↑ite (.) joyful and  
 299 happy and=  
 300 S: mm  
 301 L: =you kn↑ow and ehh (0.5) coping very well I feel

Luke's account of Deb impresses a happy, outgoing, competent woman who is coping well with her problems. Despite his position of authority at the service centre, he did not appear to place himself apart from consumers. However, he is careful to express that what he has to say of Deb is his opinion. Early in the extract, Luke makes it known that he has little knowledge of Deb. He mentions the programmes run by the centre, and states that she does not attend any that '...I'm in' (lines 283). Support staff run these programmes, yet Luke conveys joint participation. This manages a show of inclusion, encompassing all people at the centre, whether they are staff or consumers.

I asked Luke for his impression of Deb, and some of his descriptors in the latter half of the extract are 'outgoing' (line 289), and 'joyful and happy' (line 298-299). These are along the same lines as the initial depictions given by Mike and Mel. Luke also infers competence, claiming Deb to appear 'quite capable' (line 291), and 'coping very well' (line 301). Throughout this section of the extract, Luke legitimises his comments with 'I feel'. This works to give a more personalised perspective of Deb (despite his earlier claim of not knowing her well), and conveys that it is his opinion he is giving rather than that of a 'professional'.

Viv's account of Deb conveyed a woman in the process of becoming more secure in herself (see Extract 77). Like Luke, Viv's account was inclusive of all people at the service centre, as she gave an account of awareness of Deb's difficulties.

*Extract 77 (Sue-Viv/SW1/L283-305)*

- 283 S: Deb
- 284 V: mh↑m
- 285 S: ((participant's full name)) I think it is
- 286 V: yep
- 287 S: how would you describe her (.) as a person?
- 288 V: u::m (3.0) it's because I know it's difficult to say like I know
- 289 she feels insecure
- 290 S: mmm
- 291 V: so I don't- (0.5) and I know she is because she actually
- 292 t↑ells you she is but (.) outwardly she comes across as
- 293 being very sure of herself and very talkative and very- she's
- 294 lovely (.) she's very friendly and=
- 295 S: mmm
- 296 V: =only last week we sort of (.) got into disc↑uss↓ions in our
- 297 Tuesday morning group which (0.5) I could tell that she was
- 298 sort of talking about things that she wasn't free with bef↑ore
- 299 and she actually was- it was almost like 'oh wow it is okay to
- 300 say these things and is it okay' and sort of that type of
- 301 th↑ing so
- 302 S: yeah
- 303 V: I think (.) she's now becoming (.) more (.) relaxed (.) a little
- 304 bit more outgoing but I'd still do know that she's insecure in
- 305 herself (.) [yeah]

Viv's account conveys an awareness of Deb's feelings and behaviour. Like Luke, Viv's account is also inclusive, where a sense of belonging is emphasised. Thus, Viv claims a closeness to and knowledge of Deb that could only transpire through trust in a relationship. To begin, Viv claimed personal knowledge that Deb feels 'insecure' (line 289), initiating issues of stake and accountability for this claim. Viv's credibility is handled in lines 291 to 292, where she proposes that she knows how Deb feels 'because she actually t↑ells you'. This works to head off any challenge to



the statement, as it is not simply Viv's opinion, but a comment from Deb herself. The deployment of the term 'you' in this instance adds influence to the account. It infers that it is not a personal confidence, but information about herself that Deb readily shares. Viv proffers that the person Deb presented herself as was not the person that she really is. In effect, Viv suggests that Deb's public and private personas are dramatically different in that one is 'very sure of herself' (line 293), yet the other is 'insecure'. In Viv's opinion, however, the gap is narrowing.

Like Luke, Viv makes reference to the programmes run at the centre, referring to one that Deb attends as '...our Tuesday morning group' (lines 296-297). Despite Viv running the group, she impresses a sense of inclusiveness. She indicates that the group belongs to all those involved, staff and consumers. It is through Deb's attendance in this group that Viv claims the awareness of a change in Deb's behaviour over time. That is, Deb speaks more freely than she has in the past, and this mention of progress in Deb conveys a sense of becoming. Thus, Viv implies that it is her closeness and sensitivity to Deb that allows her deeper knowledge of how things might be for Deb.

### **David: Reconciling Aggression**

Talk of David appeared to revolve around the issue of aggression. One female support worker portrayed David as childish, whereas the other described him as rowdy. The two male support workers spoke about David's aggressive and sometimes offensive behaviour, yet placed blame for this behaviour elsewhere. No support worker placed blame directly upon David for his behaviour.

## A Child with Rowdy Tendencies

The two female staff members in this study described David as a friendly man. Mel described David as a naughty child who tended to try to get away with as much as he could (see Extract 78).

*Extract 78 (Sue-Mel/SW2/L445-460)*

- 445 S: ok↓ay (0.5) umm (.) David
- 446 M: David
- 447 S: David
- 447 M: oka↑y (0.5) umm Dav- how would I see h↑im?
- 448 S: how would you see h↓im?
- 449 M: u::m I'd see him a::s (1.0) a friendly (.) larger-than-life sort
- 450 of pers↑on [[[quiet laugh]]] (.) u:m (1.0) umm who: (1.5)
- 451 S: [[(laughs)]]
- 452 M: can be a bit naughty (.) somet↑imes s↓o u:m (1.5) at times
- 453 tries to (0.5) do th↓ings which he knows (.) really (.) isn't
- 454 right (.) for himself or even for other people like he's (.) you
- 455 kn↓ow not really giving other people a fair deal or something
- 456 like th↓at b↓ut he (.) gets away with ↑it or can get away
- 457 with it so he'll try
- 458 S: mmm
- 459 M: umm (.) so a bit mischievous b↓ut he's again someone that
- 460 you can warm t↑o (0.5) u:m (.) u:m (1.0) yeah

In line 452, Mel describes David as ‘...a bit naughty (.) somet↑imes’. The term ‘naughty’ might typically be used to describe the behaviour of a child rather than an adult, as a parent might scold a child for misbehaviour. Mel’s later use of the term ‘mischievous’ (line 459) references this impression of David as a cheeky child who is always getting up to something. Yet, Mel suggests that this behaviour seems to work for David, as she describes him as being a person that ‘you’ (a term suggested by Wooffitt (2001) to convey ‘most people’) could ‘warm t↑o’ (line 460).

Alternatively, Viv presented David as a rowdy, good natured, caring man (see Extract 79).

*Extract 79 (Sue-Viv/SW1/L389-413)*

- 389 S: yeah (.1.0) okay umm David
- 390 V: (1.5) mh↑m
- 391 S: David
- 392 V: (laughing) how do I see David? ((laughing))
- 393 S: how do you see David ((smiley voice))
- 394 V: u::m (1.0) David's (1.5) u::m (2.0) how do we describe
- 395 David ((smiley voice))
- 396 S: ((laugh))
- 397 V: he::'s noisy (laugh) he's bossy ((laughing)) u::m (1.0) at
- 398 the moment he's great I mean he:'s (.) >really really we↑ll<
- 399 (1.0) I'm doing some work with him on (.) weight loss and
- 400 whatn↑ot u::m he's=
- 401 S: mhm
- 402 V: =easy to communicate wi::th (1.5) u:m he's j↓ust a bit (.)
- 403 rowdy and a bit (.) you know (.) at times but apart from
- 404 that he's (.)>I th↓ink he's got- his heart's in the right place<
- 405 S: yeah
- 406 V: he's got a great natu↑re
- 407 S: mhm
- 408 V: do anything for you (.) works (.) you know around here
- 409 anything that you want done David's always eager to (.) mm
- 410 S: yeah
- 411 V: he likes t- he spends a lot of time here (.) u:m because he
- 412 likes to be occupied (1.5) u::m (0.5) I think (0.5) ye↑ah
- 413 that's probly basically how I see D↑avid yeah

The portrayal that Viv gives of David is of a friendly, boisterous man. Through a show concession (Antaki & Wetherell, 1999), she counters possible claims of antagonism with a description of David that presented him as a helpful, energetic, good-natured man who meant well. Show

concessions are drawn upon when the speaker wishes to solidify their position on a matter, and dismiss competing claims. The rhetorical structure of show concessions follows an orderly pattern of proposition, concession, and reprise. In line 402, Viv proposes that David is 'easy to communicate wi::th'. In light of her earlier comments of David as 'noisy' and 'bossy', this claim may be a contestable matter. For example, it could be difficult to communicate with a person who was dictatorial and loud about it. The concession comes in lines 402 to 403, when Viv reveals David's rowdiness. The concessionary marker of 'he's j↓ust' works to allow the introduction of 'rowdy', the possible counter-claim against David being easy to communicate with. The continuation of 'and a bit (.) you know' offers no new evidence to argue against the proposition, yet suggests that there may be more. Adding 'at times' conveys that 'rowdy' did not always occur, working to play down the effect of this term.

Contrary to typical show concessions, the reprise in this section of talk was not a repetition of the original claim. The reprise marker of 'but' is indicative that the former claim is reiterated, yet rather than stating again that David is easy to talk to, Viv claims that David means well (lines 403-404). She furthers this by saying that David has 'a great natu↑re' (line 406), and that he would 'do anything for you' (line 408), giving the example of David's assistance at the service centre. These further explanations enhance the idea of an easy going, helpful man, orienting back to the initial claim of 'easy to communicate wi::th'.

### Aggressive and Offensive, but Not His Fault!

Luke and Mike tended to focus on aggression in their accounts of David. Luke compared past and present behaviours, speaking of knowing David 'for some years' (line 307 - see Extract 80).

*Extract 80 (Sue-Luke/SW4/L306-334)*

- 306 S: okay David
- 307 L: David yes I've known David for some years yes yes
- 308 S: how would you describe David?
- 309 L: well when we first got David he was (.) very very
- 310 disruptive to his f↓amil↑y
- 311 S: mhm
- 312 L: and he was (.) qu↑ite difficult emm (0.5) (tch) with other
- 313 members as w↓ell he used to borrow a lot of cigarettes off
- 314 th↑em and was (.) quite forceful
- 315 S: ◦mhm◦
- 316 L: but s↑ince he changed medication as well which is going
- 317 back maybe (0.5) two years ago I sp↑ose maybe (1.0) ahh
- 318 (.) he has changed completely
- 319 S: yeah?
- 320 L: yes he's ehh (.) he's still got that (.) bit of forcefulness
- 321 about but (.) not so pushy with uhh members and so f↑orth
- 322 he ehh (2.0) he's more stable than he w↓as th↑en (.)
- 323 because he used to ehh (tch) ehh at one stage take his
- 324 mum's car out (.) unbeknown to his mum and and=
- 325 S: mm
- 326 L: =take stuff out of the fridge and so forth (0.5) well he's no
- 327 l↓onger like th↑at he's quite straight forward n↑ow and ehh
- 328 (.) he's going to TAFE (.) which is really good (.) I feel
- 329 S: mm
- 330 L: and ehh he's (.) holding down two jobs at the m↓om↑ent
- 331 and (.) two part-time (.)
- 332 S: oh r↑ight
- 333 L: two part-time jobs (1.0) and ehh (.) quite in charge and I
- 334 feel he's doing really well

Luke's account of David presents a contrast between the past and the present, providing a view of David as someone who was aggressive and disruptive in the past, but is currently stable and in control of himself. Descriptors of the past are given first, managing David as 'very very disruptive to his f↓amil↑y' (lines 309-310), 'qu↑ite difficult' and 'quite forceful' (lines 312-314). These terms imply a generally aggressive demeanour without actually stating it as they are applied to David's behaviour toward both family and fellow consumers. Luke goes on to give credit for the claim of a transformation in David to a change in medication, yet adds 'as well' to the end of this statement (line 316). This suggests that something else was also responsible for David to have 'changed completely' (line 318), although Luke does not say what this is. This latter claim of a complete change is softened though, as Luke concedes that David 'still' displays a 'bit of forcefulness', yet he is not as 'pushy' with other consumers as he has been (lines 320-322). David's past 'disruptive' behaviour with his family was described through examples of using his mother's car without permission and taking 'stuff out of the fridge' (line 326), implying that his disruptiveness may have primarily taken the form of dishonesty and an unwillingness to abide by parental rules. This notion of deceitfulness is reinforced by the way Luke describes the changes in David: 'he's quite straight forward n↑ow' (lines 326-327), and descriptors such as David being '...quite in charge' and 'doing really well' (lines 333-334) convey self-control, and that emotionally, David is now stable and dependable.

Mike's account of David centred on providing attributions of causality for David's difficulties and current behaviour (see Extract 81).

Mike first provided a professional opinion, followed by a personal view of what he saw to be the reasons for David's problematic behaviour.

*Extract 81 (Sue-Mike/SW3/L506-534)*

- 506 S: uhuh (1.0) okay umm (0.5) David
- 507 M: mhm
- 508 S: how would you describe David?
- 509 M: David umm (tch) (0.5) Dav↑id I would describe (.) as a guy
- 510 that's had a really hard l↑ife ((laugh))
- 511 S: mm
- 512 M: and that (.) that has had a a history of (.) really (.) serious
- 513 (.) a serious illn↓ess (.) that's really impacted on his you
- 514 know (.) who he is (.) and his quality of life and its impacted
- 515 on how he's gonna (.) his future life as well (.) umm (0.5) I
- 516 think he's really just (.) still in th↓at (0.5) time of his
- 517 recovery that umm (.) you know that he's just (2.0) I guess
- 518 an initial journey of just (.) overcoming those initial stages
- 519 of schizophrenia of (.) of the you know the really the v↓oices
- 520 the hallucinations and (.) those kind of things the positive
- 521 symptoms I g↑uess umm (0.5) and and then (.) coming into
- 522 those negative symptoms as well but then (.) I feel now that
- 523 his personality is coming out and I think (.) in that
- 524 personality is a lot of kind of hardships that he (.)
- 525 underwent when he was y↑ounger umm so (.) when I
- 526 describe him as being quite selfish and quite umm (.)
- 527 disrespectful and umm (tch) umm (0.5) and (.) intrusive I
- 528 think (.) part of it's got to do with illn- his illness but (.) a lot
- 529 of its got- I reckon a lot of it's got to do with his his
- 530 upbringing with his family and I'm not saying it's his parents
- 531 fault but I mean (.) I guess he's just umm (.) yeah (0.5) he
- 532 can be quite abrupt ((laughs))
- 533 S: mm
- 534 M: yeah (.) quite difficult

To explain David's current hardship, Mike draws upon medical discourse focusing on criteria and symptomology that correspond with a diagnosis of schizophrenia. In this extract, 'a serious illness' (line 513) and '...the voices the hallucinations...' (lines 519-520), present David as a person being overshadowed by his illness. This is further emphasised in line 518 - David is 'overcoming those initial stages' (line 518) and 'his personality is coming out'. Covering medical ground works to ensure that Mike is conveying the topic as a professional. Once this is established, Mike is then free to approach the topic of 'a hard life' from a personal perspective. However, lines 523 to 524 suggest that the emergence of David's personality is presenting its own set of difficulties.

Emphasis on these 'hardships' in David's 'younger' years (lines 524-525) works to soften the following negative construal of David as 'selfish', 'disrespectful' and 'intrusive' (lines 526-527). Mike portrays David as an offensive man, but is quick to deflect responsibility for this behaviour away from David: Mike proposes that in addition to his illness, David's 'upbringing' and 'his family' (line 530) have a lot to do with it. Showing awareness of this attribution of blame, Mike counters with 'and I'm not saying it's his parents' fault but ...' (lines 530-531). Here, the placement of the term 'but' at the end of this denial works as a refutation of the denial; the initial statement of blame retains its standing. Mike then changes direction, claiming that David 'can be quite abrupt ((laughs)) yeah (.) quite difficult', working to divert attention away from the blaming and back to David. Thus, Mike portrays David as offensive, yet blameless due to factors that are beyond David's control – his illness and his upbringing.



## Karen: Dependence

The issue of dependency and Karen's emotional problems were at the forefront of accounts given by staff members. Luke couched the notion of dependence in softer terms such as reliance, whereas both Viv and Mike were much more direct. Mel though, showed difficulty in describing Karen, inferring blunted affect to be the reason for this.

### A Blunted Woman

Mel's account of Karen did not actually give a description of the kind of person she saw Karen to be (see Extract 82). Rather, Mel busied herself with providing explanations for the lack of personality that she saw in Karen.

*Extract 82 (Sue-Mel/SW2/L544-566)*

- 544 S: umm (.) Karen
- 545 M: umm Kar[en (.)] I see h↓er as (1.0) umm (2.0) umm (1.0)
- 546 S: [yeah]
- 547 M: I guess I see her as (.) someone who (.) used to have a lot
- 548 more personality and (.) I haven't known h↓er that long
- 549 S: mm
- 550 M: probly (.) maybe a year as w↓ell (0.5) umm (.) but I get the
- 551 impression that there's more of a person in th↑ere (.) and
- 552 she's a bit blunted (.) umm
- 553 S: mm
- 554 M: whether that is because (.) of medications (.) or because of
- 555 umm the illness proc↑ess (0.5) umm (.) I th↑ink its actually
- 556 (.) a b↓it of both (.) I think (.) medications have a- you
- 557 kn↑ow has affected her personality (.) coming out and
- 558 there's just more of that stiff (.) blunted kind of (.)
- 559 appear↑ance (.) and umm (.) but y↓ou c- at the same time
- 560 when you talk to her you see that she's g↓ot- you kn↓ow

- 561           there's definitely personality there that you warm to  
 562    S:       yeah  
 563    M:       umm (.) she c↓an- you can have a laugh with her (.) umm  
 564           and all the rest  
 565    S:       mhm  
 566    M:       umm yeah

Despite claiming that Karen ‘definitely’ (line 561) has a warm personality, Mel conveys little of this personality in her account. Mel describes Karen as having a mechanistic demeanour, putting this blunted affect primarily down to medication effects. Thus, Mel infers that it is difficult to describe the kind of person that Karen is due to the way in which both her medications and her ‘illness proc↑ess’ (line 555) mask the ‘person in th↑ere’ (line 551). One of the first claims that Mel makes is that Karen ‘...used to have a lot more personality’ (lines 547-548). This suggests knowledge of Karen before her emotional problems began. As Mel is only likely to see consumers once their emotional problems are evident, this claim becomes suspect and could be a contestable issue. Mel then concedes that she has only known Karen for about a year, and goes on to adapt her initial claim by stating that it is an ‘impression’ (line 551) she has, working to circumvent any challenge to knowledge of Karen prior to Karen’s arrival at the service centre.

There is also an orientation toward the medical symptom of blunted affect – ‘she's a bit blunted’ (line 552), and Mel offers this as a reason for Karen’s minimal personality. Mel then gives two possible causes for this blunted persona: the illness itself or the effects of medication. She elaborates on the latter suggestion, drawing on the softener of ‘I think’ (line 556) to manage this as personal knowledge rather than medically recognized

knowledge. Reiterating this notion of a mechanistic kind of woman, Mel restates that Karen displays a ‘stiff (.) blunted kind of (.) appearance’ (lines 558-559). Up to this point in the account, Mel had presented Karen as a woman with barely a personality. As if in recognition of this, Mel assures that ‘you warm to’ (line 561) her and ‘you can have a laugh with her’ (line 563), drawing upon the normalising device of ‘you’ to convey that most people would say this of Karen (see Wooffitt, 2001). Yet, in this account, Mel has said little that would identify Karen from any other consumer, revealing an underlying difficulty that Mel has in describing her.

### **A Concerned Woman**

Luke based his description of Karen around a comparison between the past, when she had first arrived at the service centre, and the present (see Extract 83). The two issues of emotional distress and her marriage emerged.

*Extract 83 (Sue-Luke/SW4/L363-377)*

- 363 S: yeah (0.5) umm (.) Karen
- 364 L: Karen yeah
- 365 S: mhm (1.5) how (.) how would you describe Karen?
- 366 L: Karen ehh (.) when we first got Karen ehh she wasn't
- 367 married she'd just come from (.) (another service provider's
- 368 name) (tch) (0.5) and ehh (1.5) she was say (.) qu↑ite
- 369 distr↓essed I think early o↑n (1.0)
- 370 S: mhm
- 371 L: ehh (1.5) very paranoid I f::elt (0.5) that- the different
- 372 things that we sorta tried to do with h↑er (1.0) but then
- 373 s↑ince she got married and tha↑t I could see (.) j↑ust a
- 374 slight difference in her
- 375 S: yeah?
- 376 L: she's still a little bit ehh concerned about (0.5) ehh her
- 377 hubb↑y (0.5) but ehh I th↑ink she's (.) she's doin quite we↑ll

Luke's descriptors of Karen centred on an improvement in Karen's emotional well-being that is credited to her marriage. The first piece of information that Luke gives of Karen is her marital status upon arrival at the service centre. Here, a link emerges as Karen 'wasn't married' (lines 366-367) and she was 'qu<sup>↑</sup>ite distr<sup>↓</sup>essed' (lines 368-369). He continues to focus on emotional distress, but this time gives it the label of 'paranoid' (line 371). This shift from describing Karen as 'qu<sup>↑</sup>ite distr<sup>↓</sup>essed' to 'paranoid' produces her distress as a symptom of her illness (as paranoia is a recognised feature of schizophrenia). The 1.5 second pause before the introduction of the term 'paranoid' suggests that Luke considered the use of this term to be delicate in this context, perhaps suggesting some ambivalence about describing Karen's behaviour in medical terms.

This medical account of Karen's behaviour is further undermined by Luke's attribution for the ('slight', line 374) improvements seen in Karen: her marriage. In a move that works to avoid extremes in his claims and make the notion of change more plausible, Luke concedes that Karen is 'still a little bit ehh concerned about (0.5) ehh her hubb<sup>↑</sup>y' (lines 376-377). The term 'concerned' and the direction of this concern, 'her hubb<sup>↑</sup>y', implies that a much milder form of the earlier paranoia is 'still' present, but in Luke's opinion, Karen is now 'doin quite we<sup>↑</sup>ll' (line 377).

### **A Dependent Woman**

Extracts 84 and 85 are more direct in their assessments of Karen. Here, staff members speak of Karen as a dependent woman, who can be guarded in her conversations with staff and quite difficult to assist.

*Extract 84 (Sue-Viv/SW1/L459-475)*

- 459 S: mmm yeah (.) umm (.) Karen?  
 460 V: (1.5) u::m (.) I see Karen a::s (2.5) quite u::m (2.0)  
 461 depende↑nt  
 462 S: mm  
 463 V: u::m (0.5) lovely natu↑re likes to have a ch↑at (.) real (.)  
 464 girly type ch↑at (.) the types of things that- (.) I think she  
 465 feels quite comfortable being able to just (1.0) u::m do that  
 466 sort of thing here somet↑imes I think I see her as being  
 467 (0.5) a tad insecure in her relationsh↑ip (0.5) u::m  
 468 S: mmm  
 469 V: but I also see that- u::m she's alm- almost a bit nervous to  
 470 even discuss those sorts of things she's very (0.5) uhh loyal  
 471 (.) a loyal s↓ort of person so yeah that-  
 472 S: yeah  
 473 V: u::m (0.5) ver↓y (.) n↑ice (.) fr↑iendly yep  
 474 S: mhm  
 475 V: mhm

Throughout Extract 84, Viv qualified her claims as her opinion, working to allay any challenge to them by openly declaring her subjectivity. In Viv's opinion, Karen is a dependent woman who adheres to feminine stereotypes, but is possibly a little guarded in her talk about her private affairs. When I first ask Viv about Karen, she appears to consider my request. After two relatively long pauses Viv sums up her description of Karen in one word – ‘depende↑nt’ (line 461). The short and concise nature of this declaration lends itself to certainty. Having made this somewhat negative assessment, Viv goes on to balance this with some more positive comments, depicting Karen as a woman with a ‘lovely natu↑re’ who likes talking to people – ‘real (.) girly type ch↑at’ (lines 463-464). Viv remarks that she has gained an impression that Karen feels ‘quite comfortable’ (line

465) with these topics of conversation, but immediately contrasts this with the idea that Karen is ‘a tad insecure in her relationships’ (line 467). This works to raise the more serious issue of insecurity, but the choice of the term ‘tad’ downplays the possible connotations associated with a diagnosis of schizophrenia such as paranoia. Viv continues that Karen appears to be ‘...a bit nervous’ (line 469) when discussing deeper, more personal issues, and interprets this hesitancy as a show of loyalty. Loyalty here, implies Karen's dedication toward her relationships. Mention of Karen as insecure then, conveys an explanation of Viv's initial claim of dependence. Karen is insecure, and thus, dependent upon her partner. Yet Karen's unwillingness to talk to Viv about this is portrayed as loyalty to her partner rather than as a lack of trust in Viv or evidence of symptomology of schizophrenia.

