UNCOMMON LIVES

AN ETHNOGRAPHY OF SCHIZOPHRENIA AS EXTRAORDINARY EXPERIENCE

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DECLARATION

This dissertation contains no material which has been submitted or accepted for the award of any other degree or diploma in a university or other tertiary institution. To the best of my knowledge and belief, the dissertation contains no material previously published or written by another person, except where due reference has been made in the text. I consent to this document being made available for loan and photocopying when deposited in the university library.

Rodney H. Lucas

SYNOPSIS

This dissertation is an ethnographic account of what it is to live in the suburbs of an Australian capital city having had the extraordinary experiences which are diagnosed as schizophrenia. My ethnography is presented from the point of view of people's own homes in a 'deinstitutionalized' mental health setting. It is principally concerned with the meanings attached to such being 'at home', and with its practical consequences for the conduct of daily life. I demonstrate that with private homes as the locus of everyday activities and experiences, people diagnosed with schizophrenia had a specific facility which enabled them to evade dominant institutions and to construct counter-hegemonic understandings of, and ways of living with, schizophrenia. The home thus manifested an essential contradiction: it was constituted as part of a field of psychiatric institutions, at the same time as it facilitated an escape from those forces. This same contradiction was evident in public discourses, such as a national media campaign which simultaneously established and erased the distinctiveness of people diagnosed with a mental illness: these were people who, because of past discrimination, were deserving of special attention, the point of such attention being that they should be treated as no different from anybody else. People's lives were encircled by such contradictory propositions concerning sameness and difference, freedom and constraint, identity and dissimulation. They worked within these contradictions to build identities for themselves and construct meanings for their lives.

With this dissertation I seek to have my informants speak of and through their experiences, both of schizophrenia and its consequences. I examine what that speaking meant methodologically, as a vehicle of our relationship, and as a focus of their relationships with others (including psychiatrists). I also explore how the category 'experience' was itself constituted for those people with whom I worked. In particular, I set out the experiential and social predicaments which rendered the experience of schizophrenia extraordinary. The emphasis on, and reification of, experience is shown to be a specific effect of people's biographies, and of their ongoing social circumstances. I argue that this focus on experience, its genesis, and sustenance rendered people who were diagnosed with schizophrenia quintessentially reflexive. Thus, my ethnography accords the diverse individuals who were participants in this research the ability to reflect critically on their experiences and on their social worlds, just as it sets out the forces which facilitated, even demanded, that reflexivity. In broadest terms, then, the dissertation is concerned with a specific type of selfhood which was rendered distinctive by its emphasis on experience, and with the social conditions which made that self knowable. In this context, schizophrenia serves as a particularly apt case study in the limits and possibilities of intersubjectivity which I explore here as the capacity to render experience meaningful to both self and others.

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ACKNOWLEDGEMENTS

I want to thank, firstly, all of those people who participated in the research on which this dissertation is based. I remain astounded and humbled by their willingness to let me into their homes, and deeply appreciative of the commitment they made to sharing aspects their everyday worlds and teaching me about themselves. I hope there will yet be an opportunity to make their stories known in a less esoteric form than an academic thesis, and thereby repay the trust they put in me to convey their concerns, their insights, and their extraordinary lives to a wider audience. Some participants wished me to use their own names, but pseudonyms are employed throughout the text to protect the identity of others.

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Dr Dawn Ryan, my first supervisor, mentor and friend, died unexpectedly as I was finishing this work. I regret that she did not see it completed. In her teaching, and by example, Dawn insisted on the absolute grounding of anthropological analysis in intensive and personally challenging fieldwork. I hope that this dissertation honours her memory and does justice to her teaching.

Finally, I dedicate this dissertation to Sionne, much of whose young life has been compromised on its behalf; I hope in time she will come to understand its need and value.

INTRODUCTION

INTRODUCTION

A weak winter sun was almost warming through the plate glass window of an elegantly appointed city cafe. The gleaming expresso machines hummed and frothed. Megan and I were meeting with Wynn.[1] We always enjoyed each other's company. Wyn was an excellent raconteur and we talked and laughed for hours, buying just enough coffees to dispel what we imagined might be the concerns of the cafe management. Wynn reflected on what she had gleaned of 'youth culture' from being in a classroom for several days. She regaled us with details of her son's new job and new girlfriend. She was pleased that, at age twenty-two, he was becoming a 'responsible' adult. We gossiped about her own new lover.

Wynn had the afternoon free, having that morning finished a brief period of teaching. In a week's time she was travelling interstate for the national meeting of a government advisory body on mental health. Megan and I were revelling in the escape from our small offices in the Department of Psychiatry, where the tasks of tape transcription, 'writing up' and tracking down new participants seemed never ending.[2] Each of us was savouring the luxury of this time out from our busy schedules. The frivolity of this meeting was in marked contrast to a previous afternoon spent together in Wynn's suburban lounge room.

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[1] The name of each participant has been changed and some identifying information has been modified so as to conceal individual identities. Throughout the dissertation I provide contextual information pertinent to how we came to know and work with these participants. In this way I have sought to avoid reifying their status as clinical cases of schizophrenia. Thus, I selectively present aspects of their lives which were relevant to the relationships which developed between us.

[2] To avoid prejudging the connotations associated with terms such as 'patient', 'client', 'consumer', 'subject' or 'informant', and to convey people's active role in the research process, I use the term 'participant' throughout this dissertation. See also Chapter 4 on the contextual and strategic role of these various designations.

On that occasion she had become 'dizzy' and distressed while "translating", as she called it, a psychotic experience of having her body controlled by the movement of other people's feet.

I begin with these two contrasting interactions because they illustrate much of what I came to understand by being with people diagnosed with schizophrenia. Firstly, that we could interact in perfectly ordinary ways in a range of everyday settings, talking, laughing, gossiping and watching television together. Secondly, that were times and places when these people were compelled to talk about the most remarkable, difficult and ineffable experiences as a way of disclosing what they insisted was 'really' real about themselves and their situations. Most participants in this study insisted that it was these experiences which had to be understood if their daily lives and circumstances were to mean anything to me, or to anybody else. Such experiences, they insisted, were central to their identities and biographies. Yet they were not the only point of reference. Wynn was a teacher, an advocate, and a mother, as much as she was a hearer of 'voices'. The experiences associated with schizophrenia had to be placed in context. Much of this dissertation is an exploration of how the meaning of schizophrenia was inflected through the contexts of identity, social circumstance, material means and institutional structures which circumscribed these people's daily lives.

It was the articulation of the *ordinary* and the exceptional which I have termed '*extra*ordinary'. The people with whom I worked did ordinary things in ordinary places. They dwelt among the everyday things of the world, which were normal and normalizing, as well as taken for granted. But they also had uncommon experiences of those common things. Throughout this dissertation I note various participants' extraordinary experiences of light, gravity, sight, sound, the architectural spaces of houses and shopping centres, their own bodies, and those of other people. These things each retained their everydayness — they were still light, bodies, houses, and so on — but they took on a range of additional significances. This is what I explore as the extraordinariness of experience in schizophrenia.

This same extraordinariness — which encompassed and extended the ordinary in various remarkable ways — was what also made the ordinary a focus of intense scrutiny and exploration for many participants. This reflexivity produced a specific rupture of the bases on which experience itself was taken for granted. I shall argue that extraordinariness signalled a distance from experience as this had been understood by participants themselves prior to what they had come to know as 'psychosis'. The same extraordinariness was registered as a distance from what other people accepted as ordinary experience, or from what participants assumed other people accepted as ordinary. Participants knew this, they said, because they were 'locked up' on account of such disparities.

Moreover, from the perspective of participants it was their unusual experiences which framed, oriented and precipitated a range of ordinary experiences in response. Thus, being diagnosed with schizophrenia on the basis of those experiences had all kinds of practical consequences, including where they might live, how much income they could command, and how they might interact with others. In this way, their everyday lives were profoundly shaped by other people's assessments of their extraordinary experiences. In this way too, ordinary and extraordinary were articulated, not simply within a person's own perceptions, but as an entailment of a wider social world comprising other people, professions and institutions.

It is my thesis that this extraordinariness, which had its basis in personal experience, was elaborated and multiplied by the social conditions and institutional structures of people's everyday lives. As a consequence of their placement within a field of deinstitutionalized psychiatric services, participants continually traversed the border between their own extraordinary experiences (which highlighted their distinctiveness) and those experiences which were taken for granted by themselves as well as others (and which allowed them to lay an equal claim to ordinariness). This anomalous positioning, 'betwixt and between', was the source of a heightened reflection on the 'naturalness' (and hence rightness) which is implicit in everyday social categories and social relations. Participants embodied a confrontation with the 'naturalness' of those categories and relations which most members of a society take for granted and accept without consideration that they might be otherwise — that relationship with the everyday world which Bourdieu calls *doxa* (Bourdieu 1977: 164). Participants' experiences, their material circumstances, and their expectations for involvement in 'the community' all meant that they *lived* an alternative which challenged the dominating common sense which structures everyday practice. It was this challenge, lived practically and of necessity, which exercised participants' agency and facilitated their generation of cultural critiques.

This dissertation is concerned, therefore, with how fifty people diagnosed with schizophrenia invested their world with meaning, utilizing the resources which were available to them in their daily lives. Those resources — language, images, material forms, domestic spaces, models of experience and behaviour — necessarily involved and implicated other people, and were social and intersubjective to this extent. Such resources were often used to construct a 'social reality' which stood in opposition to those other practical realities which operated by way of different meaning frames: the diagnostic criteria of psychiatry which classified schizophrenia as an illness, the institutional structures of mental health services which subjected that illness to treatment and rehabilitation, or the milieu of a family whose members must reorient themselves in relation to a 'patient'. Rather than depicting how people diagnosed with schizophrenia were merely acted upon in a deterministic way, I seek to explore how they acted themselves to define, reproduce and transform their social world in light of alternative constructs and in respect of their own experiences.

THE DISTINCTIVE TENOR OF UNCOMMON LIVES

Even though the people with whom I worked lived in the same city as I did and could be said, from some perspectives, to be members of the same society or even ‘community’, they often seemed to confound the taken-for-granted premises of a social world of shared experience which is historically given, pragmatically negotiated and intersubjectively interpreted. That is, they contradicted some of the basic tenets of Schutz’s (1972) characterization of the everyday social world. Here I set out three of those contradictions in order to convey something of the distinctive tenor of participants’ social worlds.

First, participants confounded assumptions of a community based on ‘copresence’ and the availability of persons to each other. Schutz (1962a: 16) posits the ‘copresence’ of social actors as ‘consociates’ who share a ‘community of space’ and a physical availability, making this central to the maintenance of a shared understanding of the social world. This was problematic for those many participants who spent large amounts of time alone and had very small social networks (sometimes comprising only one or two other people). Some participants directed their principal interactions (including talking) toward their ‘voices’, which they identified as “companions” or ‘spirit guides”. Several participants asserted that they had long-term relationships with people they had met only fleetingly. Some claimed to have relationships with apparent strangers: Gerald, for example, maintained that he had a substantive relationship with the check-out operator at his local supermarket to whom he said no more than “thank-you” once a week; he believed that she monitored what was going on in his life (the “trials”) and communicated this (together with her personal support) by way of gestures and eye movements. Participants thus blurred a range of categorical distinctions between self and other — stranger and friend, confidant and enemy, consociate and contemporary — so that a stranger could appear both significant and intimate (as I was apprehended at times), or a friend could suddenly be revealed as an enemy.

Second, participants confounded the temporal integrity which Schutz posited for the socially constituted self. Schutz suggested (1962c: 308) that each person can 'recollect' the world of their past — which he called the 'world within restorable reach'. This restored world is 'substantially the same … as I had experienced it while it was within my actual reach' (ibid), and this facility is projected forward so that what is now present is presumed to be restorable in the same way some time in the future. Among participants in this study the temporal integrity of their pasts had been, to varying degrees, significantly disrupted by major psychiatric illness and hospitalization. Many participants asserted that the experiences which had initiated psychiatric intervention — together with the period of institutionalization which followed — had irreversibly transformed or even damaged them, changing forever their perceptions of the world and creating a biographical rupture which was never restorable. Several participants talked of the profound distance which separated them from their previous experiences and senses of self. (These transfiguring effects are the focus of Chapter 5.) In some cases it was asserted that even memories had been obliterated by periods of psychosis.

Third, many participants appeared to confound everyday assumptions concerning intersubjectivity, that is, of what we can presume to know of other people's minds when engaged in making sense of each other. In particular, participants confounded the 'idealization' required for assuming a reciprocity of perspectives: that is, that the differences in perspective originating from unique biographical situations are 'irrelevant' to any social interaction at hand (Schutz 1962a: 12). On the contrary, participants' 'unique' biographical situations were the *raison d'être* of the study, just as their idiosyncratic experiences were the principal source of their asserted identities (see Chapter 4). The distinctiveness and significance of personal experience was, if anything, elevated and as such could not be bracketed out from our purpose in being together. There is a further problem in following Schutz here, however, which extends beyond the taking of another's point of view. Schutz asserts (1962c: 327) that, in the everyday world, 'I take for granted until counterevidence appears not only the bodily existence of my fellow-man but also the fact that his conscious life has substantially the same structure as my own …'. I often found it difficult to presume such access to the consciousness of a participant. Indeed, to have presumed it *a priori* would have effaced the very reason for our talking together about such perplexing phenomena as 'voices' and delusions. I have not experienced what psychiatrists call hallucinations and delusions; nor do I have direct experience of the spirit visitations, telepathy, synchronicity or 'multi-consciousness' which various participants talked about. Accessing the meaning of such phenomena required an imaginative leap into previous unknown territories, rather than the diminution of encounters in terms of what I already knew (or could presume) of conscious processes, my own or anybody else's. Schutz himself acknowledged the difficulty of establishing knowledge of other minds (ibid: 314; 1972: 97ff), but stated that, over time, the 'well-ordered indications' of a person's mental life are assimilated as a series of typical signs, expressions and language elements. In the present study such 'well-ordered' schemas were available in the form of psychiatric classifications. These were avoided, however, in an attempt to glean as much as possible about participants' own understandings and representations, which were sometimes not 'well-ordered' at all.

I would argue, in fact, that these distinctions were in no way as starkly dichotomous as set out here. It was precisely the extraordinariness of participants' experience — their conflation of the ordinary and the exceptional — which mediated and bridged such dichotomies. Thus, participants knew of, and could reflect upon, their isolation by contrast with what they had known in other settings at other times. All had grown up in families; other people had been a 'copresence' for them throughout their lives. They interacted with a range of contemporaries; they dealt regularly with hospital staff, psychiatrists, Department of Community Services personnel, shopkeepers and bus drivers. In particular, they were able to sit down with me for long stretches of time and share the stories of their lives. Similarly, their appreciation of the profound disruptions caused by their experiences was framed by a sense of a past before diagnosis. As Wynn said: "I wasn't born a schizophrenic you know". The transfiguring of experience and biography (see Chapters 1 and 5 respectively) contained its own measure of before and after, losses, gains and differentiations. Although I could not take for granted that participants' consciousnesses had the same structure as my own, I could engage with them in attenuated dialogues concerning the meaning of their experiences — both what such experiences meant to them as well as what that meaningfulness might mean to me. This is the ethnographically specific way in which I use the term 'intersubjectivity' for the purposes of this dissertation. I examine it methodologically in Chapter 2, and explore it substantively as a medium of my relationship with participants in Chapters 6 and 7.

Schutz (1962b: 232) identified 'the world of the insane' as a case example of a 'sub-universe of reality' or a 'finite province of meaning' which is incompatible with the meaning of everyday life. Where does this leave those for whom this *is* everyday life — whose everyday life is socially configured as 'insane'? How do I, who do not inhabit that province, reach into it and converse with those I find there? Part of the problem is, I suggest, Schutz's conception of the boundaries of his 'provinces' as finite. Roseman (1991: 152) makes a similar point in relation to trance states: that 'provinces of meaning ... need not always be finite: participation in one province might overlay or intersect another, rendering "nonfinite" provinces of meaning'. This was prominent in the content of participants' accounts: many reported how apparently distinct enclaves of experience (memories, biographical traces, dreams, wishes, fictional worlds from literature, film or their own imaginations) were fluid and could 'erupt' into consciousness at various times. Conversely, they found that what they understood as other peoples' everyday realities to be 'fragile' and uncertain. The same fluidity is required of analysis. As Roseman argues for the Temiar, and as I demonstrate in respect of popular culture elements which were appropriated to participants' explanations and understandings (Chapter 7), the province of 'madness' is not so self-enclosed and not so impermeable to intersubjective understanding.

Ascertaining the meanings which patients make of schizophrenia has long been the focus of research into subjectivity, beginning perhaps with Jaspers' 'applied phenomenology' which '... must begin with a clear representation of what is actually going on in the patient, what he is really experiencing, how things arise in his consciousness, what are his own feelings, and so forth' (Jaspers 1968 [1912]: 1316). The purpose of such representations was to isolate, characterize and give 'conceptual form' to psychic phenomena (ibid). In the case of schizophrenia, this tradition continues with the elicitation and description of such phenomena as 'voices' or visual hallucinations as these occur in the interior of a person's head (see Cutting & Dunne 1989), or even in a 'schizophrenic brain'. Studies of subjectivity focused on the meanings which people give to these phenomena (and their treatment) within a broader social setting emerged fully with the work of Estroff (1981) and Scheper-Hughes (1979, 1987). Such studies have proliferated in a number of disciplines and 'cross-over' studies involving psychiatry, psychology, nursing and anthropology (see Clark 1995; Walton 1995; Anich 1997). This has resulted in an burgeoning literature on the social context of psychopathology, bringing social science perspectives, qualitative and narrative methodologies to an analysis of schizophrenia (see, for example, Strauss 1989, 1992, 1994; Strauss & Estroff 1989; Estroff 1989; Corin 1990; Corin & Lauzon 1992, 1994; Jenkins 1997; Desjarlais 1997; Lovell 1997).

Outside of the linked traditions of psychoanalysis and 'object relations', however, there is no comparative body of work on schizophrenia and intersubjectivity. Intersubjectivity is central to Glass' (1989) account of patients' return to 'communal attachment', but his detailed case studies focus on mania and 'borderline' psychopathologies. Poelman's

(1980) thesis is an experimental account of her attempts to induce schizophrenic 'process thinking' in herself as a way of 'getting closer' to her patients. Wulff (1993) analyzes the intentional deprivation of intersubjectivity in schizophrenia as a source of 'annulment' for the self's own existence and societal life. In interpreting the writing of a young woman diagnosed with schizophrenia, Doubt *et al.* (1995) rely on a combination of sympathy, reason and common sense as these are assumed to apply to an 'intersubjective world' common to us all. Doubt *et al.* conclude that their subject was equally capable of putting herself in the place of others so as to understand their behaviour.

It is to this small literature and this under-examined topic that I seek to contribute by way an extended ethnographic exploration of the possibility and limits of achieving intersubjectivity with some people diagnosed with schizophrenia. This achievement and its limitations are examined within the context of the specific modalities and activities by which I entered into relationship with these people as a way of coming to understand what their experiences might mean. Equally, I seek to place those relationships and that understanding within the context of specific social and institutional forces which defined their lives as people diagnosed with schizophrenia, and me as a researcher of those lives. What I emphasize throughout the dissertation, therefore, are the conditions for knowing another person, rather than what could be elicited of their subjective states by way of 'capturing descriptions' of them (cf. Anich 1997: 35). By working together to bring certain perplexing phenomena into view it was possible to delineate their features and explore their possible meanings for each of us. This required discovering (or creating) intersections between the biographies, knowledges and assumptions of both researcher and research subject. It is this which I propose as an 'intersubjective project' (see Jackson 1998) applicable to schizophrenia.

ILLNESS NARRATIVES

The recent medical anthropology literature is dominated by what have been called 'illness narratives', a survey of which is provided by Good (1994: 140-2). These are 'stories' which provide the experience of illness with an underlying coherence, a narrative trajectory and a meaning (ibid: 121). They are often presumed to encapsulate experience itself. Kleinman (1988), for example, advocates the use of 'illness narratives' to get at the meaning of illness for patients, relatives and clinicians. He suggests that 'stories about illness' provide a privileged entrée into the world of a person's suffering. They are a linguistic means which 'enable us to grasp, behind the simple sounds of bodily pain and psychiatric symptoms, the complex *inner language* of hurt, desperation, and moral pain (and also triumph) of living an illness' (Kleinman 1988: 28-9; emphasis added), here suggesting that 'inner experience' is itself language-like. According to Kleinman, the core elements of these narratives — content, structure, rhetorical devices, plot, and story line — suggest an analogy with literary texts (ibid: 233).

Saris (1995: 41) proposes that such a conception is based on an implicit model of transcription and interpretation in which a narrative text leads directly back to the original experience from which it springs. Saris critiques the apparent transparency of this model for what it ignores about the embeddedness of all such stories in institutional contexts. By 'institution' he means a structure (physical, conceptual, or both) that 'sets up' discourse and practices which are realized as technologies, narrative styles and, equally importantly, erasures and silences (here recalling Foucault as well as Bourdieu's concepts of field and symbolic violence). Saris proposes a more complex model which takes account of the constitutive relationship between texts, narratives, experience and institutions. To illustrate this model, Saris analyzes a transcribed conversation in terms of the 'institutional channels' which make possible, give shape to, and restrict the freedom of a particular story. These 'channels' manifest themselves in the story as 'institutional presences' (with references to Asylum and Church), as traces of psychiatric knowledge and praxis (categories of mental illness), specific genre forms (such as the case history), and temporal structures which pivot on the punctuation of a life by diagnosis, medication regimens, and visits to a psychiatrist. In this way he aims to demonstrate how even an account of what is clearly 'personal' experience inscribes 'institutional realities … produced as discursive objects' (Saris 1995: 65).

The issues of agency, meaning and power which Saris highlights are still to be apprehended in linguistic forms, and specifically in the production of stories. Saris locates the agency of his subject in the transcribed text itself — in its rhetorical moves, its appeals to social justice, its political critique, its silences and resistances — rather than in the person or circumstances which resulted in the particular instance of this conversation. But stories are not the only sites in which meaning, power and agency are located, just as 'discursive objects' are not the only outcome of psychiatric diagnosis and treatment: material circumstances and embodied persons are others. Moreover, it is equally necessary to account for the occurrence of stories within this context: how, when and to whom are they told and why. The world in which most participants in the present study lived was largely bereft of opportunities for telling a story (or have others listen to that story). Participants' stories of their experiences were of little value except in the unusual circumstance of there being an audience to hear them. Such an audience, they insisted, was rarely to be found. Moreover, some of the experiences they associated with schizophrenia could not be discursively reclaimed or represented, and this indeterminacy was also a vehicle of agency, identity and power for some participants (see Chapter 4). One could extend Saris' critique further — following the implicit references to Bourdieu — to show how the very agency which is manifested as storytelling, or the refusal to tell stories of illness, is itself constituted (and not just mediated) by an institutional field.

Good has confirmed the value of narratives as a particular domain of representation *about* illness and its accompanying events and activities, but resists the assumption of narrative's collapse into experience itself:

> Narrative is a form in which experience is represented and recounted, in which events are presented as having a meaningful and coherent order, in which activities and events are described along with the experiences associated with them and the significance that lends them their sense for the persons involved. But experience always far exceeds its description or narrativization. (Good 1994: 139)

Good has usefully extended the concept of illness narrative by reference to performance theory, reading response theory and the phenomenology of 'following a story' outlined by Ricoeur. To the structural consideration of plot, Good has thereby added the notion of 'emplotment': 'the activity of a reader or hearer of a story who engages imaginatively in making the sense of the story' (ibid: 144).

This reconfigures 'illness narratives' as an active search for meaning, and a jointly negotiated one, rather than a rendition of, or soliciting of, experience. It reminds us that stories about illness are stories told *to* someone in the form of an imaginative engagement, and hence are intrinsically dialogical. It is against this background that I emphasize, throughout the dissertation but especially in Chapter 6, the dialogic negotiation which was a distinctive feature of this research. Talking was the principal means of engaging with participants and entering into relationships with them (see Chapter 2). Talking was also a primary vehicle by which participants exercised their agency: revealing or concealing aspects of their lives according to their strategic calculations at the time. In particular, most conversations had a validatory aspect to them as participants sought to have us confirm the 'reality' of their accounts, the validity of their interpretations, and their value as persons. It was imperative for most participants to be judged as people who could be taken 'at their word'. Our talking together was thus also an exploration of key elements of personhood (see Taylor 1985a).

Talking had a particular valence for participants against a background of having their speech rendered as a 'symptom' of mental illness (see Chapter 6), as well as having their histories constructed as hospital case-notes to which they could neither contribute directly, nor read. As a researcher and a non-clinician, I was likewise excluded from contributing to the 'official' documentation of a person's illness. In part, it was this distance from the 'official' record which facilitated participants' engagement with the project. It was on this basis that a number of participants said that they felt freer to disclose and elaborate on the meanings which they attributed to their experiences. Thus, one of the effects of the research method was to facilitate participants' agency to narrate the significances of their own lives when, from their perspective, this capacity had been removed in many other settings. The project as a whole could be characterized as an experiment in providing a safe, non-judgmental conversational space within which participants had the opportunity to explore their own agency and identities through talking.

Accounts of schizophrenia and its consequences emerged from the research at three distinct levels. These can be distinguished as follows:

- The conversations which took place between participants and researchers in which certain phenomena, memories and stories were placed between us so that their meanings could be negotiated. Such encounters were often fraught exercises. For me, they varied considerably from illuminating to confusing. Their form also varied from the most perfunctory question-and-answer exchanges to extensive monologues which were difficult to interrupt or divert. Our talking together varied from 'idle talk' to intense philosophical debate. To gloss all of these conversations as 'narratives' is to obscure their significant differences in form and production. To gloss them all as 'illness narratives' is to collapse everything people said into a pathologized category and thereby to potentially impute an agency to illness (in this case, schizophrenia) which eclipsed the agency of any speaker. This, I argue, would enshrining a psychiatric hegemony concerning their speech which many participants rejected (see Chapter 6).

- The inscription of those conversations in the form of notes and tape transcripts. These were an invaluable resource, but they possessed attributes which were distinct from the unique encounters which were their source. Most obviously, they were fixed in space and time. They formed a material and enduring trace far removed from the ephemeral spatial and temporal constraints of their emergence from speech. To be studied and compared at a distance from their origin they had, in Tedlock's (1983: 5) evocative phrase, been 'brought to a standstill'. Thus they were subject to what Crapanzano (1992: 207) has called a 'pragmatic reduction': 'the inevitable elimination of the continuously constituted context of the *original* utterance'. Indeed, their defining attribute was that they were produced at one remove from their source, and remain removable to any number of other contexts. Freed from their discursive or performative setting, such inscriptions were 'entextualized' (Good 1994: 164, following Ricoeur), their effects and interpretations rendered 'unpredictable' because they could not be controlled by the teller of the tale. Nor could such notes and transcriptions ever be a complete record of their originating interaction. Inscription alone did not encapsulate all there was to know about the conversational space which had been created between us. It was not always possible to record non-verbal communications, emotional cues, the effect of a particular environment, feelings of rapport, attunement and alienation, or the reflexive distance of irony and sarcasm.[3] Their greatest value was perhaps as a vehicle for my memory of encounters.

- The selection, arrangement and framing of those traces into vignettes, case studies and commentaries. These were quintessentially textual productions, shaped by demands external to the original encounters (and thereby offering scope for doing violence to them through re-contextualization). These commentaries (embodied in formats like this dissertation itself) seem particularly geared to the tasks of reporting, comparison, analysis and dissemination. In this they displayed the 'pragmatic reorientation' which occurs when dialogic utterances are appropriated to tasks of representation and participation in 'secondary dialogues' (Crapanzano 1992: 207): those 'shadow dialogues of the ethnographer with his colleagues and theoretical positions'

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[3] Cf. Tedlock (1983: 5- 13) on the transformation and diminution which is entailed in creating a visible (that is, written) record of an audible performance. Areas of difficulty include the rendering of form, punctuation, pitch, loudness, amplitude, timing, contouring, syntax, rhythm, emotional tenor, acoustic changes of voice, and accompanying body movements.

> that appear at times to betray the fieldwork encounter (ibid: 206).[4] It is at this level of organization (and for the purpose of such 'secondary dialogues') that accounts of illness most obviously assume the character of 'narratives', the term itself encoding their distanced and circumscribed textual form. Equally, however, this use fulfilled the stated desire of some participants to have their concerns broadcast to a wider audience — that is, to those unknown others who were never present for our talking, but whom participants wished to influence by way of their words.

Wherever possible I have attempted to keep these levels clear in this text. Participants' own words and direct speech have been marked throughout with double quotation marks (" "). Vignettes constructed from my notes and drawn sometimes from a number of separate encounters are set out with dot points (•). The dissertation as a whole engages in multiple secondary dialogues to which participants' talk has been co-opted.

Each level was capable of 'feeding back' into the others. Thus, the transcription and reflection on one conversation generated questions which were returned to an ongoing dialogue. The influence of prior episodes of writing was also evident in peoples' talk. Elements of psychiatric history-taking — as one form of inscription with which many participants were familiar — were evident in the way some accounts were spontaneously organized into a chronological sequence (reflecting the type of 'history' found in case records[5]), or arranged according to the psychopathological categories of a Present State Examination (cf. Swartz & Swartz 1987: 401-4). These were organizational resources to which I had access as well: if I was particularly confused by the events being recounted I had recourse to questions such as 'When did this happen?', as if re-asserting the temporal framework of a well organized case history (as one obvious model for a narrative of

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[4] Saris (1995: 68) similarly reflects on the potential violence done by his own appropriation and framing of a narrative, noting that its critique of psychiatric authority is equally applicable to the academic forum of medical anthropology.

[5] See Epstein (1995); see also Barrett (1996: 110-27) on the cycle of reading, talking and writing which generated hospital case records, by which means patients learnt to articulate what was germane to the record and amenable to documentation.

events) could provide the orientation I was lacking. If, as happened on a number of occasions, I could not ascertain the source of reported conversations or actions I would ask, 'Is that what the 'voices' said?' or more rhetorically, 'But that was a delusion?', thereby invoking the psychiatric categories which I otherwise sought to eschew.

BACKGROUND TO THIS STUDY

ORIGINS

The people whose experiences are the subject of this study were all participants in a project entitled 'Cultural Factors Affecting Recovery from Schizophrenia'.[6] The project focused on the implications of a diagnosis of schizophrenia for people's day-to-day lives. It was aimed at eliciting their understandings of schizophrenia and developing a picture of the coping strategies which allowed them to live independently in an era of deinstitutionalized mental health services. Analytic techniques derived from social anthropology were used to investigate the way in which explanations of schizophrenia were reflected through each person's biography and cultural background. Family members and friends who provided support for the person were also incorporated in the study, in order to examine their understandings of psychiatric illness and the extent to which these corresponded with the explanations provided by participants. Strategies for living outside of hospital were the focus of reports to government and to organizations such as the Schizophrenia Fellowship.[7] Feedback on the research has been provided to national forums of mental health practitioners, to 'carer' groups, and to organizations such as the Schizophrenia

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[6] The project was supported by a Department of Health, Housing and Community Services (later Health and Family Services) Research and Development Grant (HS270). Additional support was provided by the National Health and Medical Research Council (Project Grant No. 930971).