Mike displayed a clinical orientation to the notion of dependence. In Extract 85, Mike spoke of Karen as having a ‘dependent personality’ (line 587), conveying that she was a very difficult woman to assist.

*Extract 85 (Sue-Mike/SW3/L582-603)*

- 582 S: mhm (.) oka↑y umm Karen
- 583 M: (tch) Karen
- 584 S: Karen
- 585 M: umm (.) how would I describe her?
- 586 S: mmm
- 587 M: u(sigh)mm (1.0) describe her as a dependent personality
- 588 ((laugh)) she's quite dependent (.) on (.) well whoever's
- 589 around her whoever's closest to her whoever she can be
- 590 whoever she can get anything from (.) umm sh- I think
- 591 she's she's in that (.) that boat (.) that helplessness b↑oat
- 592 (.) umm you know I guess that life's (.) you know that life's
- 593 (.) just (.) it'd be great you know if you can have a great life
- 594 but you know it's too hard to get s↓o (.) yeah what can I do

- 595 (0.5) that kind of attit<sup>↑</sup>ude (tch) so umm (.) yeah <sup>↑</sup>I f<sup>↓</sup>ind  
 596 <sup>↑</sup>I'd des- I'd describe her as a (.) quite difficult woman to  
 597 help (0.5) umm (1.5) (tch) but I mean, you know on a (.)  
 598 talking to her personally (0.5) umm I guess you know in  
 599 terms of j<sup>↓</sup>ust (.) what she's l<sup>↑</sup>ike her person<sup>↑</sup>ality (0.5)  
 600 umm (.) yeah she's certainly resp<sup>↓</sup>ectful and that kind of  
 601 th<sup>↑</sup>ing (.) which I like  
 602 S: yeah  
 603 M: umm (0.5) yeah umm (2.5) mm yeah

Mike describes Karen as a dependent woman with an attitude of helplessness. The extent of her dependence is emphasised through the use of a three-part list; 'whoever's around', 'whoever's closest', 'whoever she can get anything from' (lines 588-590). The final part of this list also conveys an impression that some of Karen's dependence may be strategic. Mike also promotes her as difficult to work with, which manages to explain Mike's own helplessness and keep his professional integrity intact.

In his descriptors of Karen, Mike first draws upon clinical terminology, presenting Karen as having a 'dependent personalit<sup>↑</sup>y' (line 587). He suggests that this dependence is not person specific, conveying Karen as a clingy, needy woman. Mike then elaborates upon this idea by describing Karen as in 'that helplessness b<sup>↑</sup>oat' (line 591), where she finds life 'too hard' (line 594) so does not bother trying. This subtle reference to theory (Seligman's (1975) Learnt Helplessness) manages Mike's academic proficiency, and works to set up the following complaint, where Mike describes Karen as a 'quite difficult woman to help' (lines 596-597). This complaint portrays Mike as being frustrated by his attempts to assist Karen. At stake then, is Mike's ability as a professional to support Karen. He

deploys theory to explain this lack of success, implying that it was not due to any inability on his part, but to Karen's 'attitude' (line 595).

Further reference to Mike's professional standing comes in lines 600 to 601, where he suggests that when he talks to Karen 'personally', 'she's certainly respectful and that kind of thing (.) which I like' (lines 600-601). This claim both works to soften what might be seen as a harsh judgement of Karen, and also to reinforce Mike's professional position with the members of the centre. Thus, Mike portrays Karen to be a dependant woman who is difficult to help, and works to ensure an understanding that this is not due to a lack of expertise on his part, but to Karen's attitude of helplessness.

### **Rick: Instability**

Support workers' descriptions of Rick tended to revolve around the two issues of instability and dysfunction. Luke spoke of an unstable man whose behaviour tended to be cyclical, but he was a nice lad. Viv spoke of an unstable drifter, who was quite aimless. Mel and Mike too, conveyed instability, coupled with a lack of insight where Rick led a dysfunctional kind of life.

#### **A Drifter, but a Nice Lad**

Luke and Rick had known each other for many years, and in his interview Rick had mentioned his working under Luke at one stage as a staff member at Graylands Mental Hospital (Rick/CS8/L144-148). Luke drew from this long-term association with Rick to give an account that would be rendered as trustworthy (see Extract 86).



*Extract 86 (Sue-Luke/SW4/L435-468)*

- 435 S: mm (1.5) oka↑y (.) umm (.) Rick
- 436 L: R↑↓ick(.) mhm
- 437 S: Rick yeah
- 438 L: yes I've known Rick over quite some t↓im↑e
- 439 S: mhm
- 440 L: uhh (0.5) he has shifted house (.) about every six m↓onths I
- 441 can never keep up with h↓im he shifts all over the [pl↓]a↑ce
- 442 S: [mm]
- 443 L: he has tried for (.) quite a number of j↓obs in the past (.)
- 444 but I think he's given u↑p at the m↓om↑ent because I've
- 445 asked him about (.) trying to settle into a part-time j↓o↑b
- 446 and (.) he likes industrial (.) work
- 447 S: mm
- 448 L: his father's emm (tch) been a trade assista↑nt or something
- 449 like th↑at
- 450 S: yeah
- 451 L: umm (1.5) like whenever he shifts house he usually sells
- 452 everything he's g↓ot (.) and he's got to start ag↓ain and this
- 453 is where he is at the moment
- 454 S: ahh
- 455 L: so he's buying furniture and (.) televisions and (0.5)
- 456 bedclothes and so forth at the m↓om↑ent so I'd sa::y (tch)
- 457 going through the same as probly he's done for (.) quite a
- 458 number of y↑ears
- 459 S: mm
- 460 L: very unstab↑le
- 461 S: yeah
- 462 L: umm (2.5) but he's a n↑ice l↓ad
- 463 S: mhm
- 464 L: and if we could sorta stabilise- get him sort of stable and get
- 465 him into a little job (.) he would (.) he would work really
- 466 good in a part-time j↓ob
- 467 S: yeah?
- 468 L: I feel he could yeah

Luke begins his discussion of Rick by establishing their long-term association. This provides a context for Luke's subsequent account that is not merely a momentary glimpse of a man, but is based upon years of interaction. This history is then drawn upon to convey a disruptive pattern of behaviour in Rick, building up a case for Luke's major claim of Rick as unstable and caught in a cycle that prevents him from moving forward with his life. After establishing his long-term acquaintance with Rick, Luke uses a technique similar to a three-part listing (see Jefferson, 1990), conveying three pieces of information to build his case. First, in lines 440 to 441, Luke introduces information of Rick continually shifting house, 'about every six m↓onths'. This offers a pattern of unsettled behaviour, and Luke comments that it is difficult for him to 'keep up' with Rick. Luke then expands on this patterned behaviour suggesting that when Rick moves house he sells all of his belongings and then starts again (lines 451-452). Here, a cyclical nature to the behaviour is suggested, with Luke claiming that Rick is at the beginning of this cycle (line 453). To reinforce this positioning of Rick, Luke then introduces a three-part list, stating that Rick is currently 'buying furniture and (.) televisions and (0.5) bedclothes and so forth' (lines 455-456). Jefferson (1990) suggests that the use of an end-list completers like 'and so forth' work to support the generality and extensiveness of the claim.

Luke then subtly refers back to his long-term knowledge of Rick in suggesting that this cyclical pattern of behaviour has 'proably' been occurring 'for (.) quite a number of y↑ears' (lines 457-458). The use of the softener 'proably' in this instance works to diffuse any contention that may arise from the assertion, showing Luke to be a reasonable person and not likely to go to extremes. This clears the way for his major claim of Rick;

that he is ‘very unstab↑le’ (line 460). This appears to be a conclusion of sorts, a natural end-point for all that he had said earlier. Luke follows this somewhat negative assessment of Rick with a more positive concession: ‘but he’s a n↑ice l↓ad’ (line 462). In this account, Luke’s meaning behind the term instability centres on Rick’s continually starting again, his continually moving from place to place; an unsettled man. This instability is presented as the main barrier to Rick’s getting a job and moving forward with his life in a way that Luke believes he could. The overall impression conveyed by Luke is that Rick has allowed himself to be caught in a cycle of self-defeating behaviour.

Like Luke, Viv also saw Rick as unstable, drawing upon the term ‘drift↑er’ (Extract 87, line 593). She believed that he had no ambition, yet was quite a capable man, with a ‘really helpful nature’ (line 606).

*Extract 87 (Sue-Viv/SW1/L585-610)*

- 585 S: yeah (.) okay umm (.) Rick
- 586 V: mh↑m
- 587 S: Rick (.) a lot of these people I don't know their surnames
- 588 V: yeah (.) yeah I know who you're talking ab↑out yeah
- 589 [((laughs))]
- 590 S: [((laughs))] yeah umm (.) how would you describe Rick?
- 591 V: [u:::m]
- 592 S: [as a p]erson
- 593 V: drift↑er
- 594 S: mhm
- 595 V: he seems to just wander arou↑nd drift from place to place
- 596 (.) doesn't seem to have any: amb↑ition to do anything (.)
- 597 be anyone or (.) I mean I th↓ink he's quite capable of
- 598 do↑ing s↓ometh↑ing and be↑ing s↓ometh↑ing but
- 599 S: mmm
- 600 V: he just seems to have this nature of being a real dr↑ift↓er

- 601           and  
 602    S:       mmm  
 603    V:       going from one place to another and (0.5) nice (.) I mean  
 604           great g↓uy (.) really (.) do anything for you  
 605    S:       yeah  
 606    V:       really helpful nature (.) umm but quite- he just s↓eems (.)  
 607           very very (.) unstable and  
 608    S:       mmm  
 609    V:       just doesn't know where he's going and what he's doing (.)  
 610           yeah

Viv conveys Rick as a drifter, a man who aimlessly wanders from place to place without any particular life goals or direction. In her account, Viv suggests that Rick has the ability to change this behaviour, yet infers that something within his 'nature' prevents this. She, like Luke, concludes that this wandering renders Rick as unstable. The first term that Viv uses to describe Rick is 'drift↑er' (line 593). She elaborates, claiming that Rick tends to 'wander arou↑nd drift from place to place' (line 595). This describes an aimless man, and is followed with the proposal that Rick does not have ambition; no goals in life. This drifting behaviour and lack of ambition appears to be problematic for Viv, as she follows this with the proposition that Rick is 'capable' (line 597) of changing this behaviour, of 'do↑ing s↓ometh↑ing and be↑ing s↓ometh↑ing' (line 598). Viv accounts for Rick's puzzling lack of direction or ambition by reference to his 'nature' (line 600), possibly inferring a biological disposition or genetic trait, in an attempt to explain this behaviour.

Viv goes on to describe Rick as 'nice (.) I mean great g↓uy', and of having a 'really helpful nature' (lines 603-606). Reinforcing the 'nature' argument, these descriptors promote socially desirable attributes, conveying

that 'nature' was not necessarily detrimental or negative. Drawing upon extreme case formulations (Pomerantz, 1986), Viv narrows to her major claim of Rick as 'very very (.) unstable' (line 607). The extremes here work in conjunction with explanation, as the reason given for this instability is that Rick 'just doesn't know where he's going and what he's doing' (line 609). Earlier mention of Rick as drifting from place to place, along with the proposition that Rick does not have any goals in life, manage the underlying suggestion that to be a 'drift↑er' is to be 'unstable'.

### **Lacking Insight**

Mel and Mike also focused on the notion of instability in their descriptors of Rick. In their following two extracts the additional issue of a lack of insight emerged as another explanation of Rick's beliefs and behaviour.

*Extract 88 (Sue-Mel/SW2/L641-622)*

- 641 S: okay (.) umm Rick
- 642 M: oka::y Rick I see ↓as (.) someone who (.) has had an illness  
643 for (.) a long long t↑ime (.) and umm (.) that has (1.5)  
644 really really (.) affected his (.) umm (.) capacity (.) to  
645 function umm (.) in a stable w↑ay (0.5) umm (.) see that he  
646 has (0.5) a lot of instability in his l↓ife (0.5) and it's because  
647 his umm (0.5) because of his illness (.) that's the way ↓I see  
648 ↑it
- 649 S: mhm
- 650 M: umm (.) and (.) I don't think he (.) umm sees (.) it the  
651 same w↓a↑y (0.5) umm (.) and he's got (1.5) goals (.) of  
652 living (.) independently (.) umm conducting his life (.)  
653 getting work (.) getting (.) you kn↓ow (.) accommodation (.)  
654 umm (.) all the s↓orts of (.) regular things that (.) umm  
655 you'd want to do

- 656 S: yeah  
 657 M: earn money and that sort of thing (.) umm (.) but (.) >I  
 658 mean I th↑ink< he (.) has those sorts of goals (0.5) but  
 659 umm (.) doesn't (.) realise (.) umm (.) how difficult it is for  
 660 him (.) to actually achieve th↑at  
 661 S: mm  
 662 M: umm (1.5) ye:ah

In Extract 88, Mel impresses that Rick's illness impairs his ability to function, affecting his stability in life. She describes him as having similar goals to most other people, yet suggests that it would be difficult for him to achieve those goals due to his illness. Rick's failure to see the difficulties in realising his goals that Mel sees for him is presented as being due to his illness; his lack of insight into the limitations created by his condition. Mel portrays Rick as a man who has a long-term illness. In lines 642 to 645, a causal attribution indicates that Rick's illness is responsible for impairing his stability. The use of the extreme case formulation (Pomerantz, 1986) of 'really really' emphasises the severity of the effect upon Rick's ability to function. She then acknowledges that Rick would not see his problems in the same way (lines 650-651). This acknowledgement of a difference in opinion suggests that her claim of instability may be open to possible challenge. As all consumers in this study were interviewed before support workers, it is reasonable to assume that Mel was recognising that Rick may have voiced a different perspective in his interview. Mel lists Rick's goals 'of living (.) independently (.) umm conducting his life (.) getting work (.) getting (.) you kn↓ow (.) accommodation' (lines 651-653). This was finished with an end list completer (see Jefferson, 1990) of 'all the s↓orts of (.) regular things that (.) umm you'd want to do' (lines 654-655). To want

'regular things', coupled with the invocation of the normalising device of 'you' (see Wooffitt, 2001), conveys Rick to be an average guy, wanting the same sorts of 'things' that most others would want. Mel suggests that Rick's goals in life are typical enough for Rick to be classified as an average person. The problem, according to Mel, is that Rick 'doesn't (.) realise' (line 659) the difficulty he would face in achieving those goals. Thus Rick's problems are presented as resulting from both the actual impairments caused by his illness, and his lack of insight into the existence/nature of his impairment.

Rather than a lack of insight into himself, Mike portrayed Rick as showing a lack of insight into society (see Extract 89). Mike also promoted Rick as unstable, particularly in terms of his accommodation, which Mike then transferred to all other aspects of Rick's life.

*Extract 89 (Sue-Mike/SW3/L647-689)*

- 647 S: mhm (0.5) umm (.) Rick
- 648 M: ((participant's full name))?
- 649 S: I think that's his n↑ame
- 650 M: yep yep yep (0.5) how would I [describe him?]
- 651 S: [how would yo]u describe
- 652 him?
- 653 M: (1.5) uhh (laughs) (1.5) uhh (4.5) (tch) (1.5) I would (.)
- 654 have to describe him as (1.5) a (5.5) insightless into the
- 655 way (1.0) our so(h)ciety wo(h)rks ((laughs))
- 656 S: mm
- 657 M: ↑in s↓ome resp↑ects (0.5) yeah (.) cause I mean really (.)
- 658 you know he's g↓ot I guess he's (.) he's really umm (0.5) a
- 659 (.) umm (.) very very unstable person (.) in terms of sp- (.)
- 660 particularly in terms of accommodation (.) and therefore in
- 661 terms of everything else in life
- 662 S: mm

- 663 M: I mean you know you look at accommodation as I guess  
 664 your one stable thing you gotta start off with (0.5) when  
 665 you look at your tiers of needs or whatever (.) umm (0.5)  
 666 but he's (.) travelled around (.) umm (0.5) from (.) Freo to  
 667 back here to Freo to back here for you know like a long long  
 668 time (.) and it's really difficult to be able to do anything with  
 669 h↓im (.) umm but at the same time we've got to provide a  
 670 s↓ervice to h↑im=  
 671 S: mm  
 672 M: =because I guess you know there's not enough structure set  
 673 up to say 'well no (.) you're not appropriate' or (.) 'yes  
 674 you're appropriate' (0.5) umm (.) what am I saying I mean  
 675 (1.5) humm (5.5) he's someone that I'd just grab him he's  
 676 someone that I'd really love to help (.) but I just don't  
 677 kn(h)ow I just can't (.) you know?  
 678 S: mm  
 679 M: his illness his illness (.) schizophrenia has just (1.0) grabbed  
 680 a hold of him and (1.0) and (2.5) I th↑ink (1.5) u::m (3.5)  
 681 left him very dysfunctional (.) yeah (.) umm (.) but  
 682 personality wise he's really (.) you know he's a he wants he  
 683 means well (.) he likes to do things (.) umm for you (.)  
 684 umm he likes to feel wanted (.) umm you know which I  
 685 think is is kinda good b↓ut (.) I guess he doesn't follow  
 686 through with ↓it and I think you know that's just another  
 687 indication of his you know (.) his dysfunction (.) yeah (.)  
 688 S: mm  
 689 M: dysfunctional kind of (.) life

Mike's account portrays Rick as an unstable man who lacks insight into the workings of society. Mike's frustration is apparent as he concedes his inability to assist Rick. At stake here is Mike's competence as a professional and Mike positions himself and Rick as both being rendered helpless by Rick's illness, his schizophrenia. After describing Rick as



‘insightless’ (line 654) into the workings of society, Mike then softens this with ‘↑in s↓ome resp↑ects’ (line 657). This softening works to reduce the all encompassing connotations associated with this claim. Mike then goes on to procure Rick as a ‘very very unstable person’ (line 659), giving the example of ‘accommodation’. The extreme case formulation (see Pomerantz, 1986) of ‘very very’ works to emphasise the severity of Rick’s instability. Mike then broadens the effects of Rick’s instability from accommodation to ‘everything else in life’ (lines 660-661).

Mike’s frustration with Rick emerges, as he conveys the difficulties of trying to provide assistance to Rick. He notes that, as a result of his frequent changes of address, Rick has bounced around between service centres for ‘a long long time’ (lines 667-668). The statement, coupled with the repetition of the term ‘long’, is pre-emptive of a complaint in which Mike hints at the futility of attempting to provide assistance to Rick – ‘but at the same time we’ve got to provide a s↓ervice to h↑im=’ (lines 669-670). The emphasis placed on the term ‘got’ conveys little choice in the matter. This passage of talk presents Mike as frustrated at being put in the difficult position of being obliged to attempt to assist someone who is beyond help.

A couple of very long pauses in conversation then occurs in line 675, preceding Mike’s admission that he doesn’t believe he can help Rick: ‘...I just don’t kn(h)ow I just can’t (.) you know?’ (lines 676-677). Having admitted to a frustrating and disappointing sense of personal inefficacy, Mike then goes on to give the reason for his inability to give any help to Rick; ‘illness his illness (.) schizophrenia has just (1.0) grabbed a hold of him’ (lines 679-680). The employment of (and emphasis upon) the clinical term of ‘schizophrenia’ adds power and gives medical legitimacy to this

claim. It is not Mike's fault, nor Rick's fault, but the unfortunate and irrefutable fact of 'schizophrenia', which has rendered Rick 'very dysfunctional' (line 681) and consigned him to a place beyond help. The accounts of all four support workers oriented toward issues of instability, illustrated by Rick's frequent changes in accommodation and episodes of illness.

### **Carol: Complacent or a Battler?**

Accounts of Carol were divided. One perspective portrayed a complacent woman who could do much more for herself than she currently did, while the other perspective portrayed a survivor, a battler, a woman who had achieved much despite the hardships she had endured in her life.

#### **A Complacent Woman**

Viv and Luke drew a portrait of a complacent and needy, yet capable woman. Luke tended to focus on relational issues, whereas Viv tended to focus on Carol's attitude toward herself. She promoted Carol as being comfortable the way she was, and felt that Carol needed to be pushed to achieve more in her life (see Extract 90).

*Extract 90 (Sue-Viv/SW1/L669-689)*

- 669 S: mh↑m (0.5) ok↑ay u:mm (0.5) Carol
- 670 V: mh↑m
- 671 S: Carol (.) how would you describe Carol?
- 672 V: (0.5) u::m (.) very depend↑ent (1.0) u::m (0.5) quite (.)
- 673 intellig↑ent
- 674 S: mhm
- 675 V: u:::m (2.5) negat↑ive (1.5) u::m (.) friendl↑y
- 676 S: ◦mm◦
- 677 V: u::m (1.5) able probably to do more than she do↑es (.)
- 678 yeah I th↓ink Carol's the same category I think Carol's quite

- 679           capable of working I think she's quite capable of doing more  
 680           (0.5) u::m (.) than she do↑es (0.5) I think she  
 681           underestimates her ab↑ilit↓y (.) to be able to do things  
 682    S:       mm  
 683    V:       I'm not sure whether it's her (.) ability or whether it's just  
 684           become a way of life where this is- I ex↑ist the way I am  
 685           anyway (.) and I'm quite (.) comfortable (.) so >I don't  
 686           really need to do anything else< I would l↑ike to see Carol  
 687           pushed more (.) to actually (.) achieve more yeah  
 688    S:       mhm  
 689    V:       and I think she's capable of it

Viv starts her account with descriptors of Carol that appear balanced between socially desirable and socially undesirable characteristics. The main focus of the extract, though, surrounds the issue of complacency. Viv claims that Carol is a capable woman, yet she has become complacent with her life and felt that Carol needed to be pushed to achieve more. Thus, the account conveys an impression that Carol is not living up to her potential. The first responses Viv gave to how she would describe Carol were ‘very depend↑ent’, ‘quite (.) intellig↑ent’, ‘negat↑ive’, and ‘friendl↑y’ (lines 672-675). The longer pauses either side of the claim that Carol is a ‘negat↑ive’ woman suggest that Viv has given some thought to mentioning this. She follows it with the affirmative descriptor of ‘friendl↑y’, which works to balance out any derogatory impression that she had given of Carol.

To expand upon this list of characteristics, and give a better understanding of Carol, Viv presents Carol as a ‘capable’ woman (line 679) in that Carol is able to do more than she currently does. This appears to be the main focus of the extract (Carol’s capability), yet before Viv gives her opinion, she makes a move to convey understanding of how Carol might

feel. Here, she suggests that Carol lacks self confidence, as she ‘underestimates her ab↑ilit↓y (.) to be able to do things’ (lines 680-681). This positions Viv as knowledgeable and aware of Carol’s feelings and behaviours, and provides an account of Carol’s underachievement that doesn’t suggest that Carol is shirking responsibilities. Viv then makes mention of not being sure about the use of the term ‘ab↑ilit↓y’, even though it supports her focal term of ‘capable’. Reworking her response, she suggests that Carol may have adapted to a ‘way of life’ that she is quite ‘comfortable’ with (lines 684-685), and this is the reason Carol has not been able to do anymore in her life. This reworking manages that although self-confidence is an issue for Carol, a lack of motivation or perhaps complacency is to blame. The claim that Carol’s current situation is due to lack of motivation rather than lack of capability is reinforced through Viv’s subsequent statements that Carol needs to be ‘pushed more (.) to actually (.) achieve more’ (line 687), and ‘I think she’s capable of it’ (lines 686-689).

Viv touched upon dependency in her talk of Carol, but did not elaborate. Luke described Carol as a needy woman (see Extract 91), and his attention to relationship issues and interaction with others portrays her as a woman who liked to lean on others.