[7] A non-government organization — part of a national and international network — providing education, counselling and recreational support to people with schizophrenia, and their families.

Fellowship and Clubhouse Incorporated[8] (and thus to a small number of participants who were active in these groups) by way of presentations and consultations.

Work on the original project was undertaken jointly by three researchers configured as a team: Rob Barrett, Megan Warin and myself. Fieldwork was carried out in what may be considered the mundane settings of a metropolitan city — the public hospital, the university department, the shopping mall, the suburban home — and within the recognizable structures of public medicine: the out-patient clinic, the treatment team and the 'community'.[9] Research data were gathered in the form of long, open-ended interviews devolving into conversations and more casual interactions in a range of settings. These involved a core group of fifty people who had a diagnosis of schizophrenia[10], all of whom lived in the same Australian capital city. Data from a range of sources and by way of participant observation were gathered on each person's biography, genealogy, social background, networks, domestic arrangements, hobbies, interests and day-to-day activities. A further sixty-three people who were designated by participants as being significant to them in some way were also engaged through semi-structured interviews; these were predominantly first degree relatives (parents and siblings, but also children and spouses) and, in three cases, close friends. We established additional contact with various clinical personnel providing psychiatric care and rehabilitation, including the staff of community treatment teams (psychiatrists, social workers and community nurses), the owners of boarding houses, members of a religious community, and 'key workers' who provided support to patients living outside of hospital and whom we met in participants' homes.

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[8] A non-government organization, modelled on North American examples, running a work-based rehabilitation programme for people with a range of mental illnesses.

[9] This fieldwork was conducted from May 1994 to March 1996. I continued meeting with some participants well beyond that time.

[10] Each participant was assessed diagnostically by Dr Barrett, who was trained in the use of the Present State Examination (PSE), a standardized psychiatric research instrument. The Schedule for the Assessment of Positive Symptoms (SAPS) and the Schedule for the Assessment of Negative Symptoms (SANS) were also administered. The diagnosis in each case was thereby established according to DSM-IV and ICD-10 criteria.

The project generated a large body of first-person oral accounts, as well as a substantial collection of poetry, diaries, letters and autobiographical writings. Some of this latter material was produced specifically for the project. One participant granted access to a large collection of video tapes which he had made over a number of years to 'document' his experiences; some of these tapes had previously been sent to his private psychiatrist and some to various media outlets, such as the producers of a national current affairs television program. Another participant supplied copies of the audiotapes on which he had recorded the imaginative stories which he saw as emanating directly from his experiences of schizophrenia. Most of this material —whether verbal, written, or recorded — was not amenable to standard forms of medical or psychiatric analysis (those couched in terms of biological explanation or psychoanalytic interpretation, for example). Nor was the project an epidemiological study focused on the distribution of disease. In its richness and diversity, however, the research material was especially suitable for an analysis of how the experiences associated with a diagnosis of schizophrenia were located within a specific cultural setting and time-frame[11], using ethnographic techniques to explore how individuals gave meaning to these experiences within their own lives.

While engaged in fieldwork on this government-funded project (for more details of which see Chapter 2) and as a consequence of becoming fascinated with the richness of the materials which it was generating, I conceived a project which would focus less on coping-strategies (which implied adaptation to some vaguely conceived norm of living in 'the community') and explore more fully the meanings which people made of their experiences. This developed again into a consideration of what those experiences and their meanings could mean for me and for others who have never been diagnosed with

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[11] All participants had a good command of English; those who came from a migrant background spoke English at home. The sampling was skewed in this way to ensure maximum access to the language of participants and to the meanings attributed to schizophrenia. All bar one participant were Australian citizens — the exception holding a British passport. Most of the material collected concerned experiences which had occurred within the previous two decades.

schizophrenia. The material collected for the original project was so extensive that it could support any number of analyses from a variety of disciplinary perspectives. This dissertation represents one of those analyses and one of those perspectives.

The research material was grounded in an immediate social context, which was the relationships we entered into with people, and the meticulously recorded dialogues — developed over weeks, months or, in several cases, years — which were at the heart of those relationships. This dissertation explores the knowledges of schizophrenia which emerged from those dialogues. It charts the process by which meaning was negotiated, and explores both the possibilities and the limits of understanding which emerged from such relationships.

SETTINGS AND INSTITUTIONS

Much anthropological research (traditionally conducted in places initially foreign to the researcher) has been predicated on physically leaving the institutional structures which shape the researcher's own experience and interpretations. This was often done in order to minimize the effect of such structured predispositions and to render the fieldworker more susceptible to unfamiliar configurations of social life. Rather than have these structures fade in significance, however, the present study required that my attention take on the reverse trajectory. In order to apprehend the world in which my informants lived I had to become more aware of the workings of institutions I myself was a part of, and more attuned to the frameworks of experience and interpretation which were available in my own society. A location within the institutional settings of hospital and university, for example, was important as a means of witnessing their effects, as these were the source of some of the most powerful defining parameters of what I have designated, after Bourdieu, the 'field' of schizophrenia (see Chapter 3). They provided a unique vantage point from which to view the everyday world of schizophrenia. Only by keeping these institutions in view was it possible to observe and work with their effects, and thereby reflect on their role in shaping participants' lives and on my apprehension of those lives.

Here, in the suburbs of my own city, was a world both recognizable and vastly different to that which I had previously known, and therefore disconcerting in the same way that participants said that they had found their familiar world 'strange' and foreboding after the transfiguring experiences they associated with schizophrenia. Like thousands of other city residents, I had driven past the state psychiatric hospital countless times, but I had never been into a locked ward before. My viewing of *The X Files* on television had not previously been refracted through the beliefs of a person diagnosed with schizophrenia. Even when I shopped in the same supermarket as my informant, my budget was not constrained by a disability pension, just as I was unaware of the riches to found in its garbage bins. I was thereby accorded access to places that I had never travelled to before, even though they were objectively part of my own city. I was also forced to confront previously unnoticed aspects of my own everyday world. Similarly, I was introduced to beliefs which, although held by many in my own society, I had never encountered previously. In these and many others ways, participants offered me entrée into other modes of seeing and believing, new ways of interpreting everyday occurrences, and new perspectives on the work of institutions I had previously taken for granted. In all of these ways, my encounter with schizophrenia was equally an extraordinary experience. This dissertation charts my exploration of what this extraordinariness could mean for me, as well as for the research participants.

AT HOME

Five of the participants lived in supported accommodation, boarding houses, or hostels. In each of these settings they had access to varying levels of professional (psychiatric or nursing) services. Two of the participants were of no fixed address. The remaining forty-three participants lived in a private home, either their own, their parent's, or a rental property (see Appendix 1, figures 2.1 and 2.2). It is the latter group (forming the majority of participants) which are the focus of this dissertation. These participants did not form a community as such. They were not a connected group of people sharing a physically contingent space, for example — see Clifford (1997) and Gupta & Ferguson (1997b). This was ironic in itself because, in the public discourses of mental health, these were people who had been returned to 'the community'.

With deinstitutionalization, the private home was a new site for certain types of institutional routines, as representatives of government instrumentalities (especially health professionals and potentially the police) came to the front door in order to provide services. The private home had been re-configured as the legitimate domain of a supportive, watchful extension of the state executive: the mobile mental health treatment team. Deinstitutionalization and 'community tenure' thus partook of a more general shift in health care toward patient-centred 'management' which, as Arney and Bergen (1984) have argued, allows the 'medical gaze' a much greater penetration of a person's personality and social life. Reflecting Foucault's analysis of the capillary action of power, Arney and Bergen (ibid: 87) suggest that, via the all-encompassing notion of 'management', medicine's power is exercised through normalizing strategies that permeate the intimate life of individuals.[12] The private residence has also become the focus of another sort of 'gaze' as it increasingly draws researchers eager to discover how people diagnosed with a mental illness live their daily lives (Corin 1990; Walton 1995), in contrast with the 1950s hospital (Stanton & Schwartz 1954; Caudill 1958), the 1970s out-patient clinic (Estroff 1981) and the 1980s boarding house (Hannan 1990). This dissertation is a contribution to that small but developing literature on the 'private' settings

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[12] See also Sjöström's (1997: 85) characterization of deinstitutionalization as a 're-institutionalization' in which smaller, geographically-focused treatment facilities are able to 'follow' patients more effectively by developing 'richer information about the patient's whole life situation'. The ideology of such reform is 'to normalise individuals by creating adapted environments for the mentally ill in the communities' (ibid).

and 'private' lives which have, in part, been created by deinstitutionalized mental health services.

OUTLINE OF THE DISSERTATION: AN ITINERARY

The following sets out the dissertation in outline, highlighting the relationships between its parts and pointing to some of the wider relevances of the ethnography. From de Certeau I borrow the contrast between map and itinerary: the map being a plane projection of observations on place, while the itinerary provides a discursive series of operations and movements in space (de Certeau 1988: 117-19). This latter image approximates what the fieldwork was like, moving throughout a city looking for new and multiple perspectives on a phenomena which has already been discursively constructed with such authority for nearly a century. Here, then, is an itinerary for the dissertation: a guide for journeying in the territory of extraordinary experience as embodied in the lives of some people diagnosed with schizophrenia.

The dissertation has three parts. Part I is primarily concerned with methodology although, as I emphasize throughout, this methodology emerged in dialogue with the many and varied ethnographic situations to hand, especially the distinctiveness and idiosyncrasy of each participant's own home. In Chapter 2 I set out this methodology in some detail because it had direct implications for how a view of schizophrenia was constituted by the research process itself. In Chapter 4 I argue that this process, by its very conduct, emphasized certain perspectives on participants' personhood. Moreover, I argue that participants were facilitated to *use* this process as a vehicle of their own agency, by which means they could strategically re-position themselves and their experiences by way of an 'argument of images' (Fernandez 1986) which contested the significant categories provided by psychiatry. Throughout the dissertation I have sought to reveal this reflexive effect of the project's methodology.

Part II locates participants' lives within the context of broader social conditions and institutional structures. This contextualization highlights international, national and local changes to the representation and treatment of mental illness, especially its relocation to 'the community' in the form of deinstitutionalization. In particular, Chapter 3 outlines the 'realigned' structures of psychiatric treatment within the context of local mental health policies.

Part III returns to the issues of knowing schizophrenia which were raised in Part I. Participants had to take the effects of diagnosis 'into' their daily lives, and equally sought to translate their lives 'outward' from their own experiences to whatever intersubjective and dialogic spaces they could achieve for themselves. Part III explores such a space, created in part by the research project itself, in which participants talked of and through their experiences and so sought to define who they were apart from their diagnosis.

Chapter 1 introduces the experiential 'domain' which participants insisted was the most significant for understanding their lives. With the participants acting as guides I delineate this domain, which they asserted was their principal space of operation (Fernandez 1986: 24). In particular, I highlight two qualities which participants consistently identified in the experiences they associated with schizophrenia. These were the anomaly which signalled a 'lack of fit' in respect of conventional schema, and an uncanniness by which the familiar and the strange, the known and unknown, were brought into conjunction. The chapter sets out the tropes most commonly used by participants to communicate and negotiate the meaning of their experiences. It also examines how the qualities of anomaly and uncanniness — in which the extraordinariness of experience was registered — were substantiated in participants' bodies and houses.

Chapter 2 is an extended account of the lineaments and constraints of the research process which accomplished, in varying degrees, access to private homes and private lives. Its focus, however, is on the establishment of intersubjectivity: on how the 'shared world' which was occasioned by our being together with research participants could potentially generate a 'common world' of understanding. The chapter therefore explores, via the pragmatics of fieldwork, a problem to which the dissertation as a whole is addressed, *viz.*: the extent to which it was possible to understand the meaning of extraordinary experiences to those who had them, and what that meaning could mean to others. Intersubjectivity is shown to be a measure of both familiarity and strangeness, just as it provides the basis of their mutual definition. In this way, then, intersubjectivity is explored as the foundation of extraordinariness.

In Chapter 3 I employ Bourdieu's concept of 'field' to characterize the complex configuration of knowledge, institutions, interests and representations which defined what 'schizophrenia' was in this setting. I analyze this field as a configuration of relations in which agents and institutions were determined by their mutual location within structures of power. I argue that local changes to the structure of mental health services created and sustained a range of possibilities for escaping determination by psychiatry. Central to this discussion is the role of participants' homes as a particular type of site configured by the field. These homes are shown to offer specific opportunities for resistance to, and critique of, the dominant institutional forces which shaped what it was to live with a diagnosis of schizophrenia. In Chapter 3 I explore participants' houses as a physical form which, in the local context, was historically imbued with qualities of separateness, independence and privacy. Such houses facilitated participants' social withdrawal in the manner documented by Corin and Lauzon (1992; see also Corin 1990). In Chapter 4, following Basso (1996) and Jackson (1995), I examine the more abstract and existential qualities of 'home' as a place of 'dwelling' which harboured counter-hegemonic forms of agency and identity.

It was participants' homes which not only highlighted certain types of experience — distance, withdrawal, the self-reflexive exploration of bodily dispositions and subjective states — but provided the conditions for 'experience' itself to be privileged and reified as a distinctive mode of being in a particular type of social world.[13] Chapter 3 explores this effect, also noted by Laing:

> The physical environment unremittingly offers us possibilities of experience, or curtails them. The fundamental human significance of architecture stems from this. (Laing 1967: 28)

Individual houses brought participants' material and experiential circumstances into a specific conjunction. It was their physical and economic confinement to houses that drew forth experience as the principal modality of their everyday lives. In asserting this, my ethnography confirms, by way of counter-example, Desjarlais' (1996a: 72) characterization of experience as an 'historically and culturally constituted process predicated on a certain way of being in the world'. Desjarlais suggests that experience must be examined in terms of its social production and the practices which define its use (ibid). He argues that it is only 'one possibility among many', and demonstrates ethnographically that 'some people live in terms different from experience' (ibid). The interiority, depth and coherence (ibid: 73-5) that Desjarlais says were missing from shelter life were, by contrast, heightened and intensified by the private homes in which participants in this study dwelt.

As the quintessential form of what was culturally apprehended as a 'domestic' setting, houses simultaneously effected the normalizing of experience. This articulated with public policy, where being in 'the community' was deemed to effect such therapeutic normalization as a consequence of deinstitutionalization. As pathology's most 'appropriate' location, the 'home' therefore represented a political positioning of (and

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[13] It was their own homes which provided a specific contrast with the setting of the shelter which Desjarlais analyzes, in which residents '... did not have the means to keep to themselves, remain at a distance, or maintain a position of withdrawal, foresight, or self-collection' (Desjarlais 1996b: 886).

constraint upon) the experience of mental illness. It was this positioning which also gave the category of 'experience' its political valence — one which participants could use to contest and redefine their social classification as 'schizophrenic'.

Chapter 4 highlights the multiple and varied forms of agency and identity to which the field gave rise (cf. Desjarlais 1996b: 882). The analysis thus addresses the lacunae concerning 'methods of agency' which Desjarlais (ibid) has identified in a variety of analyses concerned with personhood and subjectivity. Specifically, this study is an ethnographic exploration of what Desjarlais' has argued in reference to another, quite different, mental health setting: that agency is not 'much the same everywhere'; that it is not essential, unchanging and ontologically prior to the situations in which it arises (ibid). Rather, agency is shown to be emergent in specific political, linguistic and cultural practices, and mediated by institutions by way of contestation. The chapter therefore addresses the 'location of agency and the social conditions of its appearance or obfuscation' (Battaglia 1995: 4). It also examines the centrality of interpretation to agency — that is, the capacity of persons to interpret the actions of others and to be interpreted by others as engaging in meaningful action (see Taylor 1985a).

Chapter 5 examines the articulation of structure and experience by way of Bourdieu's concept of *habitus*. I demonstrate that participants' intensely self-reflexive stance toward themselves, their experiences and their lives confounded the production of a taken for granted world. Moreover, I demonstrate that this reflexive stance was itself sustained by participants' social circumstances, and was multiplied and accentuated by the perpetual generation of distancing and disruptive experiences — phenomenological as well as institutional. I conclude that participants' extraordinary experiences were not given by their *habitus* as an embodiment of collective history, nor were they easily articulated with society's values and regulatory principles except as 'illness' or 'madness'. This was the double source of the extraordinariness of participants' experiences, and of the reflexivity which they induced.

Reflexivity is commonly seen to emerge fleetingly in moments of crisis, danger or misapprehension, before fading again into everyday acceptance, or finding accommodation in what is unremarkable and taken for granted. Alternately, reflexivity is seen to arise spontaneously at points of structural tension, or periodically in socially acknowledged processes of transition, only to be subjected to ritualized containment and an orderly passage toward resolution and erasure. Bourdieu's notion of *habitus* is a useful encapsulation of the former process. Turner's concept of liminality addresses the latter. Chapter 5 explores the possibilities and limits of both these approaches for delineating what was distinctive about the lives of people diagnosed with schizophrenia.

Chapter 6 is concerned with talking as a principal vehicle by which participants sought to effect intersubjectivity, validate their concerns, and reflect on themselves and their experiences. Talking is shown to be a strategic, rhetorical and semantic resource with which participants negotiated identity and exhibited agency. Our dialogic encounters were settings in which these pivotal aspects of personhood were on display. The chapter is therefore an exploration of what our talking together meant in terms which are broader than the formal content of participants' speech. When combined with participants' dwelling in places that provided a specific vantage point from which to view the world, their speaking of and through experience both facilitated and substantiated the competing conceptions of identity which are discussed in Chapter 4. In this way, the 'tropes of speech and place' (van Toorn & English 1995: 1) combine to specify what was distinctive, particular and imperative in participants' social circumstances.

One of the effects of this talking together was the negotiation of experience itself, especially the extraordinary experiences which participants' identified with schizophrenia.

Their very extraordinariness challenged intersubjectivity — both its practical and methodological achievement, together with its conceptual and theoretical implications. Chapter 7 thereby returns to the issues of establishing a 'common' world which were the focus of Chapter 2. It examines those issues through a detailed case study of what for many people was the quintessential experience of schizophrenia: hearing 'voices'. The chapter explores the possibilities and limitations of what this experience could mean for each of us, researcher and participant alike. It focuses on the perplexity which exemplified 'voices' for participants, the consequences of this perplexity for their identity, and its role as a resource for both building and resisting social engagement.

The Conclusion returns to the major themes which orient the dissertation: intersubjectivity, agency, identity and reflexivity. It reiterates my thesis concerning schizophrenia as an experiential and social phenomenon predicated on a set of contradictions which emerge from, and are elaborated by, the participants' social circumstances, daily lives and biographical histories. This specifies schizophrenia as a specific form of social disjuncture which I contrast with Laing's image of schizophrenia as an existential and strategic rupture. I also propose that schizophrenia represents a case study in the possibilities, limits and transgression of intersubjectivity. I then reflect on the theoretical frameworks which I have used to formulate this view of schizophrenia, focusing on the role of agency and identity in these frameworks. Finally, I place these findings within a broader context by suggesting ways in which an ethnography of schizophrenia could be further developed in line with issues raised by cross-cultural comparison.

PART I

APPRENDING DOMAINS OF SIGNIFICANCE

EXPERIENCE AND INTERSUBJECTIVITY

Chapter 1

"A GUIDED TOUR TO SOMEWHERE UNCERTAIN" CHARACTERIZING THE DOMAIN OF EXTRAORDINARY EXPERIENCE

In this chapter I describe an ethnographic domain, following its characterization by Fernandez (1986: xii, 24) as those predominant classifications and collections of significant things which constitute the 'space' in which persons operate or are operated upon. The domain with which I am concerned comprises a set of experiences which pervade, through networks of meaning and social interaction, the everyday lives, material circumstances, beliefs and operations (of and upon) people who have been diagnosed with schizophrenia.[1]

For participants, this domain was focused on particular kinds of experiences which I characterize here as 'extraordinary'.[2] I define this extraordinariness as a specific conjuncture of the strange and the familiar — what is also termed 'uncanny' (Kristeva 1991; see below). Experience was only extraordinary to the extent that it was distinguished from the ordinary, at the same time as it encompassed this ordinariness. Ordinariness continually imposed itself through a person's own biography and history, such that experiences were only extraordinary by contrast with what participants had previously taken to be ordinary, as well as the ordinariness which they confronted in other people, in their own homes, in the everyday settings of their lives, and in the resources which were available to render their experiences understandable to both themselves and

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[1] Cf. Good and Good's (1982: 148) definition of 'illness reality' as a set of words, experiences and feelings which typically 'run together' in a given society by way of networks of meaning and interaction.

[2] Others have characterized this quality in terms of deviance (Weber 1989), inconsistency (Binswanger: 1963: 252), or anomaly (Reed 1972). I examine the latter characterization below, where I treat 'anomaly' as a particular case of extraordinariness.

others. Van den Berg (1982) has attempted to capture this quality by pointing out how even hallucinating occurs 'amid' everyday perceptions and mental processes:

> Hallucinating, according to it nature, is to see (hear, etc.) that which another does not see, amid that which everyone including the patient himself, sees. This 'amid' is a prerequisite in the same way as light is a prerequisite of darkness. To hallucinate means to have a world strictly of one's own in the framework of reference of the social world. The patient knows of his hallucinations and he can (sometimes) talk about them; they are present to him but through his story they are there for us as well. He would not be able to talk about them if he did not know about them; that is, if it were completely impossible for him to place the hallucination in our very own world by means of knowledge and telling, amid things that are things to all of us…' (van den Berg 1982: 160-1)

Participants in this study lived amid the things of this world, but they often had remarkable experiences of them. This remarkableness was not confined to symptoms of a psychotic illness, such as hallucinating, but was a quality discernible in many aspects of their everyday worlds. Throughout this dissertation I will return to this apprehension of extraordinariness in a range of everyday settings and circumstances. In this chapter I show that this extraordinariness was mediated by a series of tropes which linked participants' experiences to symbols and themes which were widely available in their culture. These tropes provided participants with images which located their accounts amid other ways of knowing and talking about experience.

This same extraordinariness perplexed participants and caused them to reflect on the nature of their experiences, just as it was the quality of our encounters which struck and engaged me. Since many of these extraordinary experiences were both highly idiosyncratic and difficult to grasp, and since the category of 'experience' is itself amorphous[3], I delineate them here by way of the examples proffered by participants in their attempts to have me understand. The chapter therefore maps out a distinctive domain, with the participants acting as guides. It delineates the location and tenor of what participants asserted was the

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[3] Cf. Corin and Lauzon (1994: 11) who assert, from a phenomenological perspective, that the 'infinite openness' of experience means that it is 'always susceptible to another, complementary reading'. See also Schutz (1972: 50), citing Husserl: 'Even an experience is not, and never is, perceived in its completeness, it cannot be grasped adequately in its full unity. It is essentially something that flows, and starting from the present moment we can swim after it, our gaze reflectively turned towards it, whilst the stretches we leave in our wake are lost to perception.'

most important thing which I had to know in order to understand them; like participants' own lives, these experiences orient the subject matter of the dissertation.

EXTRAORDINARY EXPERIENCE

Most participants in the study asserted that it was a range of extraordinary experiences which characterized their lives with schizophrenia. These were not the 'mere' experiences of everyday life, but reflected the distinction between 'experience' and 'an experience' made by Dilthey and elaborated by Turner:

> Mere experience is simply the passive endurance and acceptance of events. *An* experience, like a rock in a zen sand garden, stands out from the evenness of passing hours and years and forms what Dilthey called a "structure of experience". (Turner 1986: 35)

Schizophrenia was 'an experience' in this sense, involving unusual and outstanding phenomena which were paramount in the creation and assertion of distinctive identities, belief systems and world views.

One participant, who I have called Lawrence, attempted to illustrate this province of extraordinary experience with a series of striking images. We had known Lawrence, a man in his late twenties, for a month and had been working with him, at his home, on the nature of his experiences. In addition to what he understood as the "ordinary" experiences of psychosis — 'voices' and changing perceptions of colour, space and time — Lawrence occasionally had what he called "esoteric symptoms", including an experience of infinity which (he said) afforded him a glimpse of "ultimate reality":

> "The problem with ultimate reality is [that it's] a very emotional sort of idea, because ... obviously there's a lot of problems of fear and apprehension about that sort of idea. The one thing that struck me about this experience of infinity was the fact that I was extremely relaxed, and felt very, very calm and at peace with the world... It was like death in as much as there was no more noise, and I no longer had to organize reality."

Lawrence went on to note that such experiences,

> "... exist independently of any associations. They exist in their own right as exceptional states that aren't dependent upon other aspects of reality. They ... stand alone — they're self-sufficient experiences."

In another context he added: "I guess the fact that sometimes I see the infinite and find it difficult to recognize things — in a way, that summarizes the whole of schizophrenia". Lawrence — himself a painter — found parallels for this experience in both mysticism and abstract expressionist painting.

Ordinary experience is often inchoate and unremarkable: 'Things are experienced, but not in any way that they are composed into *an* experience' (Abrahams 1986: 61, quoting from Dewey). Binswanger similarly characterized ordinary experience as unproblematic, self-evident (and to this extent, intersubjective as well):

> Natural experience is that in which our experience moves not only unreflectively, but also unproblematically and unobtrusively, as smoothly as a natural chain of events... Even when something is unknown to us, this something does not fall out of the self-evident context that is natural experience. The chain of events in experience can therefore be "natural" only insofar as it is *inherently* consistent, that is, in our sense of being in harmony with things and circumstances, with others (whom we meet in our everyday intercourse with circumstances and things), and with ourselves: having, in a word, the sense of *residing* [*Aufenthalt* — Heidegger]. The immediateness of this residing among "things" or "circumstances" is manifested in our *letting* beings — all beings — *be* as they are in themselves. (Binswanger 1963: 251-2; original emphasis)

The experiences which participants in the present study associated with schizophrenia — together with their self-conscious apprehension of these experiences as distinctive — represented a significant disjuncture with such 'ordinary' experience. Binswanger similarly characterizes this 'break' with 'natural' experience in terms of a radical 'inconsistency': in schizophrenia, consistency is neither self-evident nor 'easy', but must be actively sought (see also Blankenburg 1980: 64). This was obvious in many participants' active search for the meaning of their experiences — such intentionality highlighting and accentuating the process, described by Schutz, in which undifferentiated 'lived experiences' become 'constituted experiences' through being distinguished, brought into relief, marked out from each another, and thereby made 'objects of attention' (Schutz

1972: 51).[4] Inconsistency, for Binswanger, 'implies precisely that inability to "let things be" in the immediate encounter with them, the inability, in other words, to reside serenely among things' — a 'drastic inability to reside undisturbedly among the things of this world' which he maintained characterizes schizophrenia (Binswanger 1963: 252).

Participants confirmed (and sought to demonstrate) this distancing from what they perceived as 'ordinary' or 'natural' experience. Both the experiences and those who experienced them were cast as 'things apart'. Experiences were extraordinary insofar as they were counterposed to the 'ordinary' flow of life. They did not, however, conform to Abrahams' definition (1986: 63) of the extraordinary as those experiences 'for which we plan and to which we look forward': those anticipated 'Big Times' which break routines through a departure into higher or deeper registers by way of celebration or aesthetic and religious immersion (ibid: 67). Instead, the experiences which concern me here conformed to the category of 'spontaneous' experiences — those moments which were 'big but which stole up on us and took us unaware' — which Abrahams asserts are a genuine rarity (ibid: 65). They were marked by their singularity, their lack of fit, and the difficulty of their comprehension for both self and others. It is to these experiences that Shokeid (1992) draws attention and seeks to reclaim as a neglected category of everyday life. Participants' experiences of schizophrenia were quintessentially of this type: they were 'the events that befall the individual unprepared and with no script in hand to guide his or her proper demeanour' (ibid: 233) and which were 'not encapsulated in an experientially standardized pattern' (ibid: 234). Following Dewey, Shokeid characterizes extraordinary experiences as those which stand out 'as a unified segment of experience-in-general that focused our attention, touched us deeply, engaged our emotions, and stimulated some whole-hearted response' (ibid: 233).

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[4] In phenomenological terms, it is this intentionality and these processes of differentiation which render 'pre-empirical' or 'pre-reflexive' lived experiences into specific phenomena (Schutz 1972: 50).

Participants' understandings of schizophrenia, the coping strategies they employed, and the very notion of 'recovery' itself — all foci of the original research project — were hardly meaningful without a clearer view of what constituted an experience for participants, the range of phenomena which they considered themselves to have experienced and, therefore, what such strategies were aimed at coping with. It became apparent that these strategies and understandings were directed toward a spectrum of extraordinary experiences which were disturbing, disorienting, chaotic and hard to grasp. The majority of participants responded to these — after an initial terror — with intrigue and perplexity. In many participants they had incited an intense quest for meaning and a search for ways in which to orient a life around them — what Corin and Lauzon (1994) characterize as the 'rearticulation' of schizophrenic experience with an everyday world comprising self, others and social roles. The significance of these concerns was reflected in my own experience as ethnographer: the encounter with some participants was itself remarkable, leaving me shocked, disquieted, disoriented, and unable to grasp what had transpired. These encounters initiated in me the same quest to find orientation, meaning and intersubjectivity which participants themselves evinced — that is, a quest to locate these experiences in relation to an ordinary, everyday world. Things would happen in these encounters which had never happened to me before — which were unscripted by my own prior knowledge or experience — and it was this which inaugurated my ethnographic quest for understanding. My perplexity was not the same as that of participants but it resonated between us and could therefore be explored dialogically to delineate its significance for each of us (see Kimura 1982: 177-9; see also Chapter 6).

Participants themselves asserted that their experiences were the most important thing about them and thereby delineated a specific domain of investigation and participation. According to many participants, it was only by attending to this category that I could understand the 'sense' and 'quality' of their world (cf. Fernandez 1986). Participants worked hard to demonstrate the practical, experiential and existential centrality of extraordinary experiences in their lives.

Likewise, this extraordinariness enveloped my own encounter with participants — it was what struck and perplexed me about them — and was the pivot of our engagement with each other.

It was this centrality which signalled the ethnographic and phenomenological importance of 'experience' as a category in terms of which participants understood themselves. It is this which made the category of 'experience' pivotal to a hermeneutics of the role of schizophrenia in shaping participants' worlds (cf. Walton 1995: 76), and which caused experience to emerge as a primary object (as well as product) of the research process.