*Extract 91 (Sue-Luke/SW4/L502-526)*

- 502 S: (1.5) yeah (2.5) okay (.) umm (.) Carol  
 503 L: Carol ((participant's surname)) yeah  
 504 S: yeah (1.0) how would you describe Carol?  
 505 L: Carol ehh (tch) well I've kn↑own Carol for a number of  
 506 y↓ears she comes to quite a few of the pr↑ogr↓ammes has  
 507 done (.) and ehh (0.5) she is a person that needs a lot of  
 508 people  
 509 S: ◦hmm◦

- 510 L: she needs- she would like a lot of help from ehh (.)  
 511 members from a lot- staff (0.5) amm  
 512 S: mm  
 513 L: she always hasn't- hasn't got money she's always short of  
 514 money for (.) whatever items she needs in the house (0.5)  
 515 a:nd she sorta- I feel she would (.) lean on any member  
 516 that would like to assist her and help her and and (.)  
 517 probably she's lost a few friends that way (.) she's got  
 518 a- a fella from the Eastern States at the mom↑et-  
 519 mom↑ent a boyfr↑iend  
 520 S: mm  
 521 L: and she's going thr↑ough a difficult t↓ime with (.) with h↓im  
 522 because she's n↑ot too sure if he wants to come over here  
 523 and (tch) get m↑arr↓ied (tch) or not  
 524 S: mm  
 525 L: so (.) she's g↑oing through a difficult t↓ime at the  
 526 mom↑ent.

Luke tends to orient toward relationships in his account of Carol – his familiarity with her, her interaction with friends, and her relationship with her boyfriend. Carol is positioned as a disorganised, needy woman with a tendency to lean on others rather than doing things for herself. This suggests a voluntary dependency, a laziness, which is managed as a possible reason for a loss of friends. As with Rick, Luke first establishes that he has ‘kn↑own Carol for a number of y↓ears’ (lines 505-506). From this knowledge base, Luke then moves to Carol's interactions with others at the service centre, where he proposes that Carol ‘needs a lot of people’ (lines 507-508), and then goes on to suggest that she ‘would like’ (line 510) more help and support than she gets. Luke gives the example that Carol was ‘always short of money’ (lines 513-514), and continues that she tends to ‘lean on’ others ‘to assist her’ (lines 515-516). Carol is positioned here as

disorganised in not budgeting her money wisely, and the suggestion that she leans on others to assist her in this area implies that Carol takes advantage of people. Thus, Luke infers that Carol has tenuous and perhaps one-sided relationships with friends.

From interactions with friends Luke progresses to intimate relationships. Here, he comments on Carol's boyfriend, conveying his disapproval. In lines 518 to 519, Luke declares that Carol has a 'fella from the Eastern States at the mom↑et- mom↑ent'. The use of a temporal qualifier suggests that Luke doesn't believe that the relationship will last. The pointing out of some difficulties in the relationship (lines 521- 523) works to support this inference, and the characteristic clicking '(tch)' both before and after the suggestion of getting 'm↑arr↓ied' manages Luke's disapproval of this idea. To Luke then, Carol's relationships are fraught with difficulties, and many of those difficulties are of her own making.

### **A Little Aussie Battler**

Mike started out his account by stating that he saw Carol as 'a little Aussie battler' (line 273 - see Extract 92). He found her easy to work with, but felt that she was unwilling to take responsibility for her problems. Like both Viv and Luke, he believed that she needed little assistance.

*Extract 92 (Sue-Mike/SW3/L721-743)*

- 721 S: okay (.) umm Carol
- 722 M: Carol ((participant's surname)) umm (tch) I would describe
- 723 her as a little Aussie battler [((laughing))]
- 724 S: [((laughing))]
- 725 M: whose got so:: m↓any (0.5) you know identifies so:: m↓any
- 726 (.) hardsh↑ips (.) u::m (.) and therefore u::m (.) not willing
- 727 to take responsibility for th↑em (0.5) u::m (.) but (.) u::m

- 728           (.) with a little bit of (.) assistance little bit prompting little  
 729           bit of (.) u:m you know reassurance (.) she's able to do it  
 730           herself
- 731   S:       mm
- 732   M:       so it's just that very very small bit of support (.) so that's  
 733           why I think you know (.) once she's got th↓at she's able to  
 734           battle on and she's able to=
- 735   S:       yeah
- 736   M:       =you know overcome things (.) which I really like I think  
 737           that attracts a lot of people (.) to working with h↑er
- 738   S:       mhm
- 739   M:       u::m (0.5) yeah (.) but u::m you know I think (.) she's like  
 740           (.) she's the kind of person that (0.5) you talk to and all  
 741           sh(h)e talks about is her pro(h)blems (.) so::
- 742   S:       mm
- 743   M:       umm you know (.) yeah (.) that's (.) how I'd describe her

When I first ask Mike how he would describe Carol, he responds that she is 'a little Aussie battler' (line 723), evoking images of a working-class underdog, a person who struggles against the odds. Mike quickly qualifies this general statement, changing 'whose got so:: m↓any (0.5)' to 'you know identifies so:: m↓any (.) hardsh↑ips' (lines 725-727). This reframing undermines a sense that the hardships are real and instead presents Carol as self-pitying without good cause. Mike also states that Carol would not 'take responsibility' (lines 726-727) for her misfortune, thus impressing that she could lessen the impact of these if she paid them less attention, or took responsibility for doing something about them. In line 728, a second theme starts to emerge, where Mike appears to orient to his role as a support worker. Mike suggests that with a little 'assistance', 'prompting', and 'reassurance' (lines 728-729), Carol would be able to take care of her own problems. This also works to minimise the severity of

Carol's hardships and to suggest that they can be 'overcome' (line 736) primarily by changing Carol's attitude toward them.

Mel's account focused on the success with which Carol had responded to difficulties in her life (see Extract 93). Mel outlined Carol's accomplishments, implying that others with the same diagnoses generally did not achieve these, thus presenting a subtle challenge to the validity of her diagnosis.

*Extract 93 (Sue-Mel/SW2/L748-771)*

- 748 S: okay (.) Carol
- 749 M: umm (.) Carol I s↓ee as a very capable (.) wom↑an
- 750 S: mhm
- 751 M: u::m (2.0) j↓ust (0.5) a very practical (.) s↓ort of woman
- 752 umm (.) who is a surviv↑or (.) u::m (0.5) has managed to
- 753 do (.) very well for hers↓elf (0.5) considering (0.5) her
- 754 situat↑ion (.) and umm (.) is n↓ot what you would say is a
- 755 typical (.) person with the diagnosis that
- 756 she's g↑ot
- 757 S: [mmm]
- 758 M: [u::m] (1.5) you kn↓ow (.) did (.) m↓arry at some stage
- 759 and did have (.) a ch↑ild and brought that child up (.) and
- 760 that child seems to be doing f↑ine and (.) u::m
- 761 S: mm
- 762 M: has a lot of fr↑iends ↓and (.) seems to be good at b↑uilding
- 763 fr↑iendships
- 764 S: mhm
- 765 M: u::m (.) has (.) you kn↓ow (.) en- achieved things in terms
- 766 of stud↑y and employment and (.) all the r↑est so umm (.)
- 767 yeah ↑I j↓ust see her as a competent (.) pers↑on (0.5) u::m
- 768 and (.) friendly person
- 769 yeah
- 770 S: yeah
- 771 M: yeah



Mel portrays Carol as a ‘survivor’, aligning with Mike’s earlier view of Carol as a ‘little Aussie battler’ (see Extract 92, line 723). From this standpoint, Mel then produces a subtle challenge to the diagnosis Carol has been given. She proposes that Carol has done ‘very well for hers↓elf (0.5) considering (0.5) her situation’ (lines 753-754). Insight into what this ‘situation’ might be emerges with Mel’s claim that Carol is not ‘typical’ (line 755) of a person with her ‘diagnosis’. Here, the category of schizophrenia has been inferred through the use of the terms ‘situation’ and ‘diagnosis’, yet that specific category remains unstated. Carol’s situation then, may be that she has been given a diagnosis of schizophrenia, yet her behaviour does not reflect her membership in this category.

Mel goes on to give examples from the three areas of personal relationships, friendships, and personal achievements to explain Carol’s atypical status. In lines 758 to 760 she states that Carol ‘did (.) m↓arry’, ‘did have (.) a ch↑ild’, and raised that child who shows no apparent problems of her own. The emphasis here on the term ‘did’ works to show a contradiction to expected patterns of behaviour, the expectation that people within the membership category of schizophrenia did not do these things. Other areas Mel highlight are Carol’s friendships and achievements. She emphasises that Carol ‘has a lot of fr↑iends’, and is adept at ‘b↑uilding fr↑iendships’ (lines 762-763). This, again, infers the opposite to most people given membership to the category of schizophrenia. Opposites are also conveyed in the areas of study and employment, where Mel procures Carol as having ‘achieved things’ (line 765). Thus, to Mel, Carol’s behaviours and achievements are not category bound, not indicative of a schizophrenia membership.

## Scott: Chronicity

Two support workers drew from medical discourse in their accounts of Scott, emphasising the chronicity of his problems through an outline of a young man with a poor prognosis. The other two support workers painted Scott as a young man struggling with his problems, and possibly becoming unwell. Most accounts were quite negative, with Viv the only person to speak of Scott as able and capable.

### A Poor Prognosis

In general, Mike proposed Scott as a ‘big kid’ (line 795 - see Extract 94). He pointed out a low intellect, a lack of maturity, and a poor prognosis as factors hindering Scott from obtaining the kind of life that Scott would like.

*Extract 94 (Sue-Mike/SW3/L791-821)*

- 791 S: ahh (0.5) umm (.) Scott
- 792 M: Scott
- 793 S: yeah (0.5) yeah (.) how would you
- 794 M: Scott is ((sigh)) I'd describe him a::s (1.5) u::m (2.0) (tch)
- 795 yeah a big kid reall↑y ((laughs)) u::m (1.0) is th↑is the way
- 796 I'm supposed to be describing them personally (.) or or
- 797 professionally?
- 798 S: as a as a person
- 799 M: as a person
- 800 S: how you see them as a person yeah
- 801 M: good I can't go around calling him a big kid as a professional
- 802 [((laughing))]
- 803 S: [((laughing))]
- 804 M: but yeah you kn↓ow he he's just someone that (.) that (.)
- 805 expects a lot more out of life
- 806 S: mm

807 M: u::m (.) but doesn't really (.) realise what's needed to be  
 808 done in order to have th↓at (.) you know what he wants in  
 809 life (.) and I think there's a level of maturity there that isn't  
 810 (.) fully developed (.) and I am aware that he has a has a  
 811 (.) low intell↑ect (.) and so that obviously impacts upon it as  
 812 well (.) umm (0.5) >but I mean I think< ((laughs)) in some  
 813 respects I find him really funny (.) I mean I think he (.) he's  
 814 like he's like a (0.5) umm (.) a regular bloke (0.5) umm  
 815 (0.5) in some respects I'd describe him as (.) as umm (.)  
 816 >you know really unfortunate in that he's< he's so young  
 817 and he's got such (.) u::m (0.5) a poor prognosis (.) you  
 818 know in terms of his illness and in terms- which is  
 819 compounded by his low intellect and (.) you know there's  
 820 not much in the comm↑unity that's really gonna be able to  
 821 (.) give him a quality of life that he's gonna accept (.) yeah

Mike's account of Scott conveys a young man with high expectations of his future. Working to protect his 'professional' status, Mike builds an argument to paint these expectations as improbable and ultimately, unrealised. That is, Mike conveys that due to a low intellect and the chronic foundation of Scott's illness, Scott will be disappointed with the outcome of his life.

After introducing Scott as 'a big kid' (line 795), Mike asks about the manner of describing people that I want in the interview – whether he should give a personal or a professional perspective. We had reached the seventh of nine primary participants before Mike asks this question, and describing someone as 'a big kid' may be crossing a professional line that Mike is possibly drawing. I emphasise 'as a person' (line 798), and Mike replies that he couldn't 'go around calling him a big kid as a professional [((laughing))]' (lines 801-802). Mike implies that as a professional he is

required to use a particular language. If he does not use this discourse, then his reputation might be at stake.

Mike then directs conversation back to Scott, where Scott's expectations of his life are made relevant. Mike suggests that Scott has a lack of awareness of himself and the world (see lines 804-808), identifying this as arising from a 'level of maturity' (line 809) that is not 'fully developed', and 'low intellect' (line 811). Thus, Scott is not made directly responsible for what Mike conveys to be naive expectations. Chronicity emerges through the notion of Scott as 'really unfortunate' (line 816) due to his youth, and his 'poor prognosis' (line 817). As Scott's 'illness' is 'compounded by his low intellect' (line 819), Mike suggests that Scott does not understand that he will never get better.

Mel also presented Scott as having a poor prognosis (see Extract 95). She said that she did not know very much about Scott, but attributed his low motivation to his illness. In her descriptors, a comparison with Karen emerged, as Mel spoke once again of a person with little personality.

*Extract 95 (Sue-Mel/SW2/L826-856)*

- 826 S: okay (mumbled) Scott
- 827 M: mhm (.) Scott=
- 828 S: yeah
- 829 M: =I don't know a huge amount about: (.) umm because he
- 830 hasn't- (.) he he's one of those people that (tch) (1.0)
- 831 doesn't talk very much doesn't come here (.) very
- 832 much
- 833 S: mm
- 834 M: isn't really accountable either might just come might
- 835 not sort of thing u::m (1.5) (tch) but I see him as (1.5)
- 836 umm (1.0) mmm (0.5) a young guy whose really quite
- 837 severely affected by his illness (0.5) umm (.) and the

- 838 illness h↓as (0.5) umm (0.5) (tch) you kn↓ow got him in a  
 839 state where he (1.5) umm (tch) d↓oesn't have much  
 840 motivation at a↑ll (.) umm to do things (1.0)  
 841 S: mm  
 842 M: isn't willing to try out new things (0.5) [really] umm (1.0)  
 843 S: [yeah]  
 844 M: and yeah he's (.) he's a bit different from K↓aren in that he's  
 845 he's blunt as well (.) but (.) I feel l↓ike there's more  
 846 personality (.) in Karen that's been (.) you know sort of  
 847 covered ↑up where I feel that there's less personalit↓y with  
 848 Sc↑ott (.) umm  
 849 S: yeah  
 850 M: things just seem to be (0.5) umm (.) very superfic↑ial (.)  
 851 with him (.) u::m (0.5) maybe (.) sort of (.) it's all been  
 852 propped up and develop↑ed (.) umm: (.) but (.) umm (0.5)  
 853 its- if there is that it's >really really deep deep down< and  
 854 it's been h↓ard (.)  
 855 S: yeah  
 856 M: to acc↑ess (.) umm (.) yeah

In her account of Scott, Mel portrays a young man who does not attend the centre very often, and when he does, he does not share himself or his world with her. To direct responsibility (and perhaps blame) away from herself for not getting to know Scott better, Mel orients toward the chronicity of his illness, drawing upon clinical reasoning. To begin her account, Mel states that she does not 'kn↓ow a huge amount abou::t' Scott (line 829). Attributions of causality for this dearth of information comes through the use of a membership category device, where Scott is classified as 'one of those people' (line 830). Category bound behaviours attributed to 'those' people are not talking very much or not attending the centre very often, and by referring to Scott in this way, Mel depersonalises his

unengaged behaviour. The characteristic clicking (tch) displayed in accounts by both Luke and Mike is also employed by Mel in this extract, indicative that she experiences difficulty in describing Scott. Here, Mel infers that Scott does not tend to share personal information with her as other consumers might do.

Mel then draws attention to the chronicity of Scott's emotional problems. Like Mike, Mel gives reference to Scott's youthfulness, as she claims that Scott is 'severely affected by his illness' (line 836). To compound the severity of Scott's illness, Mel makes a comparison with Karen (CS6). She notes that both Scott and Karen are affectively 'blunt' (line 845), yet Scott is painted as more extreme than Karen in that Scott has 'less personalit↓y' (line 847), describing him as 'very superfic↑ial' (line 850), and suggesting that Scott's personality has 'all been propped up and develop↑ed' (lines 851-852). Mel allows that she might be misreading Scott, that there might be more to his personality, but qualifies this by saying 'if there is that it's >really really deep deep down<' (line 853). Here, the repetition of the extreme case formulation of 'really' and the term 'deep' works to emphasise the difficulty that Mel has in reading Scott.

### **A Young Man Struggling**

Viv mentioned low motivation in her description of Scott, and she suggested the possibility that he might be unwell (see Extract 96). Another issue Viv oriented to in her talk was the idea that Scott had no independence from his mother.

*Extract 96 (Sue-Viv/SW1/L776-815)*

- 776 S: yeah (1.0) okay umm (.) Scott
- 777 V: mhm
- 778 S: Scott how do you see Scott?
- 779 V: (1.0) u::m (0.5) lacks motivat<sup>↑</sup>ion (1.0)
- 780 S: mhm
- 781 V: u::m (.) preoccupied wi::th (.) appearances (1.5) that's
- 782 probably just (.) at the moment though
- 783 S: mmm
- 784 V: that's that's how I see him (.) because he does go through
- 785 (.) certain stages in his l<sup>↑</sup>ife where things are very (.) you
- 786 know 'I don't look as good as I used to I'm not good looking
- 787 anym<sup>↑</sup>ore' and that sort of thing and that's=
- 788 S: mmm
- 789 V: =some of the- one of the sort of things he's been going
- 790 through at the moment but I do believe that that's
- 791 something he does go through when he's also when he's
- 792 unw<sup>↑</sup>ell
- 793 S: mm
- 794 V: u::m (1.0) he's just- he's got no:: independence at all I
- 795 mean he just (1.0) doesn't do anything for himself (.) lives
- 796 S: yeah
- 797 V: u::m (1.5) st<sup>↑</sup>ill lives with his mum who's a- who appears
- 798 to do most things for him
- 799 S: yeah
- 800 V: u::m he (.) lacks motivation to do anything with us even (.)
- 801 it's a real effort for us to actually get him to do anything
- 802 S: yeah
- 803 V: and I think lots and lots of things have been tried on (.)
- 804 Scott over the ye:ars like (.) literally for years and years (.)
- 805 u:m if you go through his file you can see everything that's
- 806 been tried and (.) he just (.) doesn't react to any of the
- 807 stuff we've been trying to get him to do and he's- he's very
- 808 young (.) so (.)
- 809 S: mmm

- 810 V: he is capable of doing (.) something with his life you know  
 811 (.) I actually find it quite frustrating with Scott because I  
 812 would love to see him doing someth↓ing because he's able  
 813 to he's capable of i↑t (.) and I really=  
 814 S: mm  
 815 V: =would like (.) yeah

The account Viv gives of Scott appears to revolve around her initial claim that Scott ‘lacks motivat↑ion’ (line 779). Positioning herself as aware and knowledgeable of Scott’s behaviours, Viv hints that a lack of independence is responsible for this low motivation. That is, Scott is not motivated to do anything for himself as his mother does everything for him. Viv conveys her frustration in that this has been going on for many years. In this sense, although she proffers Scott as a capable and able young man, she conveys that without the same independence afforded to most other adults in society, Scott will continue to struggle.

Viv’s initial claim of Scott as lacking in ‘motivati↑on’ (line 779) sets the scene for the rest of her account. She first positions herself as aware of Scott’s behaviours in orienting to Scott’s current state of mind. Using the technique of active voicing – ‘...I don't look as good as I used to I'm not good looking anym↑ore'...’ (lines 786-787) (see Wooffitt, 1992; Hutchby & Wooffitt, 1998) – Viv outlines Scott as currently preoccupied with his appearance, suggesting that this is a stage he goes through when he is not well. After establishing an awareness and knowledge of Scott’s behaviours, Viv then turns her account toward the issue of independence. Here, Scott is positioned as having no independence in that he does not ‘do anything for himself’ (line 795). The upward intonation on the word ‘st↑ill’, and the emphasis on ‘mum’ works to show disapproval in that Scott, an adult, is still



living with his mother. It appears that Viv is going to continue with a definitive statement of Scott's mother when she says 'who's a-', yet she stops herself and changes this to say 'who appears to do most things for him' (lines 797-798). This rephrasing conveys an awareness of accountability for claims made of others, and perhaps a reluctance to say anything that she might be held accountable for at a later date. Thus, Viv implies that Scott is not motivated to do anything for himself as his mother does it all for him.

This is supported by Viv's return to the issue of motivation in line 800. Here, Viv emphasises the amount of 'effort' (line 801) and the period of time that staff members have expended on Scott in trying to get him motivated – 'literally for years and years' (line 804). Viv, again, provides a warrant for her claims, conveying that her audience does not have to take her word for it; they could see for themselves by looking into his file. Viv suggests that the efforts of staff members are in vain though, as Scott does not 'react' (line 806) in a positive manner to these efforts. Viv paints Scott as a young man with his life ahead of him. She conveys her frustration in that he is not 'doing (.) something with his life' (line 810), and describes him as 'able' and 'capable' (lines 812-813). The suggestion here then is that many of Scott's problems are circumstantial, and that independence from his mother would both enable and require Scott to take charge of his own life.

Luke described Scott as a once outgoing young man, who now stayed at home watching television (see Extract 97). Again, the issue of low motivation was central, as Luke outlined a young man who was currently struggling to find his way.

*Extract 97 (Sue-Luke/SW4/L569-597)*

- 569 S: mh↑m (1.0) okay umm Scott?
- 570 L: Scott (.) Scott's been coming here quite a number of ye↓ars
- 571 S: yeah
- 572 L: and ehh (.) qu↑ite a number of the staff (mumbled) and so
- 573 forth have tried to get Scott into different things ehh (.)
- 574 he's tried working (0.5) o↓hh quite a few little j↓obs
- 575 (.) like ehh cleaning telephone boxes (0.5) amm (tch) and
- 576 doing other little (.) part-time j↓obs (0.5) but has never
- 577 stuck it o↓ut he's always (0.5) found reasons to give u↓p
- 578 S: mm
- 579 L: amm (3.0) (tch) he sorta only comes along (.) a coupla days
- 580 a w↑eek sorta th↑ing a::nd (.) sometimes he won't bother
- 581 coming
- 582 S: yeah
- 583 L: if he (.) doesn't feel like coming he won't come (1.0) yeah I
- 584 f↑eel he's struggling because the last time I phoned his
- 585 mum (.) she said he's not going ↓out so much he's sitting
- 586 watching T↓V he's not (.) going anywhere (.) being a young
- 587 fella he used to go to (.) Fremantle and go to the clubs and
- 588 go to the pub and have a few dr↑inks and so fo↑rth and
- 589 S: mm
- 590 L: I don't think he's doin that at the mom↑ent (0.5) so I feel
- 591 emm (tch) since I first kn↓own h↑im (.) where he was sorta
- 592 outgoin and would go lots a places on the weekend
- 593 S: yeah
- 594 L: to somebody that doesn't go anywhere n↓ow and sorta
- 595 struggles
- 596 S: yeah
- 597 L: that's how I see Sc↑ott

Luke first gives a general overview of Scott, establishing that he has been attending the service for many years (line 570). Like Viv, Luke introduces the notion of trying to get Scott 'into different things' (line 573),

focusing predominantly on part-time employment. Yet these jobs never seem to last, as Luke claims that Scott ‘always (0.5) found reasons to give u↓p’ (line 577). A three second pause ensues, and Luke then continues along this theme describing poor attendance at the service centre, stating that ‘sometimes he won't bother coming’ (lines 580-581). This overview works to give an impression of Scott as low in motivation, and perhaps suggests that Scott does not take the service seriously.

The main claim in the extract comes next, as Luke states ‘I f↑feel he's struggling’ (lines 583-584). Evidence for this claim is drawn from an account of Scott's current behaviour as ‘not going ↓out’ as much as he used to and ‘sitting watching T↓V’ (lines 685-586). Luke warrants this claim through reference to Scott's mum, and a telephone conversation he had with her. Not going out often and watching television may not necessarily be indicative of emotional problems though. Luke continues by giving a comparison of past to present behaviour in lines 586 to 590, working to reinforce his claim of Scott not behaving as he usually did (hence his suggestion that he is currently ‘struggling’). In the past, Scott ‘used to’ go out to pubs and ‘clubs’, whereas in the present, Luke does not ‘think’ that he is doing this. Although Luke had earlier invoked accounts of Scott's behaviour as given by Scott's mother, here he couches his perspective by saying ‘I don't think’. That is, Luke does not give a definite claim as to Scott's current behaviour, suggesting that although Scott's mother has said that Scott does not go out, Luke is not sure. To finish his account, Luke summarises by giving two extremes to support the notion of a man who is struggling (see lines 590-595). Scott is presented as a man who used to ‘go lots a places’ in the past, and a man who ‘doesn't go anywhere n↓ow’.