I was hardly the first person to be fascinated by these phenomena. They were often associated with what psychiatrists call 'psychosis': that is, auditory and visual hallucinations, delusions, and profound disturbances of the sense of self.[5] As such they have long been the focus of intense clinical scrutiny, documentation and theorizing. My own interest reproduced the 'fascination' with psychotic phenomena noted by Keitel (1989: 30): 'Realms beyond human experience exercise a fascination, a strange mixture of curiosity, anxiety and aversion, on those not afflicted by them; to have the impact of such an experience explained, while one is allowed to remain personally unaffected by it, stimulates the imagination'. Such fascination has drawn commentators and interpreters

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[5] The terms 'psychosis' and 'schizophrenia' were often used interchangeably by participants. They had presumably become familiar with both terms in a range of clinical settings, although their uses of them did not necessarily reproduce those found in such settings. For most participants, psychosis was associated with a sense of chaos (especially a chaotic "assault" of visual, auditory and physical stimuli), and with feelings of being confused, "overwhelmed" or "swamped" by such phenomena. For psychiatry, schizophrenia is the quintessential form of psychosis, 'a mode of being usually marked by the presence of true *delusions* or *hallucinations*' (Sass 1992b: 127n). These hallucinations and delusions are in turn defined in terms of 'poor reality-testing': a concept which 'corresponds more or less to lay notions of madness as being a matter of seeing or hearing things that are not there or believing things that are not true' (ibid). Thus the interchangeability of 'psychosis' and 'schizophrenia' simultaneously reflects the intermingling of professional and lay understandings of mental illness.

from many intellectual, artistic and professional fields. The sharing of this fascinated interest with participants themselves, however, meant that there were two senses in which such phenomena were not 'beyond human experience'. Firstly, they were very much part of participants' sense of themselves as people and as representatives of humanity, signifying for some the potentiality and extremities of that condition through a crystallization of 'experience-in-general' (cf. Shokeid 1992). For these participants, such experiences represented the potential and logical extension of being human (that is, of being individual, self-conscious, reflexive, suffering and transcending).[6] For one participant, schizophrenia was "more interesting than the everyday world" precisely because of the vistas it opened up and the horizons of experience which it pushed back, even while he acknowledged that it was dangerous and threatening when an "inner reality" did not mesh with the "outside reality" expressed by others. Secondly, the outline and meaning of these experiences was something which could be established between us as the result of an attenuated dialogic engagement (see Chapter 6). The project to understand experiences associated with schizophrenia — a project on which many participants were already engaged before we met them, and to which we, as 'professional' researchers, were sometimes co-opted — attested to a strong imperative to bring these phenomena within the bounds of acknowledged human experience more generally.

MAKING SENSE OF EXTRAORDINARY EXPERIENCE

Even when experiences could be diagnosed as symptoms of psychopathology this categorization did not necessarily limit or constrain how participants understood them for themselves. They described these phenomena in various ways: as heightened sensory and intellectual abilities, ESP, hearing the 'voice of God', as various forms of 'other-worldly'

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[6] Such assertions echoed Harry Stack Sullivan's striking formulation of separation and 'splitting' as central to the human condition: 'Man's first experience, birth, is schizophrenic' (Sullivan 1964: 4). See also van den Berg (1982: 163).

visitations, possession, and 'spiritual affliction', amongst others. A number of different frameworks were thus available to interpret these phenomena including spirituality, mysticism and existential philosophy, as well as psychopathology. They were also delineated with reference to other phenomena which were widely available in contemporary culture. Such delineation relied upon a metaphoric 'turning' from 'our immediate and familiar experiences — extending them — to the understanding of unfamiliar situations' as a means of discovering how to feel about and act towards the strange, the unusual or the other (Fernandez 1975: 653). With such metaphors, participants had access to other models — including moral retribution, tutelage, asceticism, humility and suffering — with which to apprehend and communicate the profound biographical rupture and reorientation which was schizophrenia.

As we sat talking at the cafe, Wynn used similar images of 'translating' and 'turning' when we asked her what it was like to recall episodes of psychosis. She talked of "sides", using her hands to signal each side of her head. The psychosis was on one side and we were on the other; she was "translating" between them. She said it was not like re-living the phenomena; rather it was like "going into the remembrance" and "talking about my dreams".

Four of the most prominent metaphoric frameworks used by participants to characterize the quality of their experiences were drugs, war, religion and death.

Drug experiences

The effects of drugs (especially marijuana and hallucinogens such as LSD) were a conspicuous analogy for many of the experiences associated with schizophrenia — one participant likening the effects of marijuana to "my normal psychosis". Another participant, Kelvin, who had undergone numerous hospitalizations in another Australian state and was therefore *au-fait* with psychiatric explanations of his 'condition', accounted for his schizophrenia — and indeed, his life — almost entirely in terms of drugs and their effects. His conversation was dominated by talk about illicit (and to a lesser extent, prescribed) drug abuse: his family history was dominated by a mother whose own psychiatric hospitalization Kelvin attributed to the over-use of recreational drugs in the 1960s; he attributed the onset of his own "problems" to a "change of dealers" which resulted in the consumption of some "laced" marijuana. When talking about the phenomena which his psychiatrist called psychosis, Kelvin used terms associated with the drug culture: they were "a big trip", or a "wild sort of trip". He used the same images of excess to describe both drug and schizophrenia experiences — "high speed mode", "over the top", "put me through the roof", "my imagination going overtime" — such that these were indistinguishable.

War trauma or post traumatic stress

Analogies to war were also ubiquitous in many peoples' accounts of schizophrenia. This was stated explicitly by one participant when he noted: "I was having a lot of physical problems and mental problems, you know, like just a battle, just a warfare situation all the way through". The analogy between schizophrenia and war as equally cataclysmic transformations of perception and identity was most striking in the case of one participant. Colin, a former athlete aged in his mid-twenties, had assumed the identity of a Vietnam veteran, even though he was only four years old at the end of that war. In a "transfer" of psychic, physical and sexual "energies" he believed that he had absorbed the "horror" of war from veterans he had met. The exceptional "power" this afforded him — together with its attendant physical debilitation and psychic peculiarities, such as "flashbacks" and post traumatic stress — was manifested as phenomena which his treating psychiatrist called schizophrenia, a diagnosis he did not accept. With Colin, the theme of battle — which many other participants used to describe the effect of 'symptoms' which "hit" or "bombarded" them — was explicitly the vehicle and the very form of his everyday experience. He was, he said, "living in a war-zone". In characterizing his daily life he said: "I've just been an open wound for the last five and a half years". Such images of openness, damage, trauma, battle and vulnerability were echoed by many other participants.

Religious models of experience

Religious analogies were prominent in several peoples' characterizations of schizophrenia, exemplified by the number of references which were made to the Biblical episode of Saul on the road to Damascus[7], or to the report by the apostle Paul concerning a man who was 'caught up into Paradise' by Christ and who heard 'things that cannot be told' and which 'man may not utter'.[8] Various participants described auditory hallucinations ('voices') as the "chatterings of evil spirits", "uninvited prayers", or the "voice of God". In addition to 'voices', Tony, a former charismatic Christian, was beset by bizarre and unaccountable physical symptoms such as twisting and shaking which occurred, he believed, in response to electro-magnetic fields (phenomena which he allowed us to record on videotape). He made use of another Biblical story about Paul to represent his experiences. He saw himself as possessing "revelatory information", and to be persecuted for this in the same way that the Biblical Paul was tormented by a thorn in his flesh, a 'messenger of Satan'. Commenting on the cause of his "physical afflictions" Tony said:

> "It's very hard to say exactly what it is, to define what it is. Paul calls it a sin that dwells within ... You could say spirits within, or sin. It's as though there's alien entities ... They're unseen and the best you can do is make as much head-way in it as you can and just come to some sort of conclusion. I'm unsure. I know that there's definitely spirits and demons. I don't deny that because of the Gospel. As a Christian I have to believe that."

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[7] On a mission to apprehend Christians and deliver them bound to the priests in Jerusalem, Saul (later known as Paul) was subject to the quintessential conversion experience: 'Now as he journeyed he approached Damascus, and suddenly a light from heaven flashed about him. And he fell to the ground and heard a voice saying to him, "Saul, Saul, why do you persecute me?" And he said "Who are you, Lord?" And he said, "I am Jesus, whom you are persecuting; but rise and enter the city, and you will be told what you are to do."' (*Acts* 9, 3-6) Others who were travelling with Saul heard the voice but saw no-one. When Saul rose from the ground he was blind and had to be led into Damascus. Following the laying on of hands by Ananias, who was instructed in this by a vision and the voice of Jesus, Saul's blindness was cured; he was baptised and began preaching.

[8] *2 Corinthians* 12, 2-4.

I asked Tony how he thought Biblical images fitted with the concept of schizophrenia. He replied:

> "Well, they say that Ezekiel was schizophrenic. He's on the ground and the spirit of God picks him up. You know, someone's looked at some of his utterances and said, 'Yes, he's schizophrenic'. He [God] also speaks through him, or he [Ezekiel] hears voices. Many of the things that happen in schizophrenia are documented in the Bible. I'm saying: 'Look, here is a manual to mental illness' ... There's key associations with voices and different things ... not just in terms of defining a voice or a picking up or a physical movement , but the physical things are there. The voices are there. The voices of angels are there. The thorn as Paul talks about in his flesh, which is a messenger."

Religious frameworks also accommodated peoples' experiences within wider schema of good and evil, sin and retribution, destiny and fate, justice and injustice, thus linking them with broader and culturally significant themes.

Death and near-death experiences

Two participants reported having had near-death experiences, one occurring in the context of a car accident and another in relation to a coma induced by multiple drug overdose. In both cases such experiences were reported as life-changing, and served to organize and communicate experiences more commonly associated with schizophrenia. For some participants the perceptual abnormalities, hyperalertness, depersonalization and 'mystic consciousness' associated with near-death experiences (see Moody 1975; Roberts & Owen 1988) — as widely reported in the mass media, or represented in popular film and television[9], for example — served as a further analogy for experiences which they interpreted within a religious or 'mystical' framework. These included the perception of light as a form of consciousness and the apprehension of a disembodied benevolent force or agency at work in their lives.[10] In an autobiographical manuscript which recounted the

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[9] The film *Flatliners* (Columbia Pictures, 1990) was broadcast on local television during the period of research. Its portrayal of near-death experiences and hallucinations, its themes of sin and guilt, as well as the seeking of experiential extremes, struck a chord with several participants.

[10] Religion and death are intimately linked, of course, suggesting other slippages between these frameworks. Sullivan (1974: 75), for example, recounts the pivotal role played by a sermon on the religious text 'To-day ye are dead and to-morrow ye shall live' in the development of a young man's schizophrenic illness. Gerald, a participant in the present study aged in his late forties, articulated a similar perception of everyday life as a kind of death in the face of a 'true life' attained through religious guidance, thereby reproducing the imagery of a transcendent 'Future Life' which is widely

history of his schizophrenia, Adam employed these images 'as a way of understanding what this experience was':

> I felt like I was being sucked out of a reality which concerned earthly things, into a reality which did not acknowledge death. Death was a translation and death was a memory. When you're dead you float away from your body. You can see a huge light above and see the earth below. You see your own body. It's the only memory I have which is always in slow motion.

Such slippages between frameworks (medical, religious and paranormal, for example) were prevalent in participants' explanations.

Associations between schizophrenia and death are common, as in the following confluence of images invoking wraiths and ghosts:

> The shadow-world inhabited by some schizophrenics and neurotics closely resembles the world of the dead, as described in some of the earlier religious traditions. Like the wraiths in Sheol and in Homer's Hades, these mentally disturbed persons have lost touch with matter, language and their fellow beings. They have no purchase on life and are condemned to ineffectiveness, solitude and a silence broken only by the senseless squeak and gibber of ghosts. (Huxley 1994: 131)

There are associations also with the 'living dead' and schizophrenia as a 'death in life'.[11] One participant described her schizophrenia as a "spiritual death". The capacity of medication to turn one into a 'zombie' — the quintessential popular image of the 'living dead' — was widely articulated. One participant insisted that she was a zombie.

Death and its contemplation were not strange to most participants. More than half of them had attempted suicide at least once (some several times), and all knew of others who had

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available in Christian cultures (cf. Sullivan ibid: 339). Another participant was immobilized by apocalyptic inevitability: "I started seeing religion as though it was like a chain of events, so I was reading the Bible as though it was a chain of events and [I believed] that I had to act out each one of these things and when it came to *Revelations* it was like I had to die or something like that ... like it was all leading to some big end or something".

[11] See Laing (1965: 175-6). Walton (1995: 129) describes two participants in her study who had 'felt dead' some time during the course of their illness and she comments: 'To feel dead while still alive is no longer to be a person at all, to have no place in the world. To feel dead while still alive is to be temporarily suspended in a place of nothingness.' (ibid) These, too, were life-changing experiences (ibid: 130). Her quoted examples include images of incapacity, 'being off the face of the earth', being in 'the black hole of Calcutta', and losing contact with people. See also Sullivan (1974: 98) on the recurring symbolism of death, rebirth, somnolence and stupor which commonly result in expressions such as "I feel half dead".

died. Death or its possibility attended participants' everyday lives, even though schizophrenia was not in itself a terminal illness. Rather than a physical or existential threat, death served as a reference point and a narrative resource. This indeterminate presence of death in life was not necessarily a morbid one but a site of transformation and a space for re-creating identities. That death often has such cultural connotations is emphasized by Taussig:

> … the space of death is notoriously conflict-ridden and contradictory; a privileged domain of metamorphosis, the space par excellence for uncertainty and terror to stun permanently, yet revive and empower with new life. In Western tradition we are well aware of how death and life, and evil and salvation, are therein conflated. (Taussig 1986: 374)

One participant, Aiden, articulated a striking image of this 'space' of death and regeneration, which he said represented the pivot of his identity as shaped by schizophrenia. He reported a recurring experience of what he called the "ethereal plane of death and rebirth". He explained that he journeyed to this "empty place" — which he also called the "plane of the soul" and "eternity" — each time he stopped taking his medication, which he did purposefully at regular intervals in order to re-activate the experience. It was a journey which, at least in its initial phases, involved a lot of pain and chaotic perceptions. In the midst of this chaos, "you want to kill yourself and put an end to it … then my mind shuts down and there's peace". The result was a kind of perceptual and emotional limbo:

> "My mind is just blank. It's just like I'm completely on my own plane. I'm lying in bed, you know, thinking of nothing. It's very peaceful."

There are no 'voices', no thoughts, and no visual hallucinations. He described this place as misty and ill-formed, without boundaries and dimensions (except an indeterminate spatial extent). He said that he loved the mist because "it's like an intermediary between form and formlessness". He cannot stay in this place for too long because he would die from lack of nourishment: the experience is so seductive that he forgets to eat or perform the usual functions of daily life. He said that he did almost die once, from pneumonia and anaemia. Aiden had incorporated the imagery of this phenomenon into one of his elaborate fictional works.

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These were not the only ways in which people represented schizophrenia, nor were they mutually exclusive. Many expressions combined these frameworks in complex and multi-layered ways which reflected one of the principal mechanisms of tropism identified by Fernandez (1975: 653): the 'turning … down by specification or up by generalization' within a lexical domain, or from one part of a domain to another (metonym), and from one domain to another (metaphor). Sometimes, however, even these processes failed to provide sufficient means to apprehend and translate unprecedented experience and imagination, which participants insisted were beyond words or any other form of communication.[12]

These were, however, among the most ubiquitous ways in which participants sought to convey their experiences. Just as importantly, these were frameworks which had a wide social currency, were readily available from a variety of sources, and were well rehearsed as vehicles by which to convey difficult ideas. Not only did they allow participants to make sense of their own experiences, but they functioned as a means to communicate that sense to others. It was via these metaphors that I began to know what participants were talking about and could begin the process of mutual interpretation, as we each had a cultural repertoire of understandings concerning drugs as disorienting, war as assaulting, death as transfiguring, and so on. This was the process by which schizophrenia was given a specific form within recognizable cultural parameters. These were also frameworks which allowed understandings of schizophrenia to escape psychiatric labelling since such tropes referred to aspects of participants' everyday worlds and to the wider culture in ways which were not encapsulated by psychopathology. These were sources of the ordinary within the extraordinary.