Here, Luke's earlier mention of Scott not going out very much has changed to Scott not going out at all.

### **Brenda: Private and Unchanging**

Accounts of Brenda given by the female staff members tended to convey a self-effacing woman, a woman who was not demanding and tried to fit in with others around her. Alternatively, the two male staff members saw Brenda as stable but rigid, a woman who did not like change. All support staff felt that Brenda revealed little of herself to them.

### **A Self-Effacing Woman**

According to Mel, Brenda tried to blend in with whatever was going on around her (see Extract 98). She presents her as a vulnerable woman who tended to think in concrete terms, pleasant, yet not forthcoming with information about herself.

*Extract 98 (Sue-Mel/SW2/L899-932)*

- 899 S: ok↓ay (.) umm (.) Brenda
- 900 M: okay Brenda I see ↓as (0.5) someone who (tch) umm (1.5)
- 901 doesn't re:ally h↓ave (.) umm (1.0) (tch) (heh) (1.0) there's
- 902 not a huge am↓ount to h↑er to her personalit↑y
- 903 S: mm
- 904 M: I see her (.) umm (1.5) just fitting in with what's around
- 905 h↑er (.)
- 906 S: yeah
- 907 M: umm (1.0) and very very (.) much j↓ust (0.5) open to
- 908 suggest↑ion (.) so- in that sense probabl↓y (0.5) u:mm
- 909 (0.5) (tch) mm (1.5) yeah (.) >I guess in that s↓ense
- 910 vulnerable<
- 911 S: ◦mm◦
- 912 M: although I don't have conc↓erns for h↓er safety (.) or

- 913 anything like that
- 914 S: yeah
- 915 M: but just umm I find th↓at (.) when you talk to Br↓enda (0.5)
- 916 she:: (0.5) seems to:: (.) umm (.) interpr↓et things quite
- 917 umm (.) concretely and (.) I don't really f↓eel that she
- 918 always understands what ↓I'm (.) saying to h↑er [umm]
- 919 S: [yeah]
- 920 M: but (.) she j↓ust (.) I wouldn't say pretends but she just
- 921 goes '↑oh yeah yeah'
- 922 S: goes along with it
- 923 M: that's right goes along with it (.) and umm
- 924 S: mhm
- 925 M: and that's the way she's do- she's coped (0.5) for (.) many
- 926 yea↑rs (.) you kn↑ow (.) she looks (.) good she looks (.)
- 927 umm (0.5) she presents really we:ll and she's (.) umm
- 928 warm and pleasant and (.) nice to ch↑at w↓ith but there's
- 929 not m↓uch that you can chat to h↑er w↑ith
- 930 S: yeah
- 931 M: she's not (.) spontane↑ous (0.5) umm (.) and that sort of
- 932 th↑ing

As with her descriptions of Karen and Scott, Mel paints Brenda as a woman who has little personality. She gives a clinically evaluative account of Brenda, focusing on intelligence and self presentation. Yet there is little sense of Brenda as a person here. Despite the inference of familiarity with her for a number of years, it suggests that Mel finds it difficult to get to know Brenda. Thus, Brenda is promoted as a self-effacing woman who tends to fit in with others' plans. To start her account, Mel appears to have difficulty in choosing her descriptors, giving a number of pauses, tongue clicks, a laugh, and minimal responses such as 'umm' (lines 900-901). Her claim that Brenda has little personality (lines 901-902) may have given her some discomfort, as this could be construed as an insult to Brenda. Yet she

doesn't show the same hesitancy when making this claim of Karen or Scott. Mel describes Brenda as a woman who tends to blend in with her surroundings rather than stand out in a crowd (lines 904-905), implying that she is a compliant woman who goes along with others' wishes.

Mel then adds that Brenda is 'very very (.) much j↓ust (0.5) open to suggest↑ion' (lines 907-908). She hesitates, invokes the tongue click, pauses and quickly moves on to state that Brenda is 'vulnerable'. Again, this is an indication that Mel is not comfortable with saying this of Brenda, implying that others may construe what she has said as an insult, and she is quick to clarify that Brenda is not gullible or silly where her personal safety is concerned (lines 912-913). The meaning behind Mel's comments of Brenda as 'open to suggest↑ion' and 'vulnerable' becomes clearer as she states that Brenda tends to 'interpr↓et things quite umm (.) concretely' (lines 916-917). Mel claims that Brenda does not properly understand what she said to her at times, and this infers below average intelligence. It seems, therefore, that the vulnerability that Mel introduces here deals with intellectual matters.

Expanding upon this, Mel gives voice to Brenda suggesting a typical response that Brenda would give to a question. She offers that Brenda does not necessarily pretend to understand, but responds to questions with "↑oh yeah yeah" (lines 920-921). This is in line with what Mel has said earlier about Brenda 'fitting in', suggesting that Brenda does not question things that she does not understand. In this way also, Mel works to reinforce Brenda as 'vulnerable'. That is, Brenda may not properly understand what others say to her, but goes along with things anyway. Mel proposes that Brenda has gone along with others for many years, and although she looks

good, presents well and is ‘warm and pleasant’ (line 928), there is little to chat with her about. Invoking Brenda’s appearance works to restrict any reference that might be drawn from her social passivity. That is, if Brenda is compliant (going along with others) and also did not take care of her appearance it might suggest clinical symptomology of depression or secondary symptoms of schizophrenia. Therefore, Brenda does not fit this criterion. This is furthered with a complaining of having little to talk about with Brenda, as Mel claims ‘she’s not (.) spontane↑ous’ (line 931). Brenda then, tends to reveal little of herself, and despite her familiarity with Brenda in terms of the time Mel has known her, this makes conversation difficult.

Compared to the descriptors that she had given of other primary participants, Viv also appeared to have trouble in describing Brenda (see Extract 99). Like Mel, she outlined difficulty in obtaining information from Brenda about herself, resulting in the proposition that Brenda was quite insular.

*Extract 99 (Sue-Viv/SWI/L905-929)*

- 905 S: oka::y (.) umm Brenda
- 906 V: mhm
- 907 S: Brenda
- 908 V: u::m (2.5) friendl↑y (.) u::m (3.5) lacks (.) motiv↑ation
- 909 probabl↑y doesn't have a lot of motivation to do a lot of
- 910 th↑ings
- 911 S: mmm
- 912 V: (1.5) u::m (2.5) ha- I think she has trouble since she
- 913 moved in by herself I think she has trouble coping with
- 914 living al↑one
- 915 S: mm
- 916 V: I think that's a bit of a hassle to h↑er because she doesn't
- 917 have the support (.) like the built in support that she used to

- 918            have from her m<sup>↑</sup>um
- 919    S:        yeah
- 920    V:        u::m (1.5) ◦I see her as being◦ (1.5) I mean its hard with
- 921            B<sup>↓</sup>ren<sup>↑</sup>da because she's one of these people that doesn't
- 922            demand a lot so
- 923    S:        mmm
- 924    V:        it's actually hard to- you actually have to dra:g everything
- 925            out of Brenda if you want to know something about Brenda
- 926            it just doesn't come free flow<sup>↓</sup>ing (.) and so she's quite
- 927            [insul]ar she's quite (0.5) u::m (.)
- 928    S:        [yeah]
- 929    V:        inside hers<sup>↓</sup>elf most of the time (.) yeah

Evident in Viv's account of Brenda is how little she knows of her. Noticeable at the beginning of Viv's account are two long pauses (line 908). These may be working to show contemplation, yet after the two descriptors of 'friendl<sup>↑</sup>y' and 'lacks (.) motiv<sup>↑</sup>ation' (line 908), she inserts the term 'probabl<sup>↑</sup>y' (line 909), which works to undermine any certainty in her statements. Two more long pauses ensue, and Viv then moves on to Brenda's living arrangements. She proposes that Brenda is experiencing difficulty living by herself, as she does not have the 'built in support' that she had in the past from her mother (lines 912-918). In this small section of talk the phrase 'I think' appears three times (lines 912, 913, & 916), and the emphasis placed on the term 'think' is again, indicative of indecision. This works to undermine certainty about what has just been said of Brenda, and suggests that there may be more to Brenda's living arrangements that Viv was unaware of.

Viv complains about the difficulty in describing Brenda, emphasising that it is 'hard' (line 920) as Brenda is 'one of these people' (line 921) that doesn't demand a lot. Drew and Holt (1988) suggest that



when formulating complaints, the invocation of idiomatic expressions may be evident. In lines 924 to 925, Viv spoke of having ‘to dra:g everything out of Brenda’. This works to enhance the legitimacy of the complaint that it is ‘hard’ to obtain information from Brenda, and the conclusion that Brenda is ‘quite [insul]ar’ in that she is ‘quite (0.5) u::m (.) inside hers↓elf most of the time’ (lines 926-929).

### A Dependent and Staid Woman

Luke saw Brenda as a stable and dependent woman, but he presented her as struggling on her own (see Extract 100). Like Viv, he highlighted accommodation issues, and he did not see her as progressing any further than she already had.

*Extract 100 (Sue-Luke/SW4/L569-597)*

- 621 S: uh↑uh (.) okay Brenda
- 622 L: Bren↑da y↑es
- 623 S: yeah (.) what kind of a person would you say that Brenda
- 624 i↓s?
- 625 L: ye↑ah (.) well ehh Brenda amm (tch) she used to stay with
- 626 her m↑um and she moved out into accommodation on her
- 627 o↑wn (.) I feel she amm (2.0) sort of (.) struggles on her
- 628 o↓wn (0.5) I th- I th↑ink her mum did a lot for h↓er (.) when
- 629 she stayed with m↑um (1.5) ehh previous to that she was
- 630 marri↓ed (.) when that came out (.) but just lately she's (.)
- 631 ehh she's moved out on her own (1.0) uhh I can't see her
- 632 going forward any (.) more than she's done so far (.) she's
- 633 been looking for work for quite some time and done (.)
- 634 part-time work as w↑ell (1.0) (tch) emm
- 635 S: ◦mm◦
- 636 L: she's very stable as far as that's concerned but she hasn't
- 637 moved a great de↓al (.) you kn↑ow

Luke's account of Brenda touches on the areas of accommodation and employment. Brenda is portrayed as a dependent woman who desires independence but struggles on her own, and who is not progressing in her life. Luke first draws attention to Brenda's living arrangements, pointing out that she used to 'stay' (line 625) with her mother but now lives on her own. He suggests that Brenda 'struggles' (line 627), supporting this with the notion that Brenda's mother 'did a lot for her' (line 628). This latter claim though, is couched with 'I th- I th↑ink', allowing for an element of uncertainty on the matter. To further this, Luke then mentions that before Brenda lived with her mother, 'she was marri↓ed' (lines 629-630). The implication here is that Brenda has been dependent upon her husband, and has switched that reliance from her husband to her mother.

Directly after the introduction of Brenda's previous marriage, Luke makes the side comment of 'when that came out' (line 630). This seemingly innocuous comment introduces the idea of Brenda withholding personal information from support workers. In addition, the remark suggests that it was damning information for some reason, though Luke does not explain why this would be. Unsaid here is that Brenda might not be trusted to divulge information about herself, akin to complaints made by the two previous support workers. It also suggests that Luke's descriptors of Brenda may be based upon assumption. That is, Luke is not entirely sure of his claims about Brenda as there may be more that Brenda is simply not revealing to him. Employment appears to be an area where Luke has more confidence in describing Brenda. He states that he cannot see a change occurring in Brenda's future, as Brenda has been seeking employment 'for quite some time' (line 633). Temporary part-time work is all that she is able

to obtain, and Luke suggests that Brenda is ‘stable as far as that's concerned’ (line 636), but has gone as far as she can go.

Mike described Brenda as rigid in that she did not like change, but also as quite a friendly woman who is very attached to her son (see Extract 101).

*Extract 101 (Sue-Mike/SW3/L869-895)*

- 869 S: yeah? (0.5) umm (.) Brenda
- 870 M: Brenda ((participant's surname)) (0.5) she ↓is (2.5) (tch)
- 871 very rigid ((laughs))
- 872 S: mm
- 873 M: rigid's the word I'd describe her a↑s (.) (mumbled) she (.)
- 874 you know my experience with h↑er she (1.5) she well she's
- 875 been coming to this programme for such a long time and
- 876 she's done exactly the same th↑ing and ((breath in)) just
- 877 can't really offer her anything e↑lse (.) that we offer can't
- 878 get her to try anything e↑lse (.) umm she's quite happy just
- 879 doing (.) what she's doing (.) and in some respects that's
- 880 really (.) umm (1.0) well rigid, but umm (.) I guess part of
- 881 her illness (.) umm (.) in just (0.5) not having the
- 882 motivation or the (.) umm initiative or even the insight into
- 883 (.) understanding how her mental health has been affected
- 884 and how it's impacting on her life (.) u::m
- 885 S: mm
- 886 M: ahh ↓I'd see her as (.) you know (.) >on a face to face
- 887 level< (.) as you know a really friendly person to talk t↑o
- 888 (0.5) u::m (.) quite (.) umm (0.5) yeah quite soc↑ial (.)
- 889 u::m (2.0) ye:ah generally takes takes good care of her
- 890 hers↑elf (.) yeah (.) u::m (.) certainly v↓ery (.) u::m (0.5)
- 891 attached to her s↑on
- 892 S: mm
- 893 M: and very (.) much the mother and friend of her s↑on
- 894 S: mm
- 895 M: yeah (.) so: (0.5) mm

Mike's account of Brenda revolves around his initial descriptor of her as 'very rigid' (line 871). He draws heavily from clinical discourse, invoking past experience to warrant and explain his comment. Mike shows difficulty in speaking of Brenda, starting with a hesitation, pause, and tongue click, before making the claim that she is 'very rigid ((laughs))' (line 871). This suggests that Mike does not approve, with the laugh perhaps an attempt to tone down the severity of the statement he has made. In my turn at talk I give a minimal response, declining the invitation to laugh with him, which would be an indicator of agreement (see Jefferson, 1979). This lack of response is taken as a challenge to the statement, as Mike goes on to explain what he means by 'rigid'. Here, the validity of the claim appears to be at stake (see Potter et. al., 1993), with Mike drawing upon past personal experience with Brenda (line 874). The length of her attendance at the programme and her repetitive behaviours are used as a justification, as Mike complains that there is nothing else to offer her that she would try.

A double standard then appears, with Mike stating that Brenda is 'quite happy just doing (.) what she's doing' (lines 878-879). For a person without a label of mentally ill, this could be taken as an indication of contentment. Yet for Brenda, it is not. Mike marries this comment to his earlier claim of rigidity (lines 879-880), and the phrasing of 'in some respects' works to show recognition of the circumstantial nature of his assertion. To strengthen the connection between the two and show a general way of being, Mike draws upon a three-part listing technique (see Jefferson, 1990), invoking clinical indicators of 'motivation', 'initiative', and 'insight' (line 882), common areas of concern in people with mental health issues (see APA, 2000). Thus, for Brenda, being 'quite happy' with

her life and not wanting to change it is indicative of rigidity, which in turn, has been asserted as an indicator of illness. This drawing upon clinical taxonomy provides for a notion of illness, but cannot quite support the idea that happiness equates to illness. To try to reconcile this, Mike alludes to the impact that Brenda's illness is having upon her life. By claiming that Brenda lacks an 'understanding' of this impact, he can then imply that although she is happy, she is unaware of the damage that her illness has caused her.

From illness talk, Mike then turns to a more personal account of Brenda, conveying this as being '>on a face to face level<' (lines 886-887). This suggests everyday, surface interaction, and Mike makes a switch from a professional role to a more personal level. He comments that Brenda is 'really friendly', 'quite soc↑ial', took 'good care of her hers↑elf', and infers that she is a good mother through her attachment to her son (lines 887-891). These descriptors align with Mike's comment of Brenda as happy with her life the way it is, yet the marker of '>on a face to face level<' relegates them to a superficial level rather than the deeper issues of illness.

### **Carl: Normalcy**

The issue of normalcy appeared to be a main theme running through all four support workers' accounts of Carl. Underlying this was the notion of whether a person who had been given a diagnosis of schizophrenia could ever obtain the status of 'normal'.

## A Man at the End of His Recovery

Mike proposed that Carl was nearing the end of his recovery (see Extract 102). Drawing heavily upon medical discourse and theory, Carl was described through clinical indicators of the diagnosis he had been given.

*Extract 102 (Sue-Mike/SW3/L937-958)*

- 937 S: mhm (.) okay last ↓one (0.5) Carl
- 938 M: Carl (participant's surname) I'd describe him as (1.0) (tch)
- 939 humm in terms of (.) schizophrenia I'd describe him as (.)
- 940 someone that's (.) k↑ind of (.) in the (0.5) early (0.5) early
- 941 stages of (0.5) >the end of his recovery< (laughs) >it's like
- 942 the end of his recovery I mean I think he's< (.) umm umm
- 943 umm I'm thinking that he had (.) he's h↓ad schizophrenia
- 944 for a very long time (.) and it has played a m- a (tch) it has
- 945 impacted on him (.) quite a l↑ot umm (0.5) but (.) since
- 946 coming here (.) u::m (.) I think his (.) level of functioning
- 947 has just improved amazingly and (.) he's such a umm you
- 948 know his his personality's much more attached and he's
- 949 certainly got a good personality a strong personality
- 950 S: mm
- 951 M: umm (.) he's a wonderful guy a nice guy very responsible (.)
- 952 umm (0.5) umm motivated (.) umm yeah has an idea of
- 953 direction in his life umm (1.0) very sociable (0.5) umm (.)
- 954 yeah (.) still a little bit (.) umm (.) maybe (.) withdrawn (.)
- 955 in some resp↑ects but yeah
- 956 S: mhm
- 957 M: ◦yeah◦
- 958 S: yeah

In Mike's account of Carl, the membership category (see Sacks, 1992) of 'schizophrenia' (line 939) dominates. He gives a clinical description of Carl's recovery process by drawing upon biomedical theory, and outlines Carl in terms of clinical indicators of abnormality. Mike

shows difficulty in starting his account through a one second pause, a tongue click and the ‘hummm’ (lines 938-939). He then invokes the membership category (see Sacks, 1992) of ‘schizophrenia’, aligning Carl with other consumers belonging to this group, and drawing upon the implications surrounding the diagnosis. In confirmation that Carl is indeed a member of this category, Mike positions Carl in terms of his recovery from illness. Mike sees Carl’s recovery as underway as he claims that Carl has reached the ‘early (0.5) early stages of (0.5) >the end of his recovery<’ (lines 940-941). He expands upon this by drawing attention to the amount of time Carl has been ill (lines 943-944). Here, there appears to be a slip of tongue as Mike states ‘...he had (.)’ pauses, and then continues with ‘he’s h↓ad schizophrenia for a very long time’. To say that ‘he had’ is suggestive that illness is no longer an issue, which does not align with the picture that Mike is painting. The correction to ‘he’s h↓ad’ suggests that the problem is still with Carl. This juggling of past and present may also convey caution that although Carl is doing well, recovery is an uncertain process.

To ward off a possible challenge to this notion of permanency in classification, Mike moves to clinical indicators of abnormality, referring to the impact it has had on Carl (line 945), Carl’s level of functioning (line 946), and Carl’s personality (line 948). In an attempt to invoke theory, Mike claims that Carl’s personality is ‘much more attached’ (line 948). The idea that Carl’s personality had somehow become unattached may stem from Bleuler’s (1950) phrenology of the splitting of psychic functions. As Carl’s emotional problems were no longer dominating his life, Mike has drawn on the theoretical notion of Carl having a ‘more attached’ personality. The added claims that Carl’s personality is ‘good’ and ‘strong’

(line 949) manage to reinforce this idea of attachment, and of Carl's personality no longer being overtaken by his illness. Mike then works to solidify the idea of recovery, listing what he sees as Carl's positive characteristics such as being responsible, motivated, having direction, and being sociable (lines 951-953). He finishes by pointing out that Carl is still a little 'withdrawn' (line 954), working to remind his audience that Carl's recovery is not complete.

### An Easy Going Guy

Luke's account of Carl was of an easy going guy, who could blend in wherever he happened to be (see Extract 103). In this extract, Luke highlighted Carl's relationship with his mother, focusing on the effect that Carl may have had upon her.

#### *Extract 103 (Sue-Luke/SW4/L656-671)*

- 656 S: mhm (0.5) oka↑y umm (.) Carl
- 657 L: which Carl? ((surnames mentioned))
- 658 S: yes Carl
- 659 L: Carl okay (.) he h↑asn't been coming here (.) very m↓uch
- 660 S: ◦mhm◦
- 661 L: just a short sp↑ell (.) he stays with his m↑um (.) ehh he's
- 662 one of those f↑ellas that's (.) very quiet and easy going (.)
- 663 and ehh I feel he wouldn't have been any trouble at all to
- 664 his m↓um (.) I feel he's (.) he's very helpful there he's he
- 665 drives her c↓ar and takes her shopping and anywhere she
- 666 wants to go he d↓oes ↓it
- 667 S: mhm
- 668 L: I feel he's one of those (.) p↑eople that could sort of blend in
- 669 anywhere sorta th↓ing (.) ◦you kn↑ow◦
- 670 S: yeah? sort of very easy going?
- 671 L: very easy going very easy going guy yeah



Luke's account of Carl tends to focus on relationships and his interaction with others. His account does not mention any negative or problematic characteristics or behaviours, painting a picture of Carl that is contrary to the classification of schizophrenia, thus setting up a subtle challenge to the continuation of Carl's diagnosis. That is, Luke does not propose Carl to be a troubled man. According to Luke, Carl has not been attending the service centre 'very m↓uch just a short sp↑ell' (lines 659-661). The idea of 'a short sp↑ell' suggests that this is temporary, and that Carl is attending the service to perhaps address a particular issue. Luke then mentions Carl's accommodation status, saying 'he stays with his m↑um' (line 661). Again, this infers transience as Carl 'stays' with his mother rather than the permanency of lives with his mother. This suggests that Carl is not dependent upon others.

In describing Carl, Luke invokes the membership category (see Sacks, 1992) of 'one of those f↑ellas' (line 662), suggesting a typical way of behaving for Carl. He aligns Carl to this group through the category bound behaviours of 'very quiet and easy going', which are not predicates of the category of people with mental illness. Luke adds that Carl '...wouldn't have been any trouble at all to his m↓um' (lines 663-664). This supplementary information with an emphasis on 'any' works to confirm Carl's rightful position in this category, as 'easy going' people do not tend to be 'trouble' for others. Luke again expands upon this by giving examples of Carl's 'helpful' (line 664) behaviour, pointing out that Carl assists his mother with shopping and outings. In line 668, Luke takes another approach to the notion of easy going, claiming that Carl is the kind of person who could 'blend in anywhere' (lines 668-669). In order to do

this, a person would not be acting out of the ordinary, and possibly bringing attention to themselves. Throughout this extract then, Luke engages in an indirect but clear challenge to Carl's diagnosis, emphasising behaviours that run contrary to those of a person within the classification of schizophrenia.

In her description, Mel portrayed Carl as a quiet, independent, trustworthy man (see Extract 104). This was qualified though, as she established that she did not know Carl well.

*Extract 104 (Sue-Mel/SW2/L977-991)*

- 977 S: okay (.) finally (.) Carl
- 978 M: ↑Carl (.) okay (0.5) Carl I don't kn↓ow very well (.) u:m
- 979 S: mhm
- 980 M: I see him ↓as a friendly (.) pleasant (.) umm (2.0) warm (.)
- 981 sort of g↑uy (0.5) umm (.) kind of (.) holds his ↑own
- 982 S: mhm
- 983 M: he's got a (.) he's ↑almost got a bit of a (tch) (0.5) quiet
- 984 dignity about him (.) there's something about him that (.)
- 985 yeah
- 986 S: mm
- 987 M: you just think (.) umm (2.5) y-he- there seems to be an
- 988 honour (.) about h↑im you kn↑ow like (.) you'd trust h↑im
- 989 S: yeah
- 990 M: u::m (1.5) yeah yeah
- 991 S: mhm (.) m-

In Extract 104, Mel negates possible challenge to her description of Carl through a concession that she does not know him well, and then puts forward her observation of Carl. Drawing upon the resource of three-part listing (see Jefferson, 1990), and at times showing difficulty in choosing descriptors, the account centres predominantly upon mannerisms. This works to give a surface impression of Carl, and confirms her unfamiliarity

with him. Mel opens her account of Carl by stating that she does not know Carl ‘very well’ (line 978). This concession works to cover any possible differences that others might make in the judgement of Carl's character. After establishing her lack of familiarity with Carl, Mel then draws upon a three-part list to give a common way of behaving for Carl - ‘friendly (.) pleasant (.) umm (2.0) warm’ (line 980). The two second gap between pleasant and warm may indicate consideration or alternatively, uncertainty, but suggests that in general, Carl is a sociable man. The addition of the end list completer – ‘holds his ↑town’ (line 981) – conveys Carl to be socially competent. As many consumers attend the service centre to improve their social and communication skills, this infers that Carl does not need assistance in this area.