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[12] Cf. Geertz (1983: 44) who alludes to the book *The Great War and Modern Memory* in which Fussel demonstrated that received conventions of writing and imagery sometimes broke down under the pressure of what was new and alien about the experiences of World War I.

SPECIFYING WHAT SORT OF 'EXPERIENCE' SCHIZOPHRENIA WAS

Each of these frameworks revealed something of how experience itself (as refracted through schizophrenia) was characterized. Its major lineaments were forcefulness, covertness, disorientation and transfiguration.

Forcefulness

The experiences associated with schizophrenia were consistently represented as a powerful force: they "hit", "attacked" and "bruised". They were an "onslaught" and an "explosion". Commenting on his experiments with LSD, Adam emphasized this explosive (and painful) analogy:

> "It's interesting. It's like schizophrenia in some ways … instead of … utilizing your conscious expression in a chronological one-word-by-one-word way, it's like thinking as though someone's put a red hot poker on your arm or something, and you really go into extremely high-speed cognition which usually bursts into pictures when it's congruent and coherent and disciplined. You burst into visions of stories and all sorts of really wonderful things."

Covertness

For some participants this force was concealed and surreptitious, "creeping up" undetected. For Marie, the assault was covert, a battle of wits. She described her 'voices' in the following militaristic terms:

> "If they want to convince you to do something they use all sorts of tactics. In the first place their tactic was to offer something good, but it was trickery. They were offering a solution to things by psychotic power. They didn't manifest themselves. They don't have to show you what they are. It's like guerrilla warfare."

One participant described schizophrenia as a "terrorist threat [from] within". It was a threat which, he believed, caused him to be apprehended as a "threat" to others, resulting in him sequestering himself inside his house and "keeping a low profile". This was an example of how subjective experience was articulated with the meaning structures of a wider social world, with profound consequences for the person's everyday practice.

Disorientation

Michele recalled the onset of schizophrenia as feeling like she was using drugs (which she had done previously, "as a kid", for fun):

> "... one minute I'd be all right and the next I'd be spinning out ... like going high. Like a high and going very vague."

Numerous other participants attested to feelings of being "out of it", "cut loose", or "lost" in a fantasy world.

Transfiguration

Many participants saw their experiences as revelatory, either prompted by, or in themselves precipitating, a change in belief. Such experiences were also seen as providing access to previously undisclosed religious or metaphysical realities. Tony's principal activity was documenting what he called the "religious schizophrenia" which had overtaken his life. Adam asserted that schizophrenia "really puts you in the picture when it comes to religious conversion".

The experiences associated with schizophrenia were thereby transfiguring and transforming. One participant, Shaun, put this succinctly in conveying to me his altered thinking. He said:

> "The state of mind that dope gives you, that altered consciousness, like alcohol, that's what you end up with. That dream-like state. That's what you end up with after a few months of hallucinations."

Shaun insisted that this 'state of mind' was always potentially available to him, whether or not he was hallucinating, should he choose to access it. It was what he tried to demonstrate by way of having us appreciate (and attempt to reproduce) the 'referencing' phenomena and synchronizations which, for him, were its everyday medium. Shaun insisted that, having been propelled into this way of thinking by psychosis, there was no "going back". Becoming aware of these phenomena had changed his sentient awareness — what he called his "consciousness". Thinking these things had changed how he thought. His experiences had transformed how he appreciated and understood the category of 'experience' itself. This transfiguring effect was an ongoing source of transformation and reflexivity for many participants (see Chapter 5). In essence I propose that the 'experiencing' of those extraordinary experiences which participants associated with schizophrenia was transfiguring in this generative and ramifying sense.

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As the metaphors of assault suggest, these experiences had a physicality about them. They were embodied. They attacked, hit and accosted the person as a physical force. They were apprehended in the body: as an "alien physical presence", as a "brain on fire", as pain, as being "torched" and "hot-wired". Not only were they registered in the body, but some participants attributed these experiences were a power to alter the body itself. For example, various participants believed that such experiences, in and of themselves, had the capacity to produce exceptional physical attributes, accelerate or diminish the body's growth, or to be the actual cause of altered brain 'chemicals' (the principal 'medical' explanation of schizophrenia which had been taught to them in a number of settings). Sometimes, most distressingly, these experiences were apprehended as phenomena which penetrated and violated the body in a sexual manner.

As the metaphors of force suggest, these experiences had a distinctive temporal dimension: their effect was sudden, "out of the blue" or instantaneous, "something just clicked". They were also experiences which had their own temporal effects: they caused time to "stand still", "go backwards", or be "distorted"; they belonged "to a part of time before language"; or they "melded different times" together.

As the metaphors of disorientation suggest, experience had spatial dimensions: those associated with schizophrenia were “off the planet”, “off the air”, “in another universe”, “in another dimension”. Their cumulative effect was summed up by one participant, Roland, as being “out of your head, out of your body, [and] out of society”. His response to being ‘thrown’ into this new way of being (cf. Walton 1995: 101ff) was to conceive of his life as a perpetual journey of discovery:

> “Schizophrenia is to be taken out of the world, into another reality. The journey is to go back into the world again, but to have learnt some lessons on the way. The purpose [of schizophrenia] is to discover your own style of living.”

This echoed Laing’s (1967: 120ff) characterization of psychosis as an epic ‘voyage’ of discovery and return.

In some circumstances these experiences were attributed an agency of their own: they were, as Shaun said, an “alter-intelligence”. ‘Voices’ were sometimes personified (literally identified as a person or group of persons with cognisance, emotion, will and agency — see Chapter 7), and had the power to “trick” and beguile. They could usurp the person’s own agency, being perceived as the cause of various involuntary actions such as automatic verbal outbursts, or being strangled by one’s own hands.

As in all metaphoric processes, any one of these dimensions could entail or draw upon another. Thus, one participant noted of her experience of *deja vu* that time was vague in the same way that her hallucinations could not be spatially pin-pointed. The force of experiences was indicative of their agency, representing their capacity to ‘hit’ and destablize the recipient. These attributes of force and agency were each apprehended in the body.

In the context of participants’ usage, each of the four frameworks — drugs, war, religion and death — also revealed a more fundamental set of referents which made them particularly apt analogies for the experiences of schizophrenia. Each represented a potentially perilous disruption of everyday life and signalled an uncertain end point (which resonated with professional constructs of schizophrenia as a 'break' with previous levels of functioning, leading to a lingering chronicity). Each could be used to express the qualities of danger, transformation and revelation which identified schizophrenia as a particular type of experience. The fearful, perilous and empirical ('real') qualities which are 'laminated' into the very concept of experience (Turner 1982: 17) were prominent in the cognitive and affective aura which participants evoked when they specified those experiences which they associated with schizophrenia. These attributes did not stay suspended in their originating phenomena (a psychotic episode, for example), but were reflected in participants' assessment and accounting for subsequent experience, and inflected their understandings of experience more generally.

Thus experience — as it was characterized and evoked by participants —was something active rather than passive. It was not simply subjective (that is, something residing irreducibly *inside* discrete persons). It entailed a practical engagement and confrontation with the world. In this it partook of some of the qualities of experience noted by Hegel (1967). For Hegel, experience is not simply one's subjective awareness of or involvement in an event — that is, a passive reception. Experience is affective. It comes as a shock, and it changes things. Experience confronts with the unexpected. It violates familiar views by forcing something new into consciousness. It is unsettling, disturbing taken-for-granted accommodations to reality and effecting a transformation of some kind. Since experience modifies or replaces what is familiar, it does not simply cause change, it is change itself (Thompson 1995: 236). It is registered in both subject and object. For Hegel, experience is not simply subjective but transcendental, because it takes me outside myself and places me inside a situation which alters my perspective. It changes, to some extent, who I am. Hegel's term for the relationship with things that affect me through experience is 'dialectical':

> This dialectical process which consciousness executes on itself — on its knowledge as well as on its object — in the sense that out of it the new and

> true object arises, is precisely what is termed Experience. (Hegel 1967: 142)

Participants' explications of experience also resonated with its characterization by Heidegger:

> To undergo an experience with something ... means that this something befalls us, strikes us, comes over us, overwhelms and transforms us. When we talk of "undergoing" an experience, we mean specifically that the experience is not of our own making; to undergo here means that we endure it, suffer it, receive it as it strikes us and submit to it. It is this something itself that comes about, comes to pass, happens. (Heidegger 1982: 57)

Heidegger was influenced by Hegel, but emphasized the revelatory aspects of experience as well as the transformative ones (see Desjarlais 1996a: 75). For Heidegger, experience does not merely change the 'inhabited' (taken-for-granted) world, it also reveals things about it that had not been known before. For Heidegger, experience elicits truth; many participants insisted that schizophrenia had initiated the same quest for truth in them.

Heidegger was also more interested in the practical, 'to-hand' aspects of experience than was Hegel (see Heidegger 1962: 95ff). He emphasized the human capacity to solicit and direct it. Experience can also be resisted: because it is transformative it can be frightening, and is resisted by 'holding back'.[13] Equally, it can assume a certain direction for a specific purpose, and it can be anticipated purposefully, deliberately and thoughtfully. Some participants certainly did this in respect of the experiences they associated with schizophrenia, soliciting them, documenting them, exploring their meaning and consequences. Like Heidegger, they also insisted that their experiences could be used to gain knowledge of the self.

From a Heideggerian perspective, the degree to which I am able to experience something is determined by how willing I am to submit to whatever it is I experience (Thompson 1995:

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[13] This is one of the two senses of 'resistance' which Kleinman (1995: 125-6) uses to explore chronic pain. Kleinman proposes that illness itself — as a source of loss, fear, menace and suffering — is an existential constraint which blocks, limits or 'derails' the flow of experience and practical action.

236). This was certainly true of my encounter with people who had been diagnosed with schizophrenia, just as it was a stance taken by many participants in respect of schizophrenia itself. It is in this way that such philosophical perspectives have a profound resonance with the ethnographic aims of the research, as well as illuminating how participants viewed and used the category of 'experience'.

AN UNCERTAIN PLACE, INEFFABLE AND ANOMALOUS

There was, in addition to these elements of revelation, rupture and transformation, a more pervasive characterization of the domain. Participants emphasized that the experiences they associated with schizophrenia were often hard to grasp. As a consequence, ineffability and anomaly were abiding features of their lives. As one participant said, schizophrenia was "a guided tour to somewhere uncertain". Not only was the destination uncertain (and psychiatry, most participants felt, was unable to clarify or alleviate this), but the 'guides' which drew one into this domain — such as 'voices' — were equally hard to grasp or comprehend (see Chapter 7). Likewise, for me, participants were often puzzling guides to this uncertain domain.

Many of the phenomena associated with schizophrenia were anomalous in the strict sense that they did not conform or sit comfortably with any pre-given, habitual or taken-for-granted schemata.[14] These were experiences which were quintessentially difficult to specify or classify. Hence the imperative for metaphoric frameworks by which to convey them. They were, to use the language of Fernandez, a compelling example of the inchoateness on which identity is predicated by way of tropic processes. As Fernandez (1986: 184) has argued in respect of Bwiti religious sermons: 'Orderliness, the structure,

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[14] Cf. Reed (1972: 9) who defines anomalous experience as that which is unusual, irregular, atypical and disordered.

perceived in one domain of experience … is used to inform and structure — [to] edify — an orderliness in another more inchoate domain of experience'.[15]

This anomalous character was evident in Aiden's comments on his experiences following the realization that he was "completely open to the world" via the media of television — a scenario in which he felt "naked", with "no boundary between me and the outside world". He was, by his own account, thrust "completely beyond everyday experience". Asked to recall what this felt like when it began Aiden responded:

> "It's sort of like a deep sensation. It's not a thought … it's like a deep feeling in your chest, I suppose. You can feel it in your bones, you know? You can feel that this is really going on. It's like with anything else, if you really believe something then you have that belief that really goes to the core and really … sends tremors through you. Sort of [a] power thing. It's a powerful experience, and that power really shakes you to the core. That was what was happening, it was really sort of getting inside me and doing things to me."

This complex imagery emphasizes the confusion of categories invoked by such pivotal experiences — experiences which Aiden said had "changed my life". They were anomalous because 'beyond' the everyday, and they further transformed a life by "sending [it] on a completely different course". Both their origins and subsequent effects were unprecedented, rendering the experience doubly strange. The transgression of taken-for-granted categories was prominent in Aiden's account. Inside and outside were conflated: the phenomenon appeared to come from outside (in this case, the television), but it enters deep into a person's core and "shakes" it up. Mind and body interpenetrate: it was a thought, a feeling, or a sensation which was registered in the physical structure (the

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[15] Dilthey, commenting on the 'incomprehensibility' of some experiences — especially those which are 'alien and terrible', strange, irreconcilable and contradictory — similarly employed the notion of 'metaphor' to describe how an individual's experience is articulated with broader (historically and culturally given) 'attitudes to life' or world-views. According to Dilthey, metaphor is a 'procedure' for,

> … understanding something which cannot be grasped as it is given to us by means of something more distinct. What is distinct becomes a means of understanding or basis for explanation of the incomprehensible. Science analyses and develops the general relationships of homogenous facts which it has thus isolated; religion, poetry and spontaneous metaphysics articulate the meaning and sense of the whole. The one knows, the other understands. Such an interpretation of the world … begins in language and develops in metaphor which is representation of one idea by another related to it and which, in some sense, illuminates it. (Dilthey 1976a: 137)

Metaphor thus clarifies the distinction between knowing and understanding which Dilthey sought to establish as a uniquely human achievement and a distinctive feature of the human world.

'bones') of the body. It was not possible to differentiate thought and feeling. Moreover, such a confusion of categories, and of cognitive and emotional responses, was associated with power: the combined effect of the various transgressions was overwhelming. This confluence, which recurred in many different accounts, was what signalled the centrality of experience in participants' understandings of schizophrenia.

In part, this characterization of the domain as anomalous and hard to grasp reflected a temporal distance from the immediacy and force of the initiating psychotic experience. All participants were at least two years away from the earliest manifestations of schizophrenia. This did not preclude the possibility of ongoing or refractory symptoms: one participant asserted that he was "psychotic all the time", despite medication. Nor did it preclude the re-emergence of severe symptoms as happened with two participants, sending them back into hospital during the period we were working with them. It did mean that all participants had had a period of time (in some cases decades) in which to accommodate these experiences, to speculate on their meaning, and to reflect on their consequences for how they understood themselves, how they interacted with others, and how they viewed and operated within a wider society.