Mel then speaks of Carl having a ‘quiet dignity about him’ (lines 983-984). At first, she claims that he has this ‘dignity’, but then softens the extremity of this statement to ‘↑almost’. Difficulty is indicated by the earlier tongue click, and the idea that there is ‘something’ (line 984) about Carl. A second term of ‘honour’ is introduced in an attempt to explain this ‘something’, and Mel settles on the idea that Carl is a man who can be trusted (line 988). The invocation of terms such as ‘dignity’, ‘honour’ and ‘trust’ suggest that Carl is a proud man who would do right by others. Thus, Mel's account conveys that Carl will not cause trouble for others, and that he is dependable and reliable. As with Luke, her description of Carl does not mention any negative attributes, although her initial concession of her unfamiliarity with Carl allows for the possibility of error.

## A 'Normal' Guy

Consumer independence was a major issue raised in Viv's account of Carl (see Extract 105), and she complained of how the mental health system tended to take this away from people. The term 'normal' appeared in her descriptors of Carl, and Viv tied the two together suggesting that 'normal' people were independent of each other.

### *Extract 105 (Sue-Viv/SW1/L1010-1041)*

- 1010 S: yeah (0.5) umm (.) and Carl (1.5) 'lucky last one' (.) Carl
- 1011 V: ye↑p (2.0) u::m (.) I think Carl's (0.5) great g↑uy (.)
- 1012 friendly
- 1013 S: mhm
- 1014 V: you kn↓ow, just a (.) normal everyday (.) see in the street
- 1015 type guy that you have a conversation with and (.) yeah (.)
- 1016 I really like Carl a l↑ot he's (.) easy to work with (.) easy to
- 1017 (.) talk to
- 1018 S: yeah
- 1019 V: u::m (1.0) I think he's got more potential th↓an- you
- 1020 kn↑ow I think we've h↓ad to u::m (.) and I'm quite
- 1021 conscious in this environment of people's independence
- 1022 being (.) destr↓oyed (.) n↓o I find
- 1023 S: mm
- 1024 V: I get really (.) eeeuuu ((indicating frustration)) when (.)
- 1025 people (.) when I first c↓ame here I can see people who
- 1026 were more (.) independent than they are now (.) and that
- 1027 frustrates m↑e
- 1028 S: mm
- 1029 V: Carl's only been here for a short t↓ime (.) and I could- I
- 1030 don't w↓ant that to happen to Ca↑rl (.) because you know,
- 1031 when he came here we used to go and pick him u↑p
- 1032 S: yeah
- 1033 V: that sort of stu↑ff and he's got his own- or he's got his
- 1034 mum's c↓ar he drives around (.) and I sort of said well (.) I

- 1035            can't see what's (.)
- 1036 S:        mm
- 1037 V:        happening here because you know Carl to me seems quite
- 1038            independent (.) I see him as being independent (.) why are
- 1039            we taking that away from h↓im why are we (.)
- 1040 S:        mmm
- 1041 V:        so that's ch↓anged he actually does his own thing n↓ow

The underlying theme of this extract is a questioning of procedure within the mental health system. Like Luke, Viv gives a subtle challenge to Carl's diagnosis. She invokes the term 'normal', which aligns with Luke's account in giving an overall perspective of Carl as easy going rather than troubled. The issue of consumer independence is also raised, where a show of concern for Carl and a siding with consumers outlines how organisational and professional procedure can be successfully contended. Viv begins her account of Carl with the descriptors of a 'great g↑uy' (line 1011) and 'friendly' (line 1012), and then offers a typical impression of Carl as a 'normal everyday (.) see in the street type guy' (lines 1014-1015) that 'you' can converse with. The normalising device of 'you' (Wooffitt, 2001) conveys that anyone could chat with Carl, and this image suggests that there is nothing out of the ordinary here. It is her use of the term 'normal' though, that infers a subtle challenge to diagnosis. That is, if Carl looks and behaves as a 'normal' person would, then the diagnosis of schizophrenia should be removed as there is nothing to substantiate it. Viv then places emphasis on the term 'easy' (line 1016), which aligns to Luke's descriptor of 'easy going' (Luke/SW4/L662). In this sense, like Luke and Mel, Viv does not paint Carl as a troubled man.

A second area of contention for Viv appears to be a lack of independence for consumers, or the taking away of that independence by the mental health system. The complaint is initially quite broad, and there is a claim that consumer independence is 'being (.) destr↓oyed' (line 022). The strength of the term 'destr↓oyed' conveys major concern, and suggests that the damage is irreparable. To support this claim, Viv draws upon a comparison between the independence that consumers had when she first started working for the service centre, and the lack of independence those same consumers have in the present (see lines 1025-1027). Carl's travel arrangements to and from the service centre are then put forward as an example, where despite his having available transport, the service would collect Carl from his place of residence and drive him to the centre (see lines 1031-1035). Thus, Viv conveys one cause of consumer dependence to be the procedures of the centre itself. She positions herself as siding with and advocating for consumers, as an outline of how this particular procedure was successfully challenged is given. The resulting claim is that Carl 'does his own thing n↓ow' (line 1041).

## **Conclusion**

Accounts given by staff members of primary participants were not simply descriptions of consumers, but vehicles for conveying the complexity of troubled selves. For each primary participant, a common theme tended to emerge from each of the extracts dealing with that person. Noticeable here was that despite this commonality between staff members, they also conveyed quite disparate perspectives in many cases. In these accounts, clinically trained support workers tended to orient toward biomedical arguments, proposing biology and genetics as explanations of

behaviour, and drew upon classifications and symptomology of disorder. Discourse of illness was prevalent in many of the descriptors given by Mel and Mike, and the diagnostic category of schizophrenia was invoked on a number of occasions (e.g. Ken, Rick, and Carl). Chronicity of illness was either inferred or stated for many consumers, and was positioned to be due to the hard-to-control nature of biological influences. Non-clinical staff members tended to orient more toward social explanations of behaviour in their accounts of consumers. The focus here was on relationships and events that had occurred in the person's life. Major events, such as bad experiences in the Army for Ken (Extract 76), were given as an explanation for the emerging problems consumers had in their lives. For primary participants who were described as not faring too well, Luke and Viv spoke of struggle. Yet, this was often tempered with the possibility of recovery.

Professional status, invoked predominantly by Mike but also occasionally by Mel, was managed to lend authority to accounts of consumers (as in Mike's account of David having 'a really hard life' (Extract 85, lines 509-510). In some cases, this status appeared to be at risk. For example, in Mike's accounts of Karen and Scott any suggestion of professional incompetence that might have been aimed toward Mike because of his inability to successfully help these consumers was redirected; by shifting blame onto Karen's attitude of helplessness, and Scott's early onset of his illness, respectively. Non-clinical staff members took care in their accounts to ensure that it was known that they were putting forward their opinion of consumers. In Luke's account of Scott (Extract 101), he manages accountability for a claim that Scott was unwell through a phone call to Scott's mother. This suggested an awareness that they could not fall

back on the possible protection and security that 'professional' discourse offered. Thus, their accounts would be more vulnerable to challenge.

Professional standing or otherwise, this did not appear to prevent staff members from making subtle challenges to diagnosis or the mental health system. A number of challenges to diagnosis were made where behaviours contrary to clinical symptomology were emphasised. In Mel's account of Carol (Extract 97), membership category devices and category bound behaviours were invoked to outline the areas of personal relationships, friendships, and personal achievements, showing that Carol was not typical of a person belonging to this classification. Viv gave challenge to procedure on a few occasions, introducing issues such as consumers receiving little attention if they were quiet (Extract 77 of Ken), and consumer independence being taken away (Extract 109 of Carl). Thus, accounts of consumers by staff members incorporated the intricacy surrounding the notion of a troubled self.

Common features were picked up by support workers for each primary participant, yet accounted for in different ways. Attention to certain features and not others may stem from the institutional setting itself where present theory dictates the importance of one characteristic over another. It is in this setting where much of primary participants' social interaction occurs. The medical influence on self-definition cannot be underestimated, particularly where there is a power imbalance. Primary participants' definitions of themselves will naturally stem from what is deemed socially acceptable and socially unacceptable behaviour.



## CHAPTER 8 – General Discussion and Conclusion

Schizophrenia has often been positioned as a problem of self where the diagnosed person is said to have lost their sense of who they are, or in other words, lost their sense of self (Bleuler, 1950; Hemsley, 1998; Mahler, 1952, 1968). This simplistic explanation discounts the multitude of social and contextual nuances that impact upon self-identity. A sense of self is not innate or developed from within, but is constructed in relationship with others, and is continually evolving. Thus, a loss of self or diminished self-identity for a person diagnosed with schizophrenia occurs within relationships, where the person's current self-identity is theoretically proposed to no longer be adequate in explaining the severe emotional distress the person now experiences.

### Problems of Self

*“Self-labelling, or seeing oneself as having a mental illness or being mentally ill, is clearly influenced by many factors, most of which are not clinical but contextual, experiential, and sociocultural”*

*(Estroff, 1991, p.361).*

When a person receives a diagnosis of schizophrenia, self-identity is challenged through negative stereotypes and clinical descriptors associated with that diagnosis (Gonzalez-Torrez, Oraa, Aristegui, Fernandez-Rivas & Guimon, 2007; Link et al., 1997). Identifiers such as irrational thoughts and behaviours, instability, and dangerousness tend to linger and continue to be associated with the diagnosed person, regardless of the extent of recovery the person has made. In order to counter images of an irrational self,

participants engaged in sense making activities to rationalise their behaviour and personal experience, and to normalise themselves by likening themselves to others in the general community.

The production and protection of a coherent, reasonable self was evident in participants' narratives. Potter et al. (1993) suggest that the use of the 'personal history' resource indicates that a major issue is at stake for the person, and this was evidenced in attendance to changes over time from past to present selves. No disruption appeared evident in the linearity, meaning or clarity of tellings, contrary to research outlining language deficits in people diagnosed with schizophrenia (Condray et al., 2002; Gruber & King, 2008; Lysaker et al., 2003; Melinder & Barch, 2003; Wrobel, 1989). This highlights the importance of differentiating between a psychotic episode and an overall diagnosis when reporting results on the schizophrenias.

Participants made frequent use of notions of a sick self when giving descriptors of past selves. This aligned with Parsons' (1951) notion of the 'sick role', where people become exempt from typical role obligations and are not deemed to be responsible for their illness. However, users of this identity are obliged to 'want to get well', and must seek out 'technically competent' assistance and cooperate with physicians. Reference to doctors, medical staff, and medication were often made in versions of self given by people adhering to this identity in what appeared to be an effort to show deference to authority, managing not only justification for problems and behaviour but also contributing to the presentation of a rational, responsible self.

Primary participants drew on a number of normalising resources in their accounts of self, aligning past versions of self to disorder and present versions of self to normalcy. As stigma and discrimination socially discredit the person and their identity (Goffman, 1959), and this is strongly related to the label of 'mentally ill' (Link et al, 1989; Link et al., 1997; Martin et al., 2000; Mouzos, 1999; Read & Law, 1999), participants were likely to be engaging in a process of destigmatisation. That is, past versions of self revealed problematic selves, whereas present versions of self were non-problematic and therefore, 'normal' or socially acceptable.

Another major technique used to 'normalise' the self was to generalise problems. Although participants expressed troubled aspects of themselves and their behaviour, others in the community were also presented as experiencing problems of some sort. As the most common reactions of people with schizophrenia to stigma tend to be isolation and avoidance (Gonzalez-Torrez et al., 2007), generalising problems to others works to circumvent stigma by presenting a socially acceptable version of the current self. That is, problems in and of themselves were not presented as unusual or 'abnormal', but as commonplace. Attention to lexical choice revealed that participants preferred lay terminology to medical discourse, and no participant used the term schizophrenia in their interviews. The absence of this label when presenting their versions of self and their life narratives suggests a distancing from the term in order to deflect notions of a non-socially acceptable self. That is, if negative characteristics are associated with the term 'schizophrenia', then distancing themselves from this term also manages a distancing from those negative characteristics.

## Problems of Relationship

*“The realities and moralities we come to inhabit are those that gain support and viability in significant sets of relationships. As we come to generate realities and moralities within specific groups--families, friendships, the workplace, the religious setting--so do our interlocutors become invaluable resources for sustaining those realities. With their support--either explicit or implicit--we gain the sense of who we are, what is real, and what is right”*

*(Gergen, McNamee & Barrett, 2001, p.679).*

Understanding and care were the two main issues that emerged in participants' versions of how others might see them. Complaints of misunderstandings and poor communication between the person and their family members highlighted problematic familial interaction. Here, the possible difficulties in expressing emotional problems, outlined in the Open Dialogue approach to emotional distress, would benefit from dialogism where communication and understanding is supported (Seikkula et al., 2000; Seikkula et al., 2003; Seikkula & Olson, 2003). For example, Karen spoke of feeling frustrated as she claimed that her family were *'still not really listening'* (Karen/CS6/L314). This is not to say that it is only the person with emotional problems who experiences difficulty with communication. As Docherty et al. (1998) point out, parental interaction with emotionally distressed offspring can often be fragmented and unstructured. Thus, communication is a two-way interaction, and others must also show an ability and willingness to understand the distressed person (Wrobel, 1989). An important point to note here is that the problems

of feeling understood that seem to arise for people with a diagnosis of schizophrenia often have their origins in not being taken seriously as authors of their own experiences. That is, medicalised social understandings of schizophrenia have a tendency to delegitimize people's accounts of their own experiences and rights to manage their own lives.

The second issue arising from participants' versions of how others might see them was that of care. Some people claimed that their families did not care for them, whereas one person asserted that his family cared too much. Disappointment was evident in accounts of a lack of care, yet some of this disappointment was conveyed as the family's failure to make their care evident to the distressed person. Studies investigating levels of emotional intensity and expression within families suggest that families high in Expressed Emotion tend to place a large amount of stress upon the diagnosed person (Butzlaff & Hooley, 1998; Jenkins & Karno, 1992; Lopez et al., 2009). On the other hand, negative affective styles or a lack of expression could be said to be just as harmful (Diamond & Doane, 1994). Rick had complained that his family did not care about him, and therefore, he did not bother with them anymore.

A number of consumers conveyed over-reliance upon others, particularly upon their family members, or alternatively, the family's over-involvement with them. The impact of this over-reliance or over-involvement upon the person's sense of self was evident in that some consumers tended to promote others' versions of themselves rather than their own. This might suggest a lack of confidence in their own accounts of self, but it also highlights the lack of credibility and power (see Rose, 1994, 2007) given to consumer versions of self. Lysaker and Hermans (2007)

suggested that people diagnosed with schizophrenia experience a ‘lessened sense of self’ as compared to their sense of self before their problems began. The authors claim that dialogue with others, particularly with their therapist, leads to regrowth or a richer sense of self. A diagnosis of schizophrenia (carrying with it the unspoken assumption of chronicity) may provide the basis with which to question consumer accounts, relegating a once credible person to now be ‘unrealistic’. When asked to describe the kind of person that he is, David presented Viv’s version of himself, situating it at a time when Viv prepared his employment resumé for him – “she reckons I’m very umm active...” (*David/CS4/L61*). This claim may show a lack of confidence that David had in his own account of himself. Yet, by offering a positive account given by a support worker at the service centre, David bolstered the reliability of this version through the inherent power that is given to expert opinion. David showed an awareness of the lack of credibility that his own account may have been given as a person diagnosed with schizophrenia.

Relationships with staff members appeared to revolve around the monitoring of the consumers’ behaviours. There are widespread misconceptions of mental health consumers as dangerous and violent (Link et al., 1999; Mouzos, 2000; Penn et al., 1999), and Carl and David showed awareness of this as they raised notions of dangerousness in their accounts of how staff members might see them. In stating; ‘they know who I am they’re not afraid of me!’ (*Sue-David/CS4/L413*), David highlighted the salience of fears and stereotypes that staff members may hold of people with a diagnosis of schizophrenia. Penn and colleagues (1999) suggested that perceived devaluation and discrimination reported by consumers tends to

diminish the more a person has had contact with mental health consumers. That the issue of dangerousness was raised by some consumers suggests that despite ongoing contact with consumers and an understanding of the context of their emotional distress, stigma and stereotypes may still emerge from mental health staff members.

Emotional support and social validation were key themes in participants' descriptions of their relationships with others. Accounts of conflict within the family arose when participants spoke of events of the past (pre-diagnosis), where they viewed their families as either unwilling to talk about personal matters or behaving in an antagonistic way toward them. Without the validating support of those closest to them, positive descriptors of self cannot be affirmed as troubled relationships interfere with the daily interchange of providing the self-affirmations of identity (Gergen, 1994, 2008, 2009). Avoidance and hostility act as barriers resulting in the questioning of the self and progressively lead to social isolation. Once a diagnosis had been given, many participants conveyed that familial conflict remained and this brought about issues such as a lack of familial support and frustration. Rosenfarb et al. (1999) proposed that people diagnosed with schizophrenia from high Expressed Emotion (EE) environments tended to react to stressful situations with anger and frustration, whereas people from low EE environments were more likely to use coping skills such as avoidance and denial. Yet Blanchard, Sayers, Collins and Bellack (2004) suggest that symptoms of schizophrenia contribute little to conflict between the diagnosed person and members of their family. That is, despite the linking of severity of symptoms to family functioning (Murray-Swank et al., 2007), family dysfunction had been occurring long before the symptoms of

schizophrenia emerged. Descriptors of ongoing familial dysfunction outline consumers who are locked within self-sustaining, debilitating patterns of relationship with no apparent exit (Gergen, 2008). Self-validating support is absent or often couched in terms of deviance, resulting in the degeneration of self-identity. A few people spoke of having an ally within the family, someone they could talk to, someone who understood them. This has a protective value for the person as it affirms understanding, meaning, and ultimately, a helpful sense of self. As family is an important source of social and economic support (Jenkins & Karno, 1992; Laing, 1969; Lopez et al., 2009), family relationships are central in the renegotiation of a sense of self.

Notions of emotional support also emerged through talk of friends. Issues were raised such as loneliness, camaraderie and the need for close friends highlighting participants' desires to avoid solitude and their need for companionship. This outlines the emotional importance of human connectivity in that despite the propensity to socially isolate themselves due to possible stigma and discrimination (Gonzalez-Torrez et al., 2007), participants were aware of the need for others in their lives, particularly those who had similar experiences to themselves. Similarities between people are also managed to validate notions of self and self-identity (Gergen, 1994, 1997). Similar meanings, purpose and unity can be found between people who share the lived experience (McAdams, 1985, 2006) of a diagnosis of schizophrenia, working to reconstruct self-identity as new ideas and concepts are integrated into existing behaviours and ideas.

Mental health staff typically know of a person's diagnosis before they get to know the person. Participants' awareness of how they might be



perceived by staff members emerged through notions of fear and dangerousness, yet they also revealed a need for not being seen to be helpless and dependent upon others. This is contrary to inclinations of mental health professionals, who tend to prefer that mental health consumers take on roles of dependency and conformity (Mechanic, 1996).

### **Contestable Selves**

*“As lay systems of meaning have become bound up with medical thought, medical languages, no matter how technical, have become influenced with cultural meanings. Medicine thus makes us what we are by reshaping the relations of meaning through which we experience our worlds”*

*(Rose, 2007, p.701).*

When mental health staff members were asked to describe each of the primary participants, common themes tended to emerge. Each theme was not so much a description of the person, but an explanation for the behaviour of a troubled self. Biomedical arguments were proposed from clinical staff, and the term schizophrenia was invoked on a number of occasions, confusing understanding that diagnostic classifications are descriptors of behaviour and not people (APA, 2000). Non-clinical staff members tended to draw upon relationships and major events that had occurred in the person's life in their descriptors of primary participants, gravitating toward social explanations of behaviour. Social approaches gave more credence to notions of improvement and recovery, whereas the biomedical explanations emphasised chronicity. An example of the

permanency of mental health classification was revealed in Mike's descriptors of Carl, where recovery is underway but may never be complete.

Medical influence upon self-definition cannot be underestimated. The impact of clinical accounts of the person may depend upon the power that both society and the person receiving that information give to the account. This can then influence subsequent behaviours and experiences of that person (Laing & Esterson, 1964). In their accounts of primary participants, the two clinical staff members invoked their professional status on a number of occasions, whereas the two non-clinical staff members worked to qualify their claims of primary participants as their opinion. The latter accounts could not fall back on the protection and security that professional discourse offers. Medicine's authority over human behaviour, deriving in part from claims of scientific expertise, informs and in many respects, reshapes vocabularies of selfhood (Rose, 2007). As notions of self and self-identity are becoming intrinsically somatic, acceptable self descriptors for both mental health consumers (see Baier & Murray, 1999) and staff members alike must be discursively medical. Consumers who don't agree with medical perspectives of themselves are said to show a lack of insight, whereas staff members who don't agree with medical doctrine would not be able to claim 'professionalism'.

## **Implications**

When prominent psychiatrists and researchers such as E. Fuller Torrey (2010) dismissively assert 'What's in a name?' they denounce the impact of diagnostic labels upon people experiencing mental illness. Torrey, claiming the clinical diagnosis of schizophrenia to be a disease of

the brain, protests against the political correctness of ‘people first’ terminology put forward by mental health organisations (or those he calls the ‘word police’):

*“Let us then propose that ‘client’ be used only in the context of psychosocial rehabilitation services and that ‘consumer’, ‘survivor’, and ‘people with lived experience’ be abolished from all federal publications when they are used to refer to people with schizophrenia. They can be consigned to the junk heap of lexicographic history.”*

(Torrey, 2010, p.2)

There are profound implications in managing a diagnosis of schizophrenia as the diagnosis itself appears to incorporate many aspects of the person’s sense of self and identity (Goffman, 1959, 1963, 1974). To describe or define a person based purely on categorical labels constructed to outline generic patterns of emotional and behavioural outcomes both denies and restricts the individuality, growth, and recovery of that person.

In a broader sense then, a shift away from the permanency of diagnostic labelling and categorical notions of self would allow for such growth and change. To do this we would need to reconceptualise the behaviours and experiences of people who would otherwise be diagnosed as ‘schizophrenic’. Mary Boyle provides a starting point in which these behaviours and experiences could alternatively be seen as some of “... the most extreme ways in which people react to or attempt to manage the distress caused by very aversive and threatening circumstances” (2004, p.460). This would entail a more thorough investigation of these reactions

and circumstances in context rather than simply dismissing them as ‘delusions’.

In order to allow for a socially validated, autonomous, legitimate self in people diagnosed with schizophrenia, the boundaries of self and identity within diagnostic labelling need to be acknowledged, broken down, and reconstructed within relationships. That is, it must be acknowledged that we are restrictive in our definitions of people with a mental illness, that these definitions impact negatively upon diagnosed people, and that we must work with the diagnosed person and their significant others to construct a more positive, socially legitimate self identity within which they can grow and recover.

Unfortunately, professional views of schizophrenia tend to refute that recovery is possible (Rao et al., 2009). For a consumer to agree with a current medical definition of self and behaviour (to show ‘insight’) they would be agreeing to a very bleak future of unchanging illness, and if these thoughts were to get them down, this sadness would also be interpreted as a symptom of their illness.

### **Limitations of the Study**

There are some limitations to this study. First and foremost, analysis was dependent upon my interpretations of the discursive interactions I had with the participants of this study. My versions of participants were put forward here. In adhering to Gergen’s (1985) epistemological position of social constructionism, alternative versions of talk would be equally valid. Established discourse and conversational methodologies were adhered to, yet talk is contextually situated and occasioned (Edwards & Potter, 1992,

2001). In this way, discourse was oriented to a particular version of self in order to maintain the integrity of that version at that particular point in time (Billig, 1987). As participants have recourse to more than one account of themselves, alternative situations may have brought forth different versions of self.

The situated and occasioned nature of the study, along with the small number of participants, does not allow for generalisation. The study's exploratory nature should be reiterated here, as the purpose was not to generalise but to explore the ways in which a person diagnosed with schizophrenia renegotiates a sense of self in relationship with others. A small number of participants allows for a deeper analysis of the nuances of self, revealing the complexities of self-identity and relationship.

No family or friends responded to invitations to participate in the study, extended via the people with a diagnosis of schizophrenia in this study. Some consumers may not have wanted their friends or family members to be involved and so did not invite their participation. Alternatively, as social isolation and familial antagonism emerged as pertinent issues for consumers, family members and friends may have been reluctant to get involved in the study with their diagnosed family member.

## **Conclusion**

This study suggests that people receiving a diagnosis of schizophrenia do experience a loss of their sense of self. This loss, though, has little to do with any intrinsic illness within the person, and more to do with their self-identity as was formerly known to them. Former notions of self are replaced with behaviours associated with the diagnostic label of

schizophrenia. The onus is placed upon the diagnosed person to renegotiate a version of self with significant others and medical experts that is socially acceptable.

That is, once a person experiencing extreme emotional distress receives a diagnosis of schizophrenia, their sense of self is indeed compromised. A label of abnormality not only impacts upon the way that others view the person, but also on the way that the person views themselves (Goffman, 1959, 1962, 1974; Sadler, 2007). A new identity associated with the diagnosis of schizophrenia is introduced, fraught with negative connotations such as dependence, dangerousness, hopelessness, and unpredictability (Lefley, 1989; Penn et al., 1999; Switaj et al., 2009). As self-identity evolves through relationship (Baumeister, 1998; Gergen 1994, 2008, 2009), interaction with new sources of information such as mental health professionals will impact upon the person's sense of themselves, becoming defining characteristics of the person or an identity classification. The diagnosed person attempts to renegotiate self-identity to allow for social acceptability, to rationalise and 'normalise' themselves. This suggests that ideas of schizophrenia colour relationships and self-identity. Rather than attributing the non-acceptance of medical self-descriptors to symptoms of disorder, future research could examine methods of allowing for an integrated self-identity outside of behavioural classifications.

## REFERENCES

- Adams, M. (2003). The reflexive self and culture: A critique. *British Journal of Sociology*, 54 (2), 221-238. doi: 10.1080/0007131032000080212
- Alanen, Y. O. (1997). Vulnerability to schizophrenia and psychotherapeutic treatment of schizophrenic patients: Towards an integrated view. *Psychiatry*, 60 (2), 142-157. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/9257354>
- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders – Text Revision (4th ed.) (DSM-IV-TR)*. Washington, D. C.: American Psychiatric Association.
- Antaki, C. (1994). *Explaining and arguing: The social organisation of accounts*. London: Sage.
- Antaki, C. & Wetherell, M. (1999). Show concessions. *Discourse Studies*, 1 (1), 7-27. doi: 10.1177/1461445699001001002
- Antaki, C., Billig, M., Edwards, D. & Potter, J. (2003). Discourse Analysis Means Doing Analysis: A Critique Of Six Analytic Shortcomings. *Discourse Analysis Online*, 1 (1). Retrieved from <http://www.shu.ac.uk/daol/previous/v1/n1/index.htm>
- Augoustinos, M. & Walker, I. (1998). The construction of stereotypes within social psychology: From social cognition to ideology. *Theory & Psychology*, 8(5), 629-652. doi: 10.1177/0959354398085003
- Baier, M., & Murray, R.L.E. (1999). A descriptive study of insight into illness reported by persons with schizophrenia. *Journal of Psychosocial Nursing and Mental Health Services*, 37 (1), 14-22. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/9921461>
- Bakhtin, M. (1984). *Problems of Dostojevshij's poetics. Theory and history of literature: Vol. 8*. Manchester, UK: Manchester University Press.
- Bateson, G. (1962). A note on the double bind. In C. Sluzki & D. Ransom's (Eds.) *Double bind: The foundation of the communicational approach to the family* (pp.39-42). New York: Grune & Stratton.

- Baumeister, R.F. (1998). The self. In D.T. Gilbert, S.T. Fiske & G. Lindzey (Eds.) *Handbook of Social Psychology* (4<sup>th</sup> ed.), pp. 680-740. New York: McGraw-Hill.
- Baumeister, R.F. (Ed.) (1999). *The Self in Social Psychology*. Philadelphia, PA: Psychology Press (Taylor & Francis).
- Baumeister, R.F. & Bushman, B.J. (2010). *Social psychology and human nature* (2<sup>nd</sup> ed.). Belmont, CA: Wadsworth/Cengage.
- Beck, A.T. & Rector, N.A. (2005). Cognitive approaches to schizophrenia: Theory and therapy. *Annual Review of Clinical Psychology*, 1, 577-606. doi: 10.1146/annurev.clinpsy.1.102803.144205
- Bentall, R.P., Kaney, S., & Dewey, M.E. (1991). Paranoia and social reasoning: An attribution theory analysis. *British Journal of Clinical Psychology*, 30, 13-23. Retrieved from <http://www.scopus.com/record/display.url?eid=2-s2.0-0025978988&origin=inward&txGid=05OpqkRWB3Vn0qHukNjjoB6%3a2>
- Bentall, R.P., Kinderman, P., & Kaney, S. (1994). The self, attributional processes and abnormal beliefs: Towards a model of persecutory delusions. *Behaviour Research and Therapy*, 32, 331-341. doi: 10.1016/0005-7967(94)90131-7
- Bentall, R.P. (2009). *Doctoring the mind: Why psychiatric treatments fail*. London: Allen Lane.
- Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. London: Penguin Books.
- Billig, M. (1987). *Arguing and thinking: A rhetorical approach to social psychology*. Cambridge, MA: Cambridge University Press.
- Birchwood, M., Mason, R., MacMillan, F. & Healy, J. (1993). Depression, demoralization and control over psychotic illness: A comparison of depressed and non-depressed patients with a chronic psychosis. *Psychological Medicine*, 23 (2), 387-395. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/8332655>
- Blackwood, N.J., Howard, R.J., Bentall, R.P., & Murray, R.M. (2001). Cognitive neuropsychiatric models of persecutory delusions. *The American Journal of Psychiatry*, 158 (4), 527-539. doi: 10.1176/appi.ajp.158.4.527



- Blanchard, J.J., Sayers, S.L., Collins, L.M. & Bellack, A.S. (2004). Affectivity in the problem-solving interactions of schizophrenia patients and their family members. *Schizophrenia Research*, 69 (1), 105-117. doi: 10.1016/j.schres.2003.07.008
- Blueler, E. (1950). *Dementia praecox or the group of schizophrenias*. New York: International Universities Press.
- Botella, L. (2000). *Clinical psychology, psychotherapy, and mental health: Contemporary issues and further dilemmas*. Retrieved from <http://www.massey.ac.nz/~ALock/virtual/Clinical.htm>.
- Boyle, M. (2002). *Schizophrenia: A scientific delusion?* (2<sup>nd</sup> ed.). London: Routledge.
- Boyle, M. (2004). Preventing a non existent illness? Some issues in the prevention of 'schizophrenia'. *Journal of Primary Prevention*, 24, 445-469. <http://dx.doi.org/10.1023/B:JOPP.0000024801.34886.a7>
- Bracken, P., & Thomas, P. (2001). Postpsychiatry: a new direction for mental health. *British Medical Journal*, 322, 724-727. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1119907/pdf/724.pdf>
- Breitborde, N.J.K., Lopez, S.R. & Nuechterlein, K.H. (2009). Expressed emotion, human agency, and schizophrenia: Toward a new model for the EE-Relapse association. *Cult Med Psychiatry*, 33, 41-60. doi: 10.1007/s11013-008-9119-x
- Brett-Jones, J., Garety, P.A., & Hemsley, D.R. (1987). Measuring delusional experiences: A method and its application. *British Journal of Clinical Psychology*, 26, 257-265.
- Butzlaff, R.L., & Hooley, J.M. (1998). Expressed emotion and psychiatric relapse: A meta-analysis. *Archives of General Psychiatry*, 55 (6), 547-552. Retrieved from <http://archpsyc.ama-assn.org/cgi/content/full/55/6/547>
- Carver, C.S., & Scheier, M.F. (1996). *Perspectives on personality* (3rd ed.). Boston: Allyn & Bacon.
- Ciudad, A., Alvarez, E., Bobes, J., San, L., Polavieja, P. & Gilaberte, I. (2009). Remission in schizophrenia: Results from a 1-year follow-up observational study. *Schizophrenia Research*, 108, 214-222. doi: 10.1016/j.schres.2008.12.004

- Coid, J.W. (1996). Dangerous patients with mental illness: increased risks warrant new policies, adequate resources, and appropriate legislation. *British Medical Journal*, *312*, 965-966. doi: 10.1136/bmj.312.7036.965
- Condray, R., Steinhauer, S.R., van Kammen, D.P., & Kasperek, A. (2002). The language system in schizophrenia: Effects of capacity and linguistic structure. *Schizophrenia Bulletin*, *28* (3), 475-490. Retrieved from <http://schizophreniabulletin.oxfordjournals.org/>
- Corcoran, R., Cahill, C., & Frith, C.D. (1997). The appreciation of visual jokes in people with schizophrenia: A study of 'mentalizing' ability. *Schizophrenia Research*, *24*, 319-327. doi: 10.1016/S0920-9964(96)00117-X
- Corcoran, R., Mercer, G., & Frith, C.D. (1995). Schizophrenia, symptomatology and social inference: Investigating theory of mind in people with schizophrenia. *Schizophrenia Research*, *17*, 5-13. Doi: 10.1016/0920-9964(95)00024-G
- Corrigan, P.W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work*, *52*(1), 31-39. Retrieved from <http://docserver.ingentaconnect.com/deliver/connect/nasw/00378046/v52n1/s4.pdf?expires=1328576556&id=67061846&titleid=6449&acname=The+University+of+Western+Australia-Library&checksum=2BACBD793957ED780498088078216E1F>
- Costa, P. T., & McCrae, R. R. (1985). *The NEO Personalit Inventory manual*. Odessa, FL: Consulting Psychologists Press.
- Cromby, J. & Nightingale, D.J. (1999). *Social constructionist psychology*. USA: Open University Press.
- DeLisi, L.E. (2001). Speech disorder in schizophrenia: Review of the literature and exploration of its relation to the uniquely human capacity for language. *Schizophrenia Bulletin*, *27* (3), 481-496. Retrieved from <http://schizophreniabulletin.oxfordjournals.org/content/27/3/481.full.pdf>
- Diamond, D., & Doane, J.A. (1994). Disturbed attachment and negative affective style. An intergenerational spiral. *The British Journal of Psychiatry*, *164*, 770-781. Doi: 10.1192/bjp.164.6.770

- Docherty, N.M. (1995). Linguistic reference performance in parents of schizophrenic patients. *Psychiatry*, 58 (1), 20.
- Docherty, N.M., Cutting, L.P., & Bers, S.A. (1998). Expressed emotion and differentiation of self in the relatives of stable schizophrenia outpatients. *Psychiatry*, 61, 269-278.
- Drew, P. & Heritage, J. (1992). *Talk at work: Interaction in institutional settings*. Cambridge: Cambridge University Press.
- Drew, P. & Holt, E. (1998). Figures of speech: Figurative expressions and the management of topic transition in conversation. *Language in society*, 27 (4), 495-522. Retrieved from <http://dx.doi.org/10.1017/S0047404598004035>
- Dudley, R.E.J., John, C.H., Young, A.W. & Over, D.E. (1997). Normal and abnormal reasoning in people with delusions. *British Journal of Clinical Psychology*, 36, 243-258. doi: 10.1111/j.2044-8260.1997.tb01410.x
- Edwards, D. (1991). Categories are for talking: On the cognitive and discursive bases of categorization. *Theory & Psychology*, 1(4), 515–542.
- Edwards, D. (2000). Extreme case formulations: Softeners, investment, and doing nonliteral. *Research on Language and Social Interaction*, 33 (4), 347-373. doi: 10.1207/S15327973RLSI3304\_01
- Edwards, D. & Potter, J. (1992). *Discursive psychology*. London: Sage.
- Edwards, D., & Potter, J. (2001). Discursive psychology. In A. McHoul & M. Rapley (Eds.), *How to Analyse Talk in Institutional Settings: A Casebook of Methods* (pp. 12-24). London & New York: Continuum International.
- Estroff, S.E. (1989). Self, identity, and subjective experiences of schizophrenia: In search of the subject. *Schizophrenia Bulletin*, 15 (2), 189-196.
- Fairclough, N. (2001). In A. McHoul & M. Rapley (Eds.), *How to Analyse Talk in Institutional Settings: A Casebook of Methods*. London & New York: Continuum International.

- Foster-Green, M., & Nuechterlein, K.H. (1999). Should schizophrenia be treated as a neurocognitive disorder? *Schizophrenia Bulletin*, 25 (2), 309-318. Retrieved from <http://schizophreniabulletin.oxfordjournals.org/content/25/2/309.full.pdf>
- Freeman, D., Garety, P.A., Kuipers, E., Fowler, D., & Bebbington, P.E. (2002). A cognitive model of persecutory delusions. *The British Journal of Clinical Psychology*, 41 (4), 331-344. Retrieved from [http://www.medecine.unige.ch/enseignement/apprentissage/amc/pediatric/organisation/documents/A\\_cognitive\\_model\\_of\\_persecutory\\_delusions.pdf](http://www.medecine.unige.ch/enseignement/apprentissage/amc/pediatric/organisation/documents/A_cognitive_model_of_persecutory_delusions.pdf)
- Frith, C.D. (1992). *The cognitive neuropsychology of schizophrenia*. Hove: Erlbaum.
- Frith, C.D., & Corcoran, R. (1996). Exploring theory of mind in people with schizophrenia. *Psychological Medicine*, 26, 521-530. Retrieved from [http://journals.cambridge.org/download.php?file=%2FPSM%2FPSM26\\_03%2FS0033291700035601a.pdf&code=5600864cf03cd7532cf84720c13bb8d5](http://journals.cambridge.org/download.php?file=%2FPSM%2FPSM26_03%2FS0033291700035601a.pdf&code=5600864cf03cd7532cf84720c13bb8d5)
- Garety, P.A., & Freeman, D. (1999). Cognitive approaches to Delusions: A critical review of theories and evidence. *British Journal of Clinical Psychology*, 38, 113-127. doi: 10.1348/014466599162700
- Garfinkel, H. (1967). *Studies in ethnomethodology*. Englewood Cliffs: Prentice-Hall.
- Gergen, K.J. (1981). The functions and foibles of negotiating self-conception. In M.D. Lynch, A.A. Norem-Hebeisen & K.J. Gergen (Eds.), *Self-Concept: Advances in theory and research* (pp. 59-73). Cambridge, MA: Ballinger.
- Gergen, K.J. (1985). The social constructionist movement in modern psychology. *American Psychologist*, 40 (3), 266-275.
- Gergen, K.J. (1989). Social psychology and the wrong revolution. *European Journal of Social Psychology*, 19, 463-484.
- Gergen, K.J. (1991). *The saturated self: Dilemmas of identity in contemporary life*. New York: Basic Books.
- Gergen, K.J. (1994). *Realities and relationships: Soundings in social construction*. Cambridge: Harvard University Press.

- Gergen, K. J. (1997). *Narrative, moral identity and historical consciousness: A social constructionist account*. Draft copy for an edited volume on narrative and historical consciousness, University of Bielefeld, forthcoming. Retrieved from <http://www.swarthmore.edu/SocSci/kgergen1/text3.html>.
- Gergen, K. J. (1999). *An invitation of social construction*. London: Sage.
- Gergen, K. J. (2008). Therapeutic challenges of multi-being. *Journal of Family Therapy*, 30, 335-350. doi: 10.1111/j.1467-6427.2008.00447.x
- Gergen, K. J. (2009). *Relational being: Beyond self and community*. New York: Oxford University Press.
- Gergen, K.J., McNamee, S., & Barrett, F.J. (2001). Toward transformative dialogue. *International Journal of Public Administration*, 24 (7/8), 679-707. Retrieved from [http://gul.gu.se/public/pp/public\\_courses/course39081/published/1288687110285/resourceId/15857424/content/Gergen\\_2001.pdf](http://gul.gu.se/public/pp/public_courses/course39081/published/1288687110285/resourceId/15857424/content/Gergen_2001.pdf)
- Goffman, E. (1959). *The Presentation of Self in Everyday Life*. New York: Anchor.
- Goffman, E. (1962). *Asylums. Essays on the Social Situation of Mental Patients and Other Inmates*. Chicago: Aldine Publishing Company.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. London: Penguin.
- Gonzalez-Torrez, M.A., Oraa, R., Aristegui, M., Fernandez-Rivas, A. & Guimon, J. (2007). Stigma and discrimination towards people with schizophrenia and their family members. *Social Psychiatry Psychiatric Epidemiology*, 42, 14-23. doi: 10.1007/s00127-006-0126-3
- Goodwin, V. & Happell, B. (2006). In our own words: Consumers' views on the reality of consumer participation in mental health care. *Mental Health Nursing*, 21(1), 4-13. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/16594876>
- Gottschalk, L.A., & Keatinge, C. (1993). Influence of patient caregivers on course of patient illness: Expressed emotion and alternative measures. *Journal of Clinical Psychology*, 49 (6), 898-912.

- Grant, P.M. & Beck, A.T. (2009). Evaluation sensitivity as a moderator of communication disorder in schizophrenia. *Psychological Medicine*, 39, 1211-1219. doi: 10.1017/S0033291709005479
- Gruber, J. & Kring, A.M. (2008). Narrating emotional events in schizophrenia. *Journal of Abnormal Psychology*, 117 (3), 520-533. doi: 10.1037/0021-843X.117.3.520
- Harre, R. (1993). *Social being* (2nd ed.). Oxford: Blackwell.
- Harre, R. & Gillett, G. (1994). *The discursive mind*. London: Sage Publications.
- Have, P. ten (1990). Methodological issues in conversation analysis. *Bulletin de Méthodologie Sociologique*, 27, 23-5.
- Have, P. ten (1999). *Doing conversation analysis: a practical guide*. London: Sage
- Hemsley, D.R. (1993). The development of a cognitive model of schizophrenia: Placing it in context. *Neuroscience and Biobehavioural Reviews*, 29 (6), 977-988.
- Hemsley, D.R. (1998). The disruption of the sense of self in schizophrenia: Potential links with disturbances of information processing. *British Journal of Medical Psychology*, 71, 115-124. doi: 10.1111/j.2044-8341.1998.tb01373.x/pdf
- Hemsley, D.R. (2005). The schizophrenic experience: Taken out of context? *Schizophrenia Bulletin*, 31 (1), 43-53. doi: 10.1093/schbul/sbi003
- Herold, R., Tenyi, T., Lenard, K. & Trixler, M. (2002). Theory of mind deficit in people with schizophrenia during remission. *Psychological Medicine*, 32, 1125-1129. doi: 10.1017/S0033291702005433
- Higgins, E.T. (1987). Self-discrepancy: A theory relating self and affect. *Psychological Review*, 94, 319-340.
- Hoffman, R.E., Hawkins, K.A., Gueorguieva, R., Boutros, N.N., Rachid, F., Carroll, K., & Krystal, J.H. (2003). Transcranial magnetic stimulation of left temporoparietal cortex and medication-resistant auditory hallucinations. *Archives of General Psychiatry*, 60, 49-56. Retrieved from <http://archpsyc.ama-assn.org/cgi/content/full/60/1/49>

- Hoffman, R.E., Rapaport, J., Mazure, C.M., & Quinlan, D.M. (1999). Selective speech perception alterations in schizophrenic patients reporting hallucinated voices. *American Journal of Psychiatry*, 156, 393-399. Retrieved from <http://ajp.psychiatryonline.org/article.aspx?volume=156&page=393>
- Hormuth, S. E. (1990). *The ecology of the self: Relocation and self-concept change*. Cambridge: Cambridge University Press.
- Hruby, G. G. (2001). Sociological, postmodern, and new realism perspectives in social constructionism: Implications for literacy research. *Reading Research Quarterly*, 36 (1), 48-64.  
doi: 10.1598/RRQ.36.1.3
- Human Rights & Equal Opportunity Commission (1993). *Human rights and mental illness: Report of the national inquiry into the human rights of people with mental illness* (vol. 1 & 2). Canberra: Australian Government Publishing Service.
- Hutchby, I. & Wooffitt, R. (1998). *Conversation analysis*. Cambridge: Polity Press.
- Ingleby, D. (1981). Understanding 'mental illness'. In D. Ingleby (Ed.), *The politics of mental health* (pp.23-71). Harmondsworth: Penguin.
- Jefferson, G. (1979). A technique for inviting laughter and its subsequent acceptance/declination. In G. Psathas (Ed.) *Everyday language: Studies in ethnomethodology*, (pp.79-96). New York, NY: Irvington Publishers.
- Jefferson, G. (1984). On the organisation of laughter in talk about troubles. In J.M Atkinson & J Heritage (Ed's.), *Structures of social action: Studies in conversation analysis* (pp.346-369). London: Cambridge University Press.
- Jefferson, G. (1985). An exercise in the transcription and analysis of laughter. In T. A. Van Dijk (Ed.), *Handbook of discourse analysis (vol.3): Discourse and dialogue* (pp.25-34). London, England: Academic Press Inc. Ltd.
- Jefferson, G. (1990). List-construction as a task and a resource. In G. Psathas (Ed.), *Interaction Competence* (pp. 63-92). Washington, D.C.: University Press of America.

- Jenkins, J.H., & Karno, M. (1992). The meaning of expressed emotion: Theoretical issues raised by cross-cultural research. *American Journal of Psychiatry*, *149*, 9–21. Retrieved from <http://ajp.psychiatryonline.org/article.aspx?volume=149&page=9>
- Johns, L.C., & McGuire, P.K. (1999). Verbal self-monitoring and auditory hallucinations in schizophrenia. *The Lancet*, *353*, 469-470. doi:10.1016/S0140-6736(98)05288-X
- Kean, C. (2009). Silencing the self: Schizophrenia as a self-disturbance. *Schizophrenia Bulletin*, *35* (6), 1034-1036. doi:10.1093/schbul/sbp043
- Keen, T.M. (1999). Schizophrenia: Orthodoxy and heresies. A review of alternative possibilities. *Journal of Psychiatric and Mental Health Nursing*, *6*, 415-424. Retrieved from <http://www.brown.uk.com/schizophrenia/keen.pdf>
- Kent, H. & Read, J. (1998). Measuring consumer participation in mental health services: Are attitudes related to professional orientation? *International Journal of Social Psychiatry*, *44* (4), 295-310. doi: 10.1177/002076409804400406
- Kinderman, P., & Bentall, R.P. (1997). Causal attributions in paranoia and depression: Internal, personal and situational attributions for negative events. *Journal of Abnormal Psychology*, *106*, 341-345. doi: 10.1037/0021-843X.106.2.341
- Kinderman, P., & Bentall, R.P. (2000). Self-discrepancies and causal attributions: Studies of hypothesized relationships. *The British Journal of Clinical Psychology*, *39*, 255-273. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1348/014466500163275/pdf>
- Kinderman, P., Prince, S., Waller, G., & Peters, E. (2003). Self-discrepancies, attentional bias and persecutory delusions. *British Journal of Clinical Psychology*, *42*, 1-12. doi: 10.1348/014466503762841977
- Kurtz, M.M. (2006). Symptoms versus neurocognitive skills as correlates of everyday functioning in severe mental illness. *Expert Review of Neurotherapeutics*, *6*(1), 47-56. doi:10.1586/14737175.6.1.47
- Laing, R.D. (1969). *The politics of the family and other essays*. Canada: CBC Publications: London: Pelican Books.