Schutz and Luckmann have pointed to the necessity of such a temporal passage for inchoate experience to be grasped as a particular type of experience with a definite meaning:

> Meaning is not a quality of certain lived experiences emerging distinctly in the stream of consciousness — that is to say, of the objectivities constituted within it. It is rather the result of my explication of past lived experiences which are grasped reflectively from an actual now and from an actually valid reference schema. As long as I am engaged in lived experiences and directed toward the Objects that are intended in them, these experiences have no sense for me … Lived experiences first become meaningful, then, when they are explicated *post hoc* and become comprehensible to me as well-circumscribed experiences. Thus only those lived experiences are subjectively meaningful which are memorially brought forth in their actuality, which are examined as regards their constitution, and which are explicated in respect to their position in a reference schema that is to hand. (Schutz & Luckmann 1974: 15-16)

Elsewhere Schutz notes (1972: 47) that the differentiation of experience within an irreversible flow of consciousness is accomplished primarily by 'remembrance', and that this remembrance presupposes a 'turning back against the stream' of duration, and a 'special kind of attitude toward that stream, a "reflection," as we will call it' (ibid):

> ... when, by my act of reflection, I turn my attention to my living experience, I am no longer taking up my position within the stream of pure duration, I am no longer simply living within that flow. The experiences are apprehended, distinguished, brought into relief, marked out from one another; the experiences which were constituted as phases within the flow of duration now become objects of attention as constituted experiences...
>
> Only from the point of view of the retrospective glance do there exist discrete experiences. Only the already experienced is meaningful, not that which is being experienced. For meaning is merely an operation of intentionality, which, however, only becomes visible to the reflective glance. (Schutz 1972: 51-2)

With this reflection, the experiences which participants associated with schizophrenia became specific phenomena.[16]

Anomaly was a distinctive feature of this domain which was constituted by the attention which participants paid to their experiences. It was especially a product of participants' interpretive quests which endlessly re-cast past experience within evolving frameworks of meaning. In contrast to the many initial experiences which unexpectedly 'hit' and assaulted them, daily life for many participants (their 'actual now' as Schutz and Berger term it) was pervaded by an ineffability and a perplexity which demanded intense watchfulness and interrogation. The social conditions — a range of circumstances beyond individual consciousness — which sustained and accentuated both the generation of anomaly and the reflection upon it are examined throughout Part II of the dissertation, especially Chapter 5.

Anomaly was an explicit component of a fifth metaphoric framework by which participants sought to convey the strangeness and ineffability of their lives: that of dreams.

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[16] See Schutz (1972: 75): 'The reflective glance is the Act (*Akt*) which raises the content of consciousness from prephenomenal to phenomenal status'.

Dreams

Among participants, dreaming was a ubiquitous metaphor for conveying the experiences of schizophrenia. One participant, for example, described a "weird perception of objects — they seemed to loom, like in a nightmare". Another commented: "I couldn't distinguish my dreams from my real life so I was acting weird at school — I thought these things had happened in real life, but others didn't know anything about it". For many participants, dreams were a way to emphasize the heightened idiosyncrasy of perception. Like death, dreams provided an experiential 'space' in which to locate transfiguration. Also like death, dreaming is quintessential ineffable and solitary (Taussig 1986: 4), even while it is a powerful cultural trope which organizes images of horror, alienation, disconnection and transmutation.

One of the activities we shared with Brian was to ride with him on his regular bus routes across the city in order to witness some of the "disturbances" which he reported happening on such occasions. The "weirdness" of having us present was part of a more general strangeness which he said he had experienced on many other occasions. Brian went on to say that he often found the bus to be a setting in which reality slipped into unreality; that while everything looked real enough there was something almost imperceptibly "wrong" with it. He said that it was like a dream: everything looked the way it should, but then unexpected or unpredictable things started to happen. He said that this shifting boundary between reality and unreality, dream and wakefulness, was "a kind of confusion" which often attended such everyday tasks. Brian also likened it to being "stoned" on drugs. He said that "being 'off your face' [on drugs] is worse, but at least you know then why you are feeling paranoid, there is a reason, whereas in this experience there is no reason at all". During the bus ride he was able to point out that he thought the teenagers who were sitting behind us were laughing at him (and thereby caused me to reflect on my own stance of ignoring certain aspects of the environment and on my own assumptions about the lack of meaning in many everyday situations). With this example — which he was quite prepared to debate, being interested in our interpretations of the phenomena — he tried to point out how the "unreality" or dream-like quality was manifested in the way that things started happening without an apparent cause. Another example of such unexpected happenings which often caught his attention was when apparently unacquainted passengers "start communicating" with each other — that mysterious if fleeting communion between strangers which began with physical proximity, a casual glance, a non-committal comment, and sometimes led to an animated conversation or a display of emotional warmth. Brian was an avid chronicler of such ordinary but imponderable transformations which, since they reflected a type of social interaction he longed for but had never attained, assumed a dream-like quality for him.

Another participant, Adam, insisted on a direct analogy between dreams and schizophrenia. For him, dreams were sensate experiences which physically attacked him in the same way that schizophrenia did. His accounts of them reversed the common sense rendering of dreams as merely 'mental' phenomena. He said:

> "I think I'm very much involved, especially in my dreams ... In the early years of my life [they] were so physically terrorising that they were more real than my waking life.
> *[I asked: What sort of terrifying dreams were they?]*
> Being totally overpowered physically — as a physical organism as opposed to a human being. I recall being in a tunnel and being squeezed all over. The colours changed from dark into light. I had dreams which were rough or smooth. I had dreams where I was tiny in a huge place and huge in a tiny place. In my dreams I'd be sucked into these energies or forces and completely out of my control, freaking right out about it. Then after that I started to have people in my dreams. I don't think that you have your own dreams. I think that you belong to, as Jung would say, the collective unconscious. Schizophrenia is like loosing control in that immediate sense."

Adam also stressed the freedom which schizophrenia had given him to explore his imagination and dreams — aspects of his experience which he identified as being devalued and disparaged in what he called "adult culture". Dreams, reverie and imagination were phenomena which oriented his everyday life around story-telling, writing, and inventing children's games.

Although Adam's reference to Jung was not uncommon amongst participants, none appeared to have read Jung on the correlation between dream states and dementia praecox (schizophrenia).[17] Whether imbibed from clinical settings, developed through conversations with other patients, or grasped through esoteric researches, several participants articulated this widely available analogy. Oscar, for example, noted:

> "I've never heard a doctor say it ... but it's often struck me that the behaviour of a person [with schizophrenia] is completely compatible with a dream you might have. Except for the hearing of voices and the modern technologies, but even then they can be articulated into dreams. I mean, you'll have a dream about a TV that can talk to you — you can have that because we are all products of what surrounds us, our cultural influences and technological influences ... [But] if you were to act that way in your normal life you would be considered mentally ill. And yet they are very compatible and they are virtually the same. It's only my personal point of view, but the experience of schizophrenia and the experience of a dream are very, very similar.
>
> ...
>
> I had a funny dream last night — 'oh I acted funny yesterday' — and yet the way I acted in both situations was very similar. What causes dreams I don't know, but everybody has them and they are a part of life...
> A dream can be quite natural. Sometimes dreams can be very irregular. It's the same with schizophrenia. And because it's something to do with the head — something to do with the workings of the head — I wouldn't mind betting they're connected somehow. It's some sort of mechanism whereby dreams are released or something ..."[18]

"Everyone dreams", asserted Oscar. In emphasizing that dreams were an experience common to everyone, Oscar sought to align his extraordinary experiences which those which he understood to be ordinary as well. Dreams could be 'natural' or 'irregular'. This was a measure of their extraordinariness, as well as the ordinariness of his schizophrenia.

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[17] On the 'collective' content of both dreams and schizophrenia see Jung (1960b: 242-3). On the general analogy between dreams and dementia praecox Jung wrote:

> In dreams we see how reality is spun round with fantasy creations, how the pale memories of the waking state assume tangible form, and how the impressions of the environment are transmogrified to suit the dream. The dreamer finds himself in a new and different world which he has projected out of himself. Let the dreamer walk about and act like a person awake, and we have the clinical picture of dementia praecox. (Jung 1960a: 86)

For a brief 'genealogical' history of the convergence of dreams and madness in nineteenth century thought see MacLennan (1992: 158-9).

[18] Such images of madness as a waking dream were also a feature of Romantic literature, exemplified by the poet Nerval's description (in *Aurélia*, 1855) of the onset of delirium as 'the overflowing of dream into real life', a proclamation cited by Moreau in his *La Psychologie morbide* of 1859 — see MacLennan (1992: 157). Freud had used the same image in *The Interpretation of Dreams* [1900], citing Kant (Cox 1996: 317).

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Coincidence, uncanniness and surreality were ubiquitous in participants' accounts of the experiences they associated with schizophrenia. They emphasized the oddness of juxtaposition, the fluidity of perception, the volatility of emotion, and the pervasive connectedness of the trivial and the profound which attended those experiences. They extrapolated these qualities into such everyday activities as walking in the street, shopping or watching television. In this way their experiences resonated profoundly with the 'ordinary' extraordinariness of everyday life described by Shokeid (1992). His examples of meeting someone familiar in an unexpected place highlight those 'uncanny reunions' and 'coincidences' in which one's presence and visibility are 'transformed and distorted' by moments out of regular time and space (ibid: 237). No less perplexing is the obverse situation in which the 'incredible meeting between strangers' transforms 'anonymity into a meaningful experience' (ibid), as Brian observed on the bus. Such responses to people and place, in which the familiar was rendered strange and the strange familiar, were widely reported by participants. So too were various ominous, 'uncanny' experiences in which the mundane space of a house or a shopping centre were menacingly transformed, or their sense of themselves was intensified and distorted by an awareness of their disconnectedness from others, or by the feeling of being bombarded by the visual and aural stimuli to be found in any public space. Drawing on Freud, Shokeid notes that the uncanny (*unheimlich*, literally 'unhomely') is frightening through the paradoxical conflation of the 'not known' and the 'familiar' (ibid) — of strangeness bound up with recognition (Sass 1992a: 55; Kristeva 1991: 182-92). Shokeid also gives the commonplace example of finding oneself in an unknown and unexpected setting and the concomitant 'existential experience … of being taken by surprise … into an unknown territory of behaviour' (Shokeid 1992: 239). This is an apt rendering of some participants' responses to their own experiences of psychosis, as it is of my experience of the project and my encounters with some participants.

In contrast to Turner's 'social dramas' which are structured by rites of passage which promise some measure of closure and a return to order and communal ethos, Shokeid emphasizes the 'mini-dramas, mostly performed backstage with no guiding and supportive audience' (ibid: 240) in which failure may carry severe sanctions. This was reflected in the agonized privacy maintained by many participants and the trepidation which often surrounded their disclosure of experiences, perceptions, and beliefs which they knew attracted some of the most severe interventions available in our society. Shokeid offers his various examples as evidence of 'an element of uncertainty and hazard in the flow of everyday life, dissolving the order of ordinary experience' (ibid: 239). These are experiences which jeopardize the integrity of persons and social positions. Their qualities — indeterminacy, incongruity, uncertainty — in the context of unexpected situations, unforeseen contingencies, and incomprehension are all congruent with the nature of experiences which participants associated with schizophrenia. Indeed, the latter seems to fulfil Shokeid's call for a research situation in which the uncertain, the arbitrary, the idiosyncratic, and the private dimensions of everyday life — the 'hidden scripts of exceptional experiences endured by individuals in a particular society' (ibid: 241) which reveal a culture and its constraints — are made available for systematic analysis.

It was the singularity and enigma of participants' experiences which produced the spectacular 'unevenness' of their lives. In participants' understandings and self-representations, these were experiences 'cut loose from the chronological stream' (Hastrup 1995: 84; cf. Shokeid op. cit.: 234) which, in turn, separated them from what they considered to be the 'normal', mundane experience of those who had never had schizophrenia, including myself. To continue the Turnerian analogy, these experiences were presented as deeply wrought dramas of rupture which were both formative and transformative, distinguishable and isolable, and which functioned as 'initiations into new lifeways' (Turner 1986: 35). Through them, radically reappraised identities and structures of experience were produced, not simply in the realm of thought and articulation but in what Turner describes as 'the whole human vital repertoire of thinking, willing, desiring and feeling, subtly and varyingly interpenetrating on many levels' (ibid). The social and experiential dimensions of this rupture are examined in greater detail in Chapter 5.

THE IMPERATIVE TO INTERPRET

Many participants were quick to point out the way in which their experiences did not fit or were 'cut off' from conventional schemas. There were practical consequences to this apprehension of schizophrenia as anomalous. In particular, it resulted in a considerable effort to interpret experience. It found expression in an imperative, evinced by numerous participants, to record and catalogue and what had happened to them. This conformed to Binswanger's (1963: 252-3) characterization of the inability to 'let things be', the imperative to 'fill the gaps in experience', and the constant seeking to re-established order. Even the frameworks which participants adopted to understand and convey their experiences did not necessarily provide definitive answers, and could themselves mirror the puzzlement and opacity of participants' concerns. While Biblical analogies illuminated some of Tony's experiences, they also opened up possibilities for interpreting others yet to be explained — religion itself offering accommodation for an abiding sense of mystery and perplexity. He said:

> "There's encouragement in it when you're alone and there's many benefits too. I don't look at it as a crutch. You know, a lot of people say [it's] a crutch. But it's a support, and a lot of the visions and things that I've had are in line with what Jesus talks about in the Gospel. But a lot of them aren't. And a lot of the things that happen aren't mentioned and I say: 'Where do you find out what's going on here?' "

These were things which participants also thought did not ‘fit’ with the common run of what they understood to be other people’s everyday experience, or with how their own experiences and socialization before the onset of schizophrenia had revealed the world to them (see Chapter 5). For participants themselves, these experiences could be “unknown”, “incomparable”, “unique”, “without meaning”, “impossible to believe”, “outside the realm of possibility”, signalling a “general loosening of parameters”. They knew these experiences did not ‘fit’ because they were ‘locked up’ on account of them, they had difficulty convincing others of their reality, or they found it hard to grasp or understand them for themselves. Yet they were compelling, transfixing and, as several participants said, “seductive”. Some people were always literally ‘at work’ interpreting their own perceptions, reactions, their relationships with other people, and their place in ‘reality’ itself. One participant reported that he had spent an entire year assessing his own thoughts, checking them to see if they were right or wrong — he joked that throughout this time he had at least taken coffee breaks. For some participants these processes of interpretation were so consuming of time and personal effort that they precluded other forms of social interaction.

It was the predominance and heightening of experiences which were powerful, overwhelming, transformative, and transgressive which initiated interpretive interest, both on the part of participants themselves — some of whom had spent a great number of years recording and examining these experiences — and subsequently in me. It was to these singular, ineffable, sometimes inarticulate experiences, and the uses to which they were put in organizing lives around the concept of schizophrenia, that I was drawn.

SUBSTANTIATING THE UNCANNY IN BODIES AND HOUSES

Participants' experiences of schizophrenia were not just a matter of images, metaphors and tropes. Such experiences had practical consequences which were played out in their circumstances and daily lives. In particular, the 'uncanniness' of participants' extraordinary experiences was substantiated in their own bodies and homes, which had thereby been rendered both familiar and strange, even to themselves. As I have already noted, and will return to at various points throughout this dissertation, extraordinariness was registered in the conflation or juxtaposition of what was both ordinary and extraordinary, expected and unexpected, familiar and unknown. Bodies and houses were two of the most immediate contexts in which this conflation was manifest.