- Laing, R.D. (1990). *The Divided Self: An Existential Study in Sanity and Madness*. Harmondsworth: Penguin.
- Laing, R.D., & Esterson, A. (1964). *Sanity, madness and the family*. London: Tavistock Publications: London: Pelican Books.
- Langan, J. (2010). Challenging assumptions about risk factors and the role of screening for violent risk in the field of mental health. *Health, Risk & Society*, 12 (2), 85-100. doi: 10.1080/13698571003632429
- Leff, J. (1992). Over the edge: Stress and schizophrenia. *New Scientist*, 133 (1802), 30-33.
- Lefley, H.P. (1989). Family burden and family stigma in major mental illness. *American Psychologist*, 44 (3), 556-560.
- Link, B.G., Cullen, F.T., Struening, E., Shrout, P.E. & Dohrenwend, B.P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review*, 54, 400-423.
- Link, B.G., Phelan J.C., Bresnahan, M., Stueve, A. & Pescosolido, B.A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness and social distance. *American Journal of Public Health*, 89, 1328-1333. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1508784/?tool=pubmed>
- Link, B.G., Struening, E., Rahav, M., Phelan, J.C. & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behaviour*, 38 (2), 177-190. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/9212538>
- Lopez, S.R., Garcia, J.I.R., Ullman, J.B., Kopelowicz, A., Jenkins, J., Breitborde, N.J.K. & Placencia, P. (2009). Cultural variability in the manifestation of expressed emotion. *Family Process*, 48 (2), 179-194. doi: 10.1002/eat20888
- Lysaker, P.H, Bell, M., Milstein, R., Bryson, G., & Beam-Goulet, J. (1994). Insight and psychosocial treatment compliance in schizophrenia. *Psychiatry*, 57 (4), 307-312.

- Lysaker, P.H. & Hermans, H.J.M. (2007). The dialogical self in psychotherapy for person with schizophrenia: A case study. *Journal of Clinical Psychology: In Session*, 63 (2), 129-139. doi: 10.1002/jclp.20336
- Lysaker, P.H., Wickett, A.M., Campbell, K. & Buck, K.D. (2003). Movement towards coherence in the psychotherapy of schizophrenia: A method for assessing narrative transformation. *Journal of nervous and Mental Disease*, 191 (8), 538-541. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/12972857>
- Mahler, M. (1952). On Child Psychosis and Schizophrenia: Autistic and Symbiotic Infantile Psychoses. *Psychoanalytic Study of the Child*, 7, 286–305.
- Mahler, M.S. (1968). *On Human Symbiosis and the Vicissitudes of Individuation*, with M. Furer. NY: International Universities Press.
- Maines, D. R. (2000). Charting futures for sociology: Culture and meaning: The social construction of meaning. *Contemporary Sociology*, 29 (4), 577-584. Retrieved from [http://links.jstor.org/sici?sici=0094-3061\(200007\)29%3A4%3C577%3ATSCOM%3E2.0.CO%3B2-E](http://links.jstor.org/sici?sici=0094-3061(200007)29%3A4%3C577%3ATSCOM%3E2.0.CO%3B2-E)
- Markus, H. & Kunda, Z. (1986). Stability and malleability of the self-concept. *Journal of Personality and Social Psychology*, 51, 858-866.
- Markus, H. & Nurius, P. (1986). Possible selves. *American Psychologist*, 41, 954-969.
- Martin, J.K., Pescosolido, B.A. & Tuch, S.A. (2000). Of fear and loathing: The role of ‘disturbing behaviour’, labels, and causal attributions in shaping public attitudes toward people with mental illness. *Journal of Health and Social Behavior*, 41(2), 208-223.
- Mathews, G., Campbell, S.E., Falconer, S., Joyner, L.A., Huggins, J., Gilliland, K., Grier, R. & Warm, J.S. (2002). Fundamental dimensions of subjective state in performance settings: Task engagement, distress, and worry. *Emotion*, 2(4), 315-340. doi: 10.1037//1528-3542.2.4315

- Mathews, A. & MacLeod, C. (2004). Cognitive vulnerability to emotional disorders. *Annual Review of Clinical Psychology, 1*, 167-195.  
Retrieved from <http://www.annualreviews.org/doi/pdf/10.1146/annurev.clinpsy.1.102803.143916>
- Mazeland, H. & ten Have, P. (1996). Essential tensions in (semi-) open research interviews. In: I. Maso & F. Wester (Eds.), *The deliberate dialogue. Qualitative perspectives on the interview* (pp. 87-114). Brussels: VUB Press.
- McAdams, D.P. (1985). *Power, intimacy, and the life story*. New York: Guilford.
- McAdams, D.P. (2006). The role of narrative in personality psychology today. *Narrative Inquiry, 16* (1), 11-18. Retrieved from <http://www.sesp.northwestern.edu/docs/publications/1049432884490a09930cdc3.pdf>
- McCay, E., Beanlands, H., Leszcz, M., Goering, P., Seeman, M.V., Ryan, K., Johnston, N. & Vishnevsky, T. (2006). A group intervention to promote healthy self-concepts and guide recovery in first episode schizophrenia: A pilot study. *Psychiatric Rehabilitation Journal, 30* (2), 105-111. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/17076053>
- McGuire, P.K., Shah, G.M.S., & Murray, R.M. (1993). Increased blood flow in Broca's area during auditory hallucinations in schizophrenia. *The Lancet, 342*, 703-706.
- McGuire, P.K., Silbersweig, D.A., Wright, I., Murray, R.M., David, A.S., Frackowiak, R.S.J., & Frith, C.D. (1995). Abnormal monitoring of inner speech: A physiological basis for auditory hallucinations. *The Lancet, 346*, 596-600.
- Mead, G.H. (1913). The social self. *Journal of Philosophy, Psychology, and Scientific Methods, 10*, 374-380.
- Mead, G.H. (1934). *Mind, self and society*. C.W. Morris (Ed.). Chicago: University of Chicago Press.
- Mechanic, D. (1996). Changing medical organization and the erosion of trust. *Milbank Quarterly, 74* (2), 171-189. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/8632733>

- Melinder, M.R.D., & Barch, D.M. (2003). The influence of a working memory load manipulation on language production in schizophrenia. *Schizophrenia Bulletin*, 29 (3), 473-485. Retrieved from <http://schizophreniabulletin.oxfordjournals.org/content/29/3/473.abstract>
- Miklowitz, D.J., Velligan, D.I., Goldstein, M.J., Neuchterlein, K.H., Gitlin, M.J., Ranlett, G., & Doane, J.A. (1991). Communication deviance in families of schizophrenic and manic patients. *Journal of Abnormal Psychology*, 100 (2), 163-173.
- Moritz, S. & Woodward, T.S. (2007). Metacognitive training in schizophrenia: from basic research to knowledge translation and intervention. *Current Opinion in Psychiatry*, 20 (6), 619-625. Retrieved from <http://www.gjpsy.uni-goettingen.de/gjp-article-moritz3.pdf>
- Moses, T. (2010). Being treated differently: Stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Social Science & Medicine*, 70, 985-993. doi: 10.1016/socscimed.2009.12.022
- Moscovici, S. (1981). On social representations. In J. Forgas (Ed.) *Social cognition: Perspectives on everyday understanding* (pp.181-209). London: Academic Press.
- Moscovici, S. (1984). The phenomenon of social representations. In R.M. Farr & S. Moscovici (Ed's.), *Social representations* (pp.3-69). Cambridge: Cambridge University Press.
- Mouzos, J. (1999). *Homicidal Encounters: A Study of Homicide in Australia 1989-1999. Research and Public Policy Series, No. 28*, Australian Institute of Criminology, Canberra.
- Mujika-Parodi, L. R., Greenberg, T., Bilder, R. M., & Malaspina, D. (2001). *Emotional impact on logic deficits may underlie psychotic delusions in schizophrenia*. Retrieved from <http://www.hrcr.ed.ac.uk/cogsci2001/pdf-files/0669.pdf>.
- Murray, M.G. & Steffen, J.J. (1999). Attitudes of case managers toward people with serious mental illness. *Community Mental Health Journal*, 36 (6), 505-514. doi: 10.1023/A:1018707217219

- Murray-Swank, A., Glynn, S., Cohen, A.N., Sherman, M., Medoff, D.P., Fang, L.J., Drapalski, A. & Dixon, L.B. (2007). Family contact, experience of family relationships, and views about family involvement in treatment among VA consumers with serious mental illness. *Journal of Rehabilitation Research and Development*, 44 (6), 801-812. Retrieved from <http://www.rehab.research.va.gov/jour/07/44/6/Murray-Swank.html>
- Neisser, U. (1993). The self perceived. In U. Neisser (Ed.), *The perceived self: Ecological and interpersonal sources of self-knowledge* (pp.3-21). New York: Cambridge University Press.
- Neisser, U. & Jopling, D.A. (Eds.). (1997). *The conceptual self in context: Culture, experience, and self-understanding*. Cambridge: Cambridge University Press.
- Norman, R.M.G., & Malla, A.K. (1993). Stressful life events and schizophrenia 1: A review of the research. *British Journal of Psychiatry*, 162, 161-166.
- Parker, I. (1996). Discursive complexes in material culture. In J. Haworth (Ed.), *Psychological research* (pp.185-196). London: Routledge.
- Parker, I. (1998). Constructing and deconstructing psychotherapeutic discourse. *European Journal of Psychotherapy and Counselling*, 1 (1), 65-78. Retrieved from <http://dx.doi.org/10.1080/13642539808400506>
- Parsons, T. (1951). *The Social System*. Glencoe, IL: Free Press.
- Penn, D.L. (2000). Some reflections on social-cognitive research in schizophrenia. *Psychiatry*, 63 (4), 339-343. Retrieved from <http://www.psy.vanderbilt.edu/faculty/sohee/penn.htm>
- Penn, D.L., D.L., Kommana, S., Mansfield, M., Link, B.G., (1999). Dispelling the stigma of schizophrenia: II. The impact of information on dangerousness. *Schizophrenia Bulletin*, 25, 437-446. Retrieved from <http://schizophreniabulletin.oxfordjournals.org/content/25/3/437.long>

- Ronccone, R., Falloon, I.R.H., Mazza, M., De Risio, A., Pollice, R., Necozone, S., Morosini, P.L., & Casacchia, M. (2002). Is theory of mind in schizophrenia more strongly associated with clinical and social functioning than with neurocognitive deficits? *Psychopathology*, *35* (5), 280-289. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/12457019>
- Pomerantz, A.M. (1984). Agreeing and disagreeing with assessment: Some features of preferred/dispreferred turn shapes. In J. M. Atkinson & J. Heritage (Eds.), *Structure of Social Action: Studies in Conversation Analysis* (pp.57-101). Cambridge: Cambridge University Press.
- Pomerantz, A.M. (1986). Extreme Case Formulations: A Way of Legitimizing Claims. *Human Studies*, *9*, 219–30.
- Potter, J. (1996). *Representing reality: Discourse, rhetoric and social construction*. London: Sage Publications Ltd.
- Potter, J. (1998). Qualitative and discourse analysis. In A.S. Bellack & M. Hersen (Eds), *Comprehensive Clinical Psychology: Volume 3* (pp.117-144). Oxford: Pergamon.
- Potter, J. & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.
- Potter, J., Edwards, D., & Wetherell, M. (1993). A model of discourse in action. *American Behavioural Scientist*, *36*, 383-401.
- Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A. & Luty, J. (2009). A study of stigmatized attitudes towards people with mental health problems among health professionals. *Journal of Psychiatric and Mental Health Nursing*, *16*, 279-284. doi: 10.1111/j.1365-2850.2008.01369.x
- Read, J., Haslam, N., Sayce, L. & Davies, E. (2006). Prejudice and schizophrenia: a review of the ‘mental illness is an illness like any other’ approach. *Acta Psychiatr Scand*, *114*, 303-318. doi: 10.1111/j.1600-0447.2006.00824.x
- Read, J. & Law, A. (1999). The relationship of causal beliefs and contact with users of mental health services to attitudes to the ‘mentally ill’. *International Journal of Social Psychiatry*, *45*, 216-229. Retrieved from <http://isp.sagepub.com/content/45/3/216.long>

- Read, J., Mosher, L.R. & Bentall, R. (Eds.) (2004). *Models of madness: Psychological, social and biological approaches to schizophrenia*. New York: Brunner-Routledge.
- Ricoeur, P. (1984). *Time and narrative*. Chicago, IL: University of Chicago Press.
- Ritsner, M., Modai, I., Endicott, J., Rivkin, O., Nechamkin, Y., Barak, P., Goldin, V., & Ponizovsky, A. (2000). Differences in quality of life domains and psychopathologic and psychosocial factors in psychiatric patients. *Journal of Clinical Psychiatry*, 61 (11), 880-889. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/11105747>
- Roe, D. & Davidson, L. (2005). Self and narrative in schizophrenia: Time to author a new story. *Medical Humanities*, 31, 89-94. doi:10.1136/jmh.2005.000214
- Rose, N. (1994). Medicine, history and the present. In C. Jones & R. Porter (Eds.). *Reassessing Foucault: power, medicine and the body* (pp.48-72). Routledge: London,.
- Rose, N. (2007). Beyond medicalisation. *Lancet*, 369, 700-702. doi:10.1016/S0140-6736(07)60319-5
- Rosenfarb, I.S., Nuechterlein, K.H., Goldstein, M.J. & Subotnik, K.L. (2000). Neurocognitive vulnerability, interpersonal criticism, and the emergence of unusual thinking by schizophrenic patients during family transactions. *Archives of General Psychiatry*, 57, 1174-1179. Retrieved from <http://archpsyc.ama-assn.org/cgi/content/full/57/12/1174>
- Rosenfarb, S., Ventura, J., Nuechterlein, K.H., Goldstein, M.J., Snyder, K.S. & Hwang, S. (1999). Expressed emotion, appraisal and coping by patients with recent-onset schizophrenia: a pilot investigation. *Scandinavian Journal of Behaviour Therapy*, 28 (1), 3-8. doi: 10.1080/028457199440070
- Rosenfield, S. (1997). Labeling mental illness: The effects of received services and perceived stigma on life satisfaction. *American Sociological Review*, 62, 660-672. Retrieved from <http://links.jstor.org/sici?sici=0003-1224%28199708%2962%3A4%3C660%3ALMITEO%3E2.0CO%3B2-4>

- Rothbaum, F., Rosen, K., Ujiie, T., & Uchida, N. (2002). Family systems theory, attachment theory, and culture. *Family Process, 41* (3), 328-350. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/12395563>
- Rusch, N., Angermeyer, M.C. & Corrigan, P.W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry, 20*(8), 529-539. doi: 10.1016/j.eurpsy.2005.04.004
- Sacks, H. (1992). *Lectures on conversation*. G. Jefferson (Ed.). Oxford: Blackwell.
- Sadler, J.Z. (2003). Mental health II: Issues in diagnosis. In S.F. Post (Ed.) *The encyclopaedia of bioethics* (3<sup>rd</sup> ed.) (pp. 1810-1815). New York: MacMillan Reference USA.
- Sadler, J.Z. (2007). The psychiatric significance of the personal self. *Psychiatry, 70* (2), 113-129. doi: 10.1521/psyc.2007.70.2.113
- Sass, L.A. (2007). 'Schizophrenic person' or 'person with schizophrenia'? An essay on illness and the self. *Theory and Psychology, 17*, 395-420. doi: 10.1177/0959354307073152
- Scheff, T. (1966). *Being mentally ill*. Chicago: Aldine
- Scheff, T. (1999). *Biological psychiatry and labelling theory*. Academy for the Study of the Psychoanalytic Arts. Retrieved from <http://www.academyanalyticarts.org/scheff.htm>
- Scher, M.B. (1994). *Soliloquy or Psychosis? A Cultural Look at Schizophrenia*. Retrieved from <http://www.cultural.com/~strange/schizophrenia.html>
- Schegloff, E. A. & Sacks, H. (1973). Opening up closings. *Semiotica, 8*, 289-327.
- Seikkula, J. (2008). Inner and outer voices in the present moment of family and network therapy. *Journal of Family Therapy, 30* (4), 478-491. doi: 10.1111/j.1467-6427.2008.00439.x



- Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J. & Lehtinen, K. (2006). Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*, 16 (2), 214-228. Retrieved from <http://www.power2u.org/downloads/fiveyearocpsychotherapyresearch.pdf>
- Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J. & Sutela, M. (1995). Treating psychosis by means of open dialogue. In S. Friedman (Ed.) *The reflective team in action* (pp. 62-80). New York: Guilford Press.
- Seikkula, J., Arnkil, T. & Eriksson, E. (2003). Postmodern society and social networks: Open and anticipation dialogues in network meetings. *Family Process*, 42 (2), 185-203. doi: 10.1111/j.1545-5300.2003.42201.x
- Seikkula, J. & Olson, M.E. (2003). The open dialogue approach to acute psychosis: Its poetics and micropolitics. *Family Process*, 42 (3), 403-418. doi: 10.1111/j.1545-5300.2003.00403.x
- Seikkula, J., Aaltonen, J. & Alakare, B. (2000). A two year follow-up on open dialogue treatment in first episode psychosis: Need for hospitalisation and neuroleptic medication decreases. *Social and Clinical Psychiatry*, 10 (2), 20-29. Retrieved from <http://www.mindfreedom.org/kb/mental-health...open...seikkula.../file>
- Seligman, M. E. P. (1975). *Helplessness and Depression*. San Francisco: Freeman.
- Smith, D.E. (1978). 'K is mentally ill' the anatomy of a factual account. *Sociology*, 12 (1), 23-53.
- Smith, T.E., Hull, J.W., Israel, L.M., & Willson, D.F. (2000). Insight, symptoms, and neurocognition in schizophrenia and schizoaffective disorder. *Schizophrenia Bulletin*, 26 (1), 193-200. Retrieved from <http://schizophreniabulletin.oxfordjournals.org/content/26/1/193>.lon
- Strauss, J.S. (1994). The person with schizophrenia as a person 2: Approaches to the subjective and complex. *British Journal of Psychiatry*, 164, 103-107.

- Switaj, P., Wciorka, J., Smolarska-Switaj, J. & Grygiel, P. (2009). Extent and predictors of stigma experienced by patients with schizophrenia. *European Psychiatry, 24* (8), 513-520. doi: 10.1016/j.eurpsy.2009.06.003
- Tajfel, H. & Turner, J.C. (1979). An integrative theory of intergroup conflict. In W.G. Austin & S. Worchel (Ed's.), *The social psychology of intergroup relations* (pp.33-47). Monterey: Brooks-Cole.
- Torrey, E.F. (2010). Patients, clients, consumers, survivors et al: What's in a name? *Schizophrenia Bulletin*, Advanced Access (Sept 16), doi: 10.1093/schbul/sbq102
- Tsuang, M. T. & Paraone, S. V. (2000). The frustrating search for schizophrenia genes. *American Journal of Medical Genetics, 97*,1-3. doi: 10.1002/(SICI)1096-8628(200021)97:1<1::AID-AJMG1> 3.0.CO;2-P
- Tsuang, M. T., Gilbertson, M. W., & Faraone, S. V. (1991). The genetics of schizophrenia: Current knowledge and future directions. *Schizophrenia Research, 4*, 157-171.
- Turner, J.C. (1982). Towards a cognitive redefinition of the social group. In H. Tajfel (Ed.), *Social identity and intergroup relations* (pp.15-40). Cambridge, UK: Cambridge University Press.
- Turner, E. H., Matthews, A. M., Linardatos, B. S., Tell, R. A., & Rosenthal, R. (2008). Selective publication of antidepressant trials and its influence on apparent efficacy. *New England Journal of Medicine, 358* (3), 252–260. Retrieved from <http://www.nejm.org/doi/pdf/10.1056/NEJMSa065779>
- Van Os, J., Burns, T., Cavallaro, R., Leucht, S., Peuskens, J., Helldin, L., Bernardo, M., ... Kane, J.M. (2006). Standardized remission criteria in schizophrenia. *Acta Psychiatrica Scandinavica, 113*, 91-95. doi: 10.1111/j.1600-0447.2005.00659.x
- Vauth, R., Kleim, B., Wirtz, M. & Corrigan, P.W. (2007). Self-efficacy and empowerment as outcomes of self-stigmatizing and coping in schizophrenia. *Psychiatry Research, 150*, 71-80. doi: 10.1016/j.psychres.2006.07.005

- Verkuyten, M. (2001). Personhood and Accounting for Racism in Conversation. *Journal for the Theory of Social Behaviour* 28 (2), 147-167. doi: 10.1111/1468-5914.00068
- Watson, A.C., Corrigan, P., Larson, J.E. & Sells, M. (2007). Self-stigma in people with mental illness. *Schizophrenia Bulletin*, 33(6), 1312-1318. doi: 10.1093/schbul/sbl076
- Weeks, W. & Quinn, M. (2000). *Issues facing Australian families: Human services respond* (3<sup>rd</sup> ed.). Sydney, NSW: Pearson Education Australia Pty Limited.
- Wegner, D. M., & Vallacher, R. R. (Eds.). (1980). *The self in social psychology*. New York: Oxford University Press.
- Williams, C.C., & Collins, A.A. (2002). The social construction of disability in schizophrenia. *Qualitative Health Research*, 12 (3), 297-309. doi: 10.1177/104973202129119900
- Wooffitt, R. (1992). *Telling Tales of the Unexpected: The Organisation of Factual Discourse*. Hemel Hempstead: Harvester.
- Wooffitt, R. (2001). Raising the Dead: Reported Speech in Medium-Sitter Interaction. *Discourse Studies*, 3 (3), 351-374. doi: 10.1177/1461445601003003005
- Wrobel, J. (1989). *Language and schizophrenia*. Philadelphia: John Benjamins Publishing.

## APPENDICES

## APPENDIX A

### Manager Approach Protocol

#### Outline of Study and Procedures:

Managers of services who assist people with mental health issues will be approached through an introductory letter. This letter will outline the study that I wish to conduct, and ask for an appointment to talk with the manager in person. In person, I will go into more detail regarding the study and ask their permission to talk with their clients, clients' families and friends, and support staff. They will be shown the handout that I intend to give to people, the demographic information that I require, and the questions that I intend to ask participants.

I feel that it is important to involve managers in this process, as they will need to know of anything that may directly affect clients. They know the clients very well, and will also be able to advise me on current issues relating to specific people who wish to participate in my study. These may be small nuances such as a person feeling off colour that day or larger issues such as a major event recently occurring in the person's life. This will prevent any misunderstandings taking place throughout the data gathering process. Finally, they will be better able to advise with the co-ordination of interviews, so as not to interrupt the daily routine of participants.

Informed Consent:

I will tell managers that I will only be involving people aged 18 years or over, and they must be able to give informed consent. All participants will be asked to sign a written consent form. Those people who are receiving heavy doses of medication will not be approached to participate in this study.

Confidentiality and Extreme Circumstances:

The conversations will be electronically recorded, and I will also request that these be conducted in a private area on the service provider's premises. This will ensure confidentiality, a familiar surrounding for people, and safety for both the participants and myself as qualified people who usually assist them will be available should anything out of the ordinary occur.

It will be made clear to managers that all information obtained throughout the study will be strictly confidential. Only in extreme circumstances, such as a person disclosing suicidal thoughts or the intention to harm another person, will information be fed back to the support worker. Under no circumstances will anything that a person (client, support worker, or friend or family member) says to me be fed back to staff, families or friends.

Non-Clinical Nature of the Study:

We will then discuss the exact protocol that I will use when talking to people. I will indicate the importance of a relational approach to the study in that I am not necessarily concentrating only on individuals. Rather, I am investigating the relationships between people, which entails talking to the person with a psychiatric diagnosis and those in their immediate surroundings.

The conversations that I will engage people in are NOT clinically based and will not require formal clinical training. The questions do not involve specific information regarding a particular disorder to be revealed. For example, I will NOT be asking people about delusional beliefs that they may have had or hallucinations such as hearing voices. However, the questions that I will ask do require understanding and empathy from myself, and through my work with people with disabilities, I do believe that I possess these qualities.

Further to this, I will also make it clear that my conversations with participants are not advocating any kind of treatment. All participants will be functioning members of society, who live and participate within the community.

Participant Handout and Coercion:

I will ask managers to give potential participants the handout on my behalf, describing the study that I wish to conduct. I would then ask the managers if they could inquire with their clients as to whether they would like to participate in the study. I will make it clear that I do not wish for people to be coerced into participating. The decision must be entirely theirs. Consequently, if people are unsure and would like to think about it some more, I am quite happy for them to take the handout home and make their decision at a later date. Paramount to this, I will obtain the manager's assurance that if a person refuses to participate, this will not affect the assistance that the service provides them with in any way. Managers will be aware that once a person decides that they would like to talk to me, I will ask them if I could also approach that person's support workers, family members and friends to participate in the study. Of course, they may not wish for me to talk to certain people and these wishes will be taken into account.

Feedback of Results:

Managers will be advised that if they would like a general outline of the results of my study, I would be happy to keep a record of their name and organization and send this to them after the completion of the study. The managers will be thanked for their time and assistance and will be kept informed of any issues that may arise (both during the study and after the results have been collated).



## APPENDIX B

### Letter to Managers



**Murdoch**  
UNIVERSITY

Hi. Thank you for taking the time to read this. My name is Sue Stanley and I am a PhD student at Murdoch University. I would appreciate any time that you could spare to assist me with my research.

#### Aims:

My study proposes a relational approach in assessing the beliefs and experiences surrounding people who have been given a primary diagnosis of schizophrenia in Western Australia. This will be achieved by outlining how clients identify themselves and their responses to this self identity. It will also incorporate those views and responses of people closest to the person such as family members, friends, and support workers. Negative views of the self will then be investigated to see how they manifest in the overall well-being of the client.

#### Methodology:

I have developed a semi-structured interview and wish to conduct one-on-one, recorded conversations with - a) the person who has been given the diagnosis; b) family members and close friends of that person, and; c) support workers, both professional and non-professional. This relational approach will allow for a greater overall understanding of both the person and the situation. I will request that the conversations with clients be conducted on your premises in a private area. This will ensure comfort, confidentiality, and safety for all concerned. All information given during the conversations will be strictly confidential and no names or any other personal identifiers will be used in any publication arising from the research.

I wish to take an holistic approach to these issues, talking to services that deal specifically with people with psychiatric disabilities, but also with those services that assist people with disabilities across the board. I would appreciate any feedback that you may be able to give me on this project as I believe that you have a unique outlook on these issues. If it is convenient with you, I would like to make an appointment to further discuss this in person. If you have any questions about this project please feel free to contact either myself or my supervisors:

Susanne Stanley                      Murdoch University – 042 264 1800  
[sstanley@central.murdoch.edu.au](mailto:sstanley@central.murdoch.edu.au)

Dr. Ngaire Donaghue                Murdoch University – 9360 6450

Dr. Pia Broderick                      Murdoch University – 9360 2860

Alternatively, you can contact Murdoch University's Human Research Ethics Committee on 9360 6677, or the Chairman of the Fremantle Hospital & Health Services Human Research Ethics Committee on 9431 2929 should you have any other concerns. Thank you.

## APPENDIX C

### General Handout



**Murdoch**  
UNIVERSITY

Hi. Thank you for taking time to read this. My name is Sue Stanley and I am a PhD student at Murdoch University. I would appreciate any time that you could spare to assist with my research.

My research examines how people see themselves (how they would describe themselves), both now and before they started experiencing the problems they currently have, and asking about past experiences that people have had. I believe that it is very important to know how people feel about themselves, and to ask them directly rather relying too heavily upon expert opinion. I would also like to talk to friends and family members, along with the support workers who assist people who are having difficulties. As a participant, this would give you the opportunity to voice your opinions and be heard, enabling a broader understanding of the issues that you face and the situation that you are currently in. Your participation is entirely voluntary, and you may change your mind at any stage.

What I require is about an hour of your time to be able to sit down and talk to you about how you feel and how you see others. This will be done on the premises of one of the services that assists you, in an area that you feel comfortable with and that will give us some privacy. Our conversation will be recorded, and this will be kept strictly confidential. Only in extreme circumstances, such as a person disclosing suicidal thoughts or the intention to harm another person, will information be fed back to your professional support worker. Under no circumstances will anything else that a person (client, support worker, or friend or family member) says to me be fed back to staff, families or friends. The only other people who may hear the tapes are my two supervisors, who will also keep the information that you give in confidence. No full names or any other identifying material will be given to anyone or used in any publication arising from this research. There are some basic background questions that I also need to ask such as age and general diagnosis, which is simply for data comparison purposes. Your participation will not affect any support that you currently receive from services, as this research is completely independent from those services.

I would appreciate any help that you may be able to give me with my research. If you would like to participate in this study, could you please inform the manager of your current service. The manager will notify me, and we can all decide upon a time and day that is convenient for you.

If you have any questions about this project please feel free to contact either myself or my supervisors:

|                     |   |
|---------------------|---|
| Susanne Stanley     | Murdoch University – 042 264 1800<br><a href="mailto:ssstanley@central.murdoch.edu.au">ssstanley@central.murdoch.edu.au</a> |
| Dr. Ngaire Donaghue | Murdoch University – 9360 6450  |
| Dr. Pia Broderick   | Murdoch University – 9360 2860  |

Alternatively you can contact Murdoch University's Human Research Ethics Committee on 9360 6677, or the Chairman of the Fremantle Hospital & Health Service Human Research Ethics Committee on 9431 2929.

Thank you

## APPENDIX D

### Consent Form



**Murdoch**  
UNIVERSITY

Hi. Thank you for taking the time to read this. My name is Sue Stanley and I am a PhD student at Murdoch University. I would appreciate any time that you could spare to assist me with my research.

My research is examining how people see themselves (how they would describe themselves), both now and before they started experiencing the problems they currently have, and asking about past experiences that people have had. I believe that it is very important to know how people feel about themselves, and to ask them directly rather relying too heavily upon expert opinion. I would also like to talk to friends and family members, along with the support workers who assist people who are having difficulties. As a participant, this would give you the opportunity to voice your opinions and be heard, enabling a broader understanding of the issues that you face and the situation that you are currently in. Your participation is entirely voluntary, and you may change your mind at any stage.

What I require is about an hour of your time to be able to sit down and talk to you about how you feel and how you see others. This will be done on the premises of one of the services that assists people, in an area that you feel comfortable with and that will give us some privacy. The conversation that we have will be recorded, and all information that you give me will be kept strictly confidential. Only in extreme circumstances, such as a person disclosing suicidal thoughts or the intention to harm another person, will information be fed back to management. Under no circumstances will anything that a person (client, support worker, or friend or family member) says to me be fed back to staff, families or friends. The only other people who may hear the tapes are my two supervisors, who will also keep the information that you give in confidence. No full names or any other identifying material will given to anyone or used in any publication arising from this research. There are some basic background questions that I also need to ask such as age and general diagnosis, which is simply for data comparison purposes. Your participation will not affect any support that you currently receive from services, as this research is completely independent from those services. If you have any questions about this project please feel free to contact either myself or my supervisors:

|                     |   |
|---------------------|---|
| Susanne Stanley     | Murdoch University – 042 264 1800<br><a href="mailto:sstanley@central.murdoch.edu.au">sstanley@central.murdoch.edu.au</a> |
| Dr. Ngaire Donaghue | Murdoch University – 9360 6450  |
| Dr. Pia Broderick   | Murdoch University – 9360 2860  |

Alternatively you can contact Murdoch University's Human Research Ethics Committee on 9360 6677, or the Chairman of the Fremantle Hospital & Health Service Human Research Ethics Committee on 9431 2929.

Thank You.

## Consent Form

I (the participant) have read the information above. Any questions I have asked have been answered to my satisfaction. I agree to take part in this activity, however, I know that I may change my mind and stop at any time without prejudice to any future assistance the service provides me with.

I am 18 years old or over.

I understand that all information provided is treated as confidential and will not be released by the investigator unless required to do so by law.

I agree for this interview to be electronically recorded.

I agree that research data gathered for this study may be published provided my name or other information which might identify me is not used.

Participant/Authorised Representative: \_\_\_\_\_

Date: \_\_\_\_\_

Investigator: \_\_\_\_\_

Date: \_\_\_\_\_

## APPENDIX E

### Demographics – Primary Participant

Below are a few questions about yourself that are necessary for evaluating the information that I receive. These questions are quite general and will not specifically identify you from other people who decide to participate in this study.

Please answer all questions by ticking the appropriate box.

1. Age:
 

|                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 18-27                    | 28-37                    | 38-47                    | 48-57                    | 58+                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
  
2. Gender:
 

|                          |                          |
|--------------------------|--------------------------|
| Female                   | Male                     |
| <input type="checkbox"/> | <input type="checkbox"/> |
  
3. Ethnicity:
 

|                          |                           |                          |
|--------------------------|---------------------------|--------------------------|
| Anglo Australian         | Aboriginal/TSI Australian | Other                    |
| <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |

If you have ticked other, please specify your country of birth

\_\_\_\_\_

4. Types of services that you receive assistance from:  
(You may tick more than one):
 

|                          |                          |                              |                          |
|--------------------------|--------------------------|------------------------------|--------------------------|
| Recreation               | Employment               | Housing and<br>Accommodation | Other                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> |
- If you have ticked other, please specify the type of service
- \_\_\_\_\_
5. Have you been diagnosed with any Secondary Disorders?  
(You may tick more than one):
 

|                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Substance-Related        | Mood                     | Anxiety                  | Personality              | Other                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If you have ticked other, please specify the type of disorder

\_\_\_\_\_

6. Who do you currently live with?

Live Alone

Parents

Relatives

Friend/s

7. What is your marital status?

Single

Married

De-facto

8. Do you have any children?

Yes

No

If you have ticked yes, please specify how many children you have

\_\_\_\_\_

9. What is your current work status?

F/Time

Casual

P/Time

Unemployed

10. How would you describe your health in general?

Excellent

Good

Fair

Poor

## Demographics – Family Member/Friend

Below are a few questions about yourself that are necessary for evaluating the information that I receive. These questions are quite general and will not specifically identify you from other people who decide to participate in this study.

Please answer all questions by ticking the appropriate box.

1. Age:
 

|                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 18-27                    | 28-37                    | 38-47                    | 48-57                    | 58+                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
  
2. Gender:
 

|                          |                          |
|--------------------------|--------------------------|
| Female                   | Male                     |
| <input type="checkbox"/> | <input type="checkbox"/> |
  
3. Ethnicity:
 

|                          |                           |                          |
|--------------------------|---------------------------|--------------------------|
| Anglo Australian         | Aboriginal/TSI Australian | Other                    |
| <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |

If you have ticked other, please specify your country of birth

\_\_\_\_\_

4. Types of services that your family member/friend receives assistance from: (You may tick more than one):
 

|                          |                          |                              |                          |
|--------------------------|--------------------------|------------------------------|--------------------------|
| Recreation               | Employment               | Housing and<br>Accommodation | Other                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> |

If you have ticked other, please specify the type of service

\_\_\_\_\_

5. Has your family member/friend been diagnosed with any Secondary Disorders?
 

If no, then leave blank. If yes, then you may tick more than one box.

|                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Substance-Related        | Mood                     | Anxiety                  | Personality              | Other                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If you have ticked other, please specify the type of disorder

\_\_\_\_\_

6. What is your relationship to the person?

|                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Mother                   | Father                   | Sister                   | Brother                  | Other                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If you have ticked other, please specify your relationship

\_\_\_\_\_

7. Who does your family member/friend currently live with?

|                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Lives Alone              | Parents                  | Relatives                | Friend/s                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

8. What is your marital status?

|                          |                          |                          |
|--------------------------|--------------------------|--------------------------|
| Single                   | Married                  | De-facto                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

9. Do you have any children?

|                          |                          |
|--------------------------|--------------------------|
| Yes                      | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> |

If you have ticked yes, please specify how many children you have

\_\_\_\_\_

10. What is your current work status?

|                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| F/Time                   | Casual                   | P/Time                   | Unemployed               | Other                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If you have ticked Other, please specify

\_\_\_\_\_

11. How would you describe your health in general?

|                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Excellent                | Good                     | Fair                     | Poor                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

12. How would you describe the general health of your friend/family member?

|                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Excellent                | Good                     | Fair                     | Poor                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



## Demographics – Support Worker

Below are a few questions about yourself that are necessary for evaluating the information that I receive. These questions are quite general and will not specifically identify you from other people who decide to participate in this study.

Please answer all questions by ticking the appropriate box.

1. Age:
 

|                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 18-27                    | 28-37                    | 38-47                    | 48-57                    | 58+                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
  
2. Gender:
 

|                          |                          |
|--------------------------|--------------------------|
| Female                   | Male                     |
| <input type="checkbox"/> | <input type="checkbox"/> |
  
3. Ethnicity:
 

|                          |                           |                          |
|--------------------------|---------------------------|--------------------------|
| Anglo Australian         | Aboriginal/TSI Australian | Other                    |
| <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |

If you have ticked other, please specify your country of birth  
\_\_\_\_\_
  
4. Type of service that you are working for. (You may tick more than one):
 

|                          |                          |                              |                          |
|--------------------------|--------------------------|------------------------------|--------------------------|
| Recreation               | Employment               | Housing and<br>Accommodation | Other                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> |

If you have ticked other, please specify the type of service  
\_\_\_\_\_
  
5. Years working in this field:
 

|                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Less than 1              | 1-2yrs                   | 2-5yrs                   | 5yrs+                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
  
6. Education:
 

|                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Yr 12                    | TAFE Diploma/Certificate | University Degree        | Other                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If you have ticked other, please specify\_\_\_\_\_

7. Who does the person that you are supporting currently live with?
- |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Lives Alone              | Parents                  | Relatives                | Friend/s                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

8. What is your marital status?
- |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|
| Single                   | Married                  | De-facto                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

9. Do you have any children?
- |                          |                          |
|--------------------------|--------------------------|
| Yes                      | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> |

If you have ticked yes, please specify how many children you have

\_\_\_\_\_

10. What is your current work status?
- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| F/Time                   | Casual                   | P/Time                   | Unemployed               | Other                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If you have ticked Other, please specify

\_\_\_\_\_

11. How would you describe your health in general?
- |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Excellent                | Good                     | Fair                     | Poor                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

12. How would you describe the general health of the person that you assist?
- |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Excellent                | Good                     | Fair                     | Poor                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## APPENDIX F

### Interview Questions

|                    |
|--------------------|
| <b>SELF SURVEY</b> |
|--------------------|

#### **Beliefs of Self:**

1. Many different terms are used to describe people with mental health concerns such as clients, consumers, service users. What do you prefer, or what would be a more appropriate term to use?
2. How would you generally describe yourself as a person?
3. How would you describe yourself before your problems began?

#### **Well-Being**

4. Could you tell me how you felt about your life before you started having problems?
5. How do you generally feel about yourself now? Today?  
Your future?

#### **Experiences**

6. Could you tell me about things that you do now that you didn't do before you started having problems?

#### **Beliefs of Others Beliefs of Self:**

7. How do you think your friends/family would describe you in general?
8. How do you think the support staff would describe you in general?
9. Is there any difference between professional and non-professional support staff in the way that they see you as a person?  
- What sort of differences do you think there might be?

#### **Well-Being**

10. How do you think that your friends/family might see your life now as compared to before your problems began?

#### **Experiences**

11. Is there anything else that you can tell me about your experiences since you started to have problems?

**Beliefs of Others:**

12. Could you tell me about your family/friends?
13. In what ways might your family/friends influence how you see yourself?
14. How would you describe the support staff that you deal with?
15. In what ways might the support staff influence how you see yourself?
16. Is there any difference between professional and non-professional support staff?
  - Could you tell me what that difference might be?
  - In what ways are they the same?
17. Could you tell me how your family or friends may have changed since your problems began?

**Well-Being**

18. How do you feel about your family/friends in general?
19. How do you feel about the support workers that assist you in general?

**Experiences**

20. Could you tell me how your family or friends behaviour towards you may have changed since your problems began?
21. Could you tell me how the support workers that you deal with behave towards you?
22. How do you feel about the questions that I've asked you today?

|                              |
|------------------------------|
| <b>FAMILY/FRIENDS SURVEY</b> |
|------------------------------|

**Beliefs of Self:**

1. Many different terms are used to describe people with mental health concerns such as clients, consumers, service users. What do you prefer, or what would be a more appropriate term to use?
2. How would you generally describe yourself as a person?
3. How would you see yourself differently if \_\_\_\_\_ did not have these problems?

**Well-Being**

4. How did you feel about your life before \_\_\_\_\_ started having problems?
5. How do you generally feel about yourself? Today?  
Your future?

**Experiences**

6. Could you tell me about things that you do now that you didn't do before \_\_\_\_\_ started having problems?

**Beliefs of Others Beliefs of Self:**

7. How do you think \_\_\_\_\_ would describe you in general?
8. How do you think the support staff would describe you in general?

**Experiences**

9. Is there anything else that you can tell me about \_\_\_\_\_'s experiences since he/she began having problems?
10. Is there anything else that you can tell me about the experiences that you have had since \_\_\_\_\_ began having problems?

**Beliefs About Primary Participant/Support Workers:**

11. How would you describe \_\_\_\_\_?
12. How do you think that he/she would describe himself/herself?
13. Could you tell me in what ways \_\_\_\_\_ may have changed since he/she began having problems?
14. How would you describe \_\_\_\_\_'s support workers?
15. Do you think that there is any difference between the professional and non-professional support staff in the way that they see \_\_\_\_\_?
  - Could you tell me what that difference might be?
  - In what ways are they the same?

**Well-Being**

16. How do you think \_\_\_\_\_ feels about his/her life in general? His/her future?

**Experiences**

17. Does \_\_\_\_\_ act differently toward you now as compared to before his/her problems started occurring?  
- Could you give me an example of this?
18. How do you feel about the way in which \_\_\_\_\_'s support workers behave towards him/her?
19. How do you feel about the questions that I've asked you today?

|                             |
|-----------------------------|
| <b>SUPPORT STAFF SURVEY</b> |
|-----------------------------|

**Beliefs of Self:**

1. Many different terms are used to describe people with mental health concerns such as clients, consumers, service users. What do you prefer, or what would be a more appropriate term to use?
2. How would you generally describe yourself as a person?
3. How do you think that you would see yourself differently if you had chosen another occupation?

**Well-Being**

4. How do you generally feel about yourself? Today?  
Your future?

**Experiences**

5. Could you tell me about the things that you do now that you didn't do before you started working in this area?

**Beliefs of Others Beliefs of Self:**

6. How do you think \_\_\_\_\_ would describe you?
7. How do you think other support staff would describe you?
8. How do you think that \_\_\_\_\_'s family/friends would describe you?

**Experiences**

9. Is there anything else that you can tell me about the experiences that \_\_\_\_\_ has had since you have known him/her?

**Beliefs About Primary Participants/Primary Participants' Friends/Family Members/Fellow Support Workers:**

10. How would you describe \_\_\_\_\_?
11. How do you think that he/she would describe himself/herself?
12. How would you describe \_\_\_\_\_'s friends/family?
13. How do you think that they would describe \_\_\_\_\_?
14. How would you describe \_\_\_\_\_'s other support workers?
15. Do you think that there is any difference between the professional and non-professional support staff in the way that they see \_\_\_\_\_?
  - Could you tell me what that difference might be?
  - In what ways are they the same?

**Well-Being**

12. How do you think \_\_\_\_\_ feels about his/her life in general?
13. How do you think that \_\_\_\_\_'s family/friends see his/her life?

**Experiences**

14. Could you tell me how \_\_\_\_\_ behaves toward you?
15. Could you tell me how \_\_\_\_\_ behaves toward his/her family/friends?
16. How do you feel about the questions that I've asked you today?



## APPENDIX G

### Participant Approach Protocol

There will be two stages concerning the approach of participants in this study. In the first stage, primary participants will receive the general handout from the manager of a service that assists them, and initial consent for participation in the study will be obtained. The second stage will deal with the one-on-one recorded conversations that I will have with participants. Participants will be able to change their minds in regard to their involvement at any stage of this process. Protocol for friends and family members will necessarily follow that of primary participants in regard to stage two.

#### STAGE 1:

##### Manager Assistance:

People who have been given a primary diagnosis of schizophrenia will receive a handout from the manager of an organisation that they receive assistance from. The manager will explain the study to them and obtain consent to participate. People will be told that the conversation will be electronically recorded, that they will be required to sign a consent form, and that I also wish to speak with friends and family members of theirs along with support workers who are currently assisting them. If they do not wish for me to talk to any particular person, their request will be respected.

People will also be advised that our conversation will be strictly confidential and private. No identifying names will be used in the transcriptions, the

conversations that we will have will be on a first name basis only, and the only people who may listen to the recordings will be my two supervisors at Murdoch University. They will be assured that any information that they give me will not be passed on to others, except in extreme circumstances (which will be elaborated upon with them). They will be advised that they are free to refuse and that this would not affect any assistance or treatment that they (or their relatives or friends) may be receiving from the service provider. If the person agrees to speak with me, we (along with the manager) will organise a time that is suitable for the both of us to meet.

People will always have a choice in this process, and managers will be asked not to coerce people into participating. People will also have the option of taking the handout home to think about it some more. No one will be pressured into making an 'on the spot' decision. Alternatively, I may be on the service provider's premises at the time the handouts are dispersed. In this case, I will speak to those people interested in participating in the study in person.

## STAGE 2:

### Semi-Structured Interviews:

Participants will, once again, be advised that their involvement in the study is entirely voluntary. If they agree to continue, they will be informed that they may stop our conversation at any time and if they say anything that they do not wish to appear on the transcribed documents, I will respect their wishes. A consent form will be shown and explained to participants, with their signature being obtained before any conversations are recorded. It is

possible, however, that a negative event that a person may have experienced (or are presently experiencing) may have emanated from the service provider that they are currently with. This may make people quite hesitant to provide any kind of identifying material. Therefore, to respect the privacy of individuals, they will be informed that the consent form that they have signed will be stored separately from the recorded interview. Further, if people become distressed at any time during the conversation, the interview will be terminated immediately with the appropriate people being informed. All due care and concern will be given to participants.

#### Friends, Relatives and Support Workers:

As previously stated, relatives, friends and support workers of the person will be approached to participate in the study also. As with the client approach, this will be entirely voluntary. During Stage 2 of the approach protocol, I will ask primary participants to give their friends and family members a copy of the General Handout. At this point, they will have the opportunity to express any concerns that they may have with my talking to specific people. Initial contact will be made over the phone with a full explanation of the study given. They will also receive the General Handout before any conversation is recorded in order for them to be properly informed of the study.

Support workers will be approached through the manager of the service that they work for, with the General Handout being provided to them. Again, people will be assured of strict confidentiality, with protocol necessarily

following that of primary participants in that they will be given ample opportunity to refuse participation.

Feedback of Results:

Participants will be advised that if they would like a general outline of the results of the study (written in lay terms), I would be happy to keep a record of their name and contact details and send this to them after the completion of the study. These details will be stored separately from any data collected. The participants will be thanked for their time and assistance.

## APPENDIX H

### Transcription Conventions

Adaptation of Jeffersonian Transcription Conventions (Antaki, Billig, Edwards & Potter, 2002, p.16; Jefferson, 1985; Potter, 1996, p.233-234).

|                   |  |
|-------------------|--|
| <u>walked out</u> | Underlining indicates words or parts of words which are stressed by the speaker  |
| the::n            | Colons marked by the prolongation of the sound immediately before; more colons would show a longer prolongation (Ah:::).                     |
| ↑ <u>O</u> ka↓y   | Arrows precede marked rises and falls in intonation  |
| ?                 | The question mark indicates a questioning intonation (there is no necessary correspondence with utterances participants treat as questions). |
| .                 | The full stop marks a completing intonation (not necessarily a grammatical full stop).   |
| ,                 | The comma marks a continuing intonation (not necessarily a grammatical comma).   |
| cu-               | A dash marks a noticeable and abrupt termination of a word or sound.   |
| [yeah]<br>[yeah]  | The square brackets mark the onset and completion of overlapping talk.   |
| run=on            | Where one turn runs into another with no interval this is marked by an equals symbol.  |
| (0.5)             | Numbers in brackets are the times of pauses in tenths of a second.   |
| (.)               | A just noticeable pause which is hearable but too short to measure.  |
| ◦yeh◦             | Talk that is quieter than the surrounding talk is enclosed by degree symbols.  |
| WHERE             | Talk that is louder than the surrounding talk is capitalised.  |
| →                 | Arrows in the margins simply pick out lines of transcript for discussion in text.  |

|            |  |
|------------|--|
| (like)     | Where the transcriber is doubtful of a word or phrase it will be placed in parenthesis; if no guess is plausible these parentheses are left empty. |
| ((laughs)) | Clarifactory comment is placed in double parentheses.  |
| [...]      | Where material from tape has been omitted for reasons of brevity this is indicated by square brackets around three full stops.                     |
| >fast<     | Talk noticeably quicker than the surrounding talk.   |
| wo(h)rd    | 'Laughter' within words.   |
| (tch)      | clicking your tongue.  |

The code at the end of the transcription provides a range of information such as who is talking and what section of the transcript it comes from.