The attention which participants paid to their experiences, and the efforts they made to represent these metaphorically, attested to a high level of reflexivity. Sass (1992a) is the leading proponent of a view which emphasizes reflexive 'hyperawareness' as a key attribute of schizophrenia itself. He describes (ibid: 228) those alterations of perception in which a person begins to take particular notice of phenomena previously identified with the self — such as thoughts, or sensations within the body — that become all the more distant, concrete and apparently removed from the self as a consequence of the increasing attention paid to them:

> There is a loss of tacit forms of knowing; and instead of inhabiting the body and being immersed in the sensory world, there is a kind of disengagement, a detachment that may be akin to certain forms of phenomenological "reflection" — the contemplative stance that, in Merleau-Ponty's words, "slackens the intentional threads which attach us to the world and thus brings them to our notice". (Sass 1992a: 228)

Describing aspects of 'schizophrenic attention and perception', Sass also notes a heightened focus, awareness of anomaly[19], and a prolonged concentration on objects, all of which are accompanied by difficulties in the capacity 'to shift out of this general mode

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[19] Cf. Aiden's 'Great Archive of Anomalies' derived from video and television, discussed in Chapter 2.

and adopt the more intuitive, spontaneous, or practical mode of everyday life' (ibid: 72).[20] There is an 'anxious directedness' and a 'hyperintentionality' toward what would otherwise be voluntary faculties such as attention, muscular control, and purposiveness: 'The patient, it seems, is plagued ... by hyperawareness, a constant, compulsive need to exercise his own consciousness' (ibid: 68). This 'disturbing self-consciousness', awareness of choice, and a 'conscious, controlled mode of functioning' are said to disrupt more automatic or spontaneous processes (ibid).[21] Much of this attentiveness, purposiveness and intentionality was evident among participants in the present study. This was evident in the example of one participant who observed and chartered his own thoughts for a year in an attempt to ascertain their "correctness", or in the way that many others not only attended to 'voices', but also solicited these phenomena and then quizzed them as to their origin and meaning.[22]

Many participants attested to how they were compelled to this purposiveness by the unusual nature of what they had experienced during psychosis or a schizophrenic 'episode'. These experiences stood out against a background of 'ordinary' experiences — not only those which were ongoing and taken for granted by others around them, but against all that they had known and understood about themselves, their bodies, their minds and their everyday worlds before the onset of 'voices', or hallucinations, or spirit visitations. This was the source of 'uncanniness', and it was this which forced participants to question and reflect.

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[20] See also Walton's (1995: 111-15) descriptions of the 'breakdown of smooth non-reflexive action', the feeling of being 'unfamiliar' amongst things in the world, and the breakdown of the 'ready-to-hand' among participants in her study.

[21] See also Blankenburg (1980: 64) on the 'achievement character' of schizophrenia. This refers to 'clinical observations' that the 'absorption or entanglement in everyday being with others and among things' is not an 'easy' mode of existence for schizophrenics, and that 'what is taken-for-granted in healthy individuals comes about only by a special achievement for these patients'.

[22] Such attentiveness is sometimes actively encouraged, as amongst 'voice-hearers' who repudiate the label 'schizophrenia'. Thus, a Hearing Voices Network newsletter has published instructions for a 'rigorous process analysis and focusing technique' which can reportedly be used to identify the type, circumstance and quality of delusions and hallucinations. See B. Hafner, 'Insightful waking REM (schizophrenia)',*Voices*, 12, 1994, p. 5.

BODIES

Lacking an obvious physical stigmata, participants' bodies harboured a perplexing mystery. All had been instructed regarding the source of pathology in their brain chemicals or their genes, but these offered only experientially distant explanations for phenomena which were often palpably real, physical and immediate. The indeterminacy of these explanations, together with their multiplicity, meant that most participants supplemented them with others which had a more telling relevance to their beliefs, biographies and everyday concerns. The conjunction of a pathologized body and non-pathological understandings of what had "really gone on" rendered the experience of schizophrenia especially uncanny.

Many participants emphasized the physicality of their experiences of schizophrenia. I have already noted its apprehension in terms of pain and assault. One young man detailed the sensations of his "bleeding heart"; another woman had packed her head in ice because she believed her brain was "on fire". Many described the sheer physical exhaustion of warding off 'voices', controlling thoughts and 'staying in reality':

> "I just lie in bed ... because physically, I'm exhausted. Because all my energy's going to my head. All my thoughts are up [in my head] ... and my body's just really, you know, exhausted... It's bloody hard to get to sleep as well. Your body's really tired, but your thoughts are still going."

Several participants reported that their bodies had become strange to them as a consequence of their experiences and the frameworks of understanding which surrounded these. One young woman believed that her arms and legs had been shortened in an attempt to hide the fact that she was not like other people: "I've been cut down to size [because] I'm completely different from everybody else". Gerald described how, as a young man attempting to account for his slim build, he became convinced that he had tape-worms and had attempted surgery on himself to remove them; this was followed by a number of other self-mutilations in imitation of Jesus Christ. When confronted with shortness of breath on the running field, Gerald attributed it to a punctured lung which he surmised had been sustained as a result of his father attempting to murder him as a child. He was also convinced that his neck had been tampered with, concluding that doctors had twisted his neck vertebrae, puncturing his larynx and putting a "knot" in his throat. During the period of fieldwork he was receiving multiple chiropractic treatments for this 'condition'[23], as well as lessons to realize a singing voice that the 'voices' had revealed to him.

Numerous participants attested to how they constantly monitored their own and other people's bodies. At our very first meeting with our first participant, Wynn instructed us in the bodily deportments which she insisted were essential to working with people diagnosed with schizophrenia. Basically her advice was to relax, to sit very still, to avoid movement of the hands and feet, and to desist from quick or unsignalled movements generally — "simple and calm" being her summary of the required disposition. She said:

> "You need to be very attentive to breathing, coughing, eye movements, and especially the positioning and movements of the feet. Where feet are positioned, where they are pointing, whether they are wagging or still, have an overwhelming significance. They are much more important than words. The psychotic person is picking these movements up as a language."

All such actions (from her own experience and from working with many other people with schizophrenia) were liable to be "read" as potentially hostile. Wynn's advice engendered in me an abiding circumspection about bodily deportment, gesture, and voice which was amplified by subsequent participants who attested to the significance they placed on various forms of non-verbal communication, their own as well as other people's. This significance was heightened by the failures and difficulties which many participants experienced with spoken language (see Chapter 6). More generally, many participants were highly conscious of their own bodily comportment against a background of experiences in which, they said, a lack of coordination and involuntary modifications of movement had been induced by various medications.[24]

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[23] Gerald insisted that he had not disclosed the "true purpose" of this treatment to the several different chiropractors he attended weekly.

[24] Many participants commented on, for example, the distinctive 'shuffling' gait they said was induced by Modecate and which some used to identify other people with schizophrenia. Participants also reported a range of physical effects — restlessness, up-turned eyes, the involuntary shaking of limbs — which heightened the awareness of their own bodies, rendering the latter a focus of reflection and conscious management. The excessive salivation and weight gain which they associated with Clozapine had a similar effect. In addition to medication side-effects, Walton (1995: 118-20) has noted that many

This attention to the body was highlighted by Adam who, in an attempt to ascertain a particular significance he suspected was contained in other people's behaviour, sought to manipulate his own 'body language'. He wrote:

> I thought that there might be an answer in gesture so I thought to watch [other people's] behaviour to ascertain what it was. I divested myself of natural gesticulation for a year, in 1980, and watched body language without permitting any of my own.

Lawrence similarly attended to the minutiae of other people's actions:

> "I sometimes find it difficult understanding people's mannerisms, and again I invest them with all sorts of strange [meanings] which are completely improbable, but quite real at the time. They could be part of a code. It's very difficult to say, but they might have some very specific meaning. Just the way people do things, the way they pick up objects, put down objects, just the way they move and organize themselves in space, you can usually tell something about them."

For Brian, sociality was always in danger of being effaced by the "negative signs" he detected in body language: "a positive sign might be smiling or a willingness to talk, then that person will cross their arms or legs — that's the negative sign". In this way, Brian's social interactions were under a constant threat of negation, since "reading these signs is never ending" — he was "always doing it". Going into a strange situation, Brian said that he would first generalize about people from their body language in order to get "a general idea" of what they were thinking; only then would he work out a plan for how to act and communicate. Brian's focus on the body affected our own interactions with him, such that his self-consciousness about his own and other people's bodies ramified into a shared reflexivity about the position and movement of each of our bodies whenever we were together. It was this, in part, which made our one restaurant meal together so stilted (see Chapter 2). Brian's self-consciousness made him stand out on the bus or in the shopping mall because of the hyper-vigilance and furtive mannerisms which it generated; in his bedroom, however, where a degree of self-reflection was appropriately contained, he appeared comfortable and relaxed.

'psychological' symptoms (such as lack of motivation) are in fact apprehended physically: in tiredness, heaviness, and an inability to 'propel the body into the world' (ibid: 118).

HOUSES

Participants' use of their houses was probably not dissimilar to that of many other suburban residents. To the extent that most participants had grown up in a similar type of accommodation they could, and did, use their houses in culturally appropriate (that is, self-evident, common sensical and unremarkable) ways.[25] Their homes were disposed as kitchens, bathrooms, living rooms and bedrooms, which were used in ways which participants took for granted because they had grown up with these usages and associated meanings. In part, this familiarity was an effect of the physical structures themselves: in the fixed definition of rooms which determined their function (cf. M. Thomas 1997: 105), and in the placement of furniture and equipment. The uses to which these spaces could be put — especially along a public/private continuum (see Chapter 3) — were thereby also constrained to some extent. There were limits on where cooking, sleeping, or our talking together could take place, for example. Such constraints tended to render practices within the house 'normal' and taken for granted.[26] As structures which embodied taken-for-granted ways of moving in space, of walking, of sitting, of expressivity, and therefore of

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[25] Bourdieu (1977: 89) suggests that this space is intimately linked to the earliest learning processes by which durable schemes of thought, action and perception (which comprise the *habitus*) are produced and reproduced. That this is an ongoing, practical effect (and not just confined to early socialization) is explored by Biln (1991) in respect of American 'single family home' designs. Biln details a view of the contemporary house as a social and subjective 'terrain' created by the relationship between 'topography' and 'choreography': the former denoting material, 'bounded space'; the latter being a 'notation' for the performance of social repertoires (bodily mobility and fixity, sequential and temporal actions, social interaction, etc.). Domestic architecture is, then, a 'material and symbolic landscape controlling and directing patterns of everyday interaction, differentially enacting controls on co-presence and privacy, and generally constituting a *topographic environment* of social and subjective constraints and enablements' (Biln 1991: 52; original emphasis).

[26] They were also 'understandable' insofar as Taylor (1979: 48) asserts that everyday practices are, by definition, intersubjectively meaningful: 'The meanings and norms implicit in ... practices are not just in the minds of the actors but are out there in the practices themselves, practices which cannot be conceived as a set of individual actions, but which are essentially modes of social relation, of mutual action'. See also Bourdieu (1990a: 58) on the mutual intelligibility of practices generated by the *habitus*: 'The homogeneity of *habitus* that is observed within the limits of a class of conditions of existence and social conditionings is what causes practices and works to be immediately intelligible and foreseeable, and hence taken for granted... Automatic and impersonal, significant without a signifying intention, ordinary practices lend themselves to an understanding that is no less automatic and impersonal'.

states of subjectivity[27], these houses implied a *habitus* which was shared with many other people in Australian society.

Many psychotic experiences, however, disrupted the taken-for-granted valence of the house. Such experiences often effected a confrontation between what was understandable and taken for granted (say, the safety and privacy of one's own home), and that which was inexplicable and terrifying (say, the intrusion of surveillance equipment and the broadcast of intimate activities). In this confrontation lay the uncanniness of extraordinary experience, as well as ordinary spaces.

In his semantic study of the German adjective *heimlich* — 'friendly', 'comfortable' — Freud detected the presence of its antonym, *unheimlich* — 'concealed, kept from sight', 'deceitful and malicious', 'behind someone's back'. Thus Freud found that 'the familiar and intimate are reversed into their opposites [and] brought together with the contrary meaning of "uncanny strangeness"' (Kristeva: 1991: 182). As a consequence, 'everything is *unheimlich* that ought to have remained secret and hidden but has come to light' (ibid: 183, citing Schelling). Participants reported similar reversals and conjunctions in the experiencing of their houses. What was 'friendly' and 'comfortable' as a suburban residence could also harbour frightful secrets, or render its occupant susceptible to threatening revelations. Jeff, for example, was confined to his house by a fear that aspects of his life (especially the sexual abuse he had endured as a child and his later drug abuse and prostitution) would be revealed somehow if he ventured outside. In his view, these were things which had brought on the schizophrenia (especially his "paranoia" about people finding out about his past): "if I hadn't done them and if I didn't have the family background it [schizophrenia] wouldn't have come on". He added:

> "It is still difficult. I'm afraid. I want to do something with my painting in the future. I want to make some money out of it. That's what I do best, I want to

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[27] Since bodily practice is 'always associated with a tone of voice, a style of speech, and ... a certain subjective experience' (Bourdieu 1977: 87).

> become better and better. By the time I reach forty I should be a really excellent painter, but I'm afraid … that when I do decide to do something, all the things that I've done in my life are going to come out and they're going to ruin me. Like Prince Charles and Princess Diana, all the scandal comes out. It gives me great fear."

Jeff's house was a refuge, magically protected (see Chapter 3) in order to keep these things secret.

Numerous participants stated that their houses had been rendered decidedly 'unhomely' by intrusions of various kinds: 'bugging', surveillance (by cameras, planes and vehicles), or by the visitation of 'voices', spirits and 'ghosts'. Even more distressing than the intrusions themselves was the presumed 'broadcast' of this material to a wider 'audience':

- Francis described a period of what she called "full-blown psychosis" lasting two years, "twenty-four hours around the clock, full on crazy". During this time she believed that there were "cameras up above the house, in outer space somewhere" that could see and record through the ceilings. She believed that,

  > "… the media was going to make a movie of me … they were going to actually set me up with a lover and have the cameras on all day long and take in our conversations [and] absolutely everything we did within that house … We were sort of trapped — shut — in this house… They could zero in down through the ceiling and watch everything … and have showings of our relationship within the house. That was exactly what it was like."

  As a consequence, Francis began to "act" her daily life, including her sex life, according to how she believed it was "scripted" by these unknown media interests.

- Susan similarly believed that her daily life was being projected somewhere:

  > "They'll see it on the wall, like a TV usually. And when I'm psychotic, that is really bad because you don't get any privacy, not at all … You feel like you're on TV *all the time* [emphasis] and it really wears you out. It's horrible… It's projected … doing the washing, sweeping the floors, in the toilet, everything. Oh, they know what I'm thinking because they can hear it. So you get no privacy inside your head or out … It's like living in a glass cage."

Such intrusions were often focused on those spaces which are culturally marked as the most intimate and private:

- Kate, a woman in her early twenties, described hearing the "souls" of a group of young men who had, she believed, put a "curse" on her. As well as controlling her thoughts, these entities "watched" her constantly. Even the presumed privacy of the bathroom was violated, so that she had gone through a period of showering in her clothes and urinating through her underwear.

The bathroom and its associated activities were widely reported as attracting surveillance. One woman, for example, had become suspicious of her mother revealing intimate details about her: "… she kept on complaining about how much toilet paper I use, so I thought she was rushing off down the street telling everybody how much toilet paper I used". Another young man described how he thought that his friends could see him in the shower and were filming him; he said:

> "I didn't feel alone even when I was alone. It was embarrassing because I thought they all had videotapes … and they were showing everyone."

One participant had begged his parents for a lock to be installed on his bedroom door because he believed that someone was entering his room at night and raping him. Another participant related the "overwhelming fear" which was her experience of schizophrenia to a childhood history of sexual abuse: "If you are afraid in your own home with your parents, you'll never feel safe or secure anywhere, will you?" With these examples it became obvious that, in many peoples' experience, homes were not necessarily inviolate. The specific form of the violation was often apprehended as a making public of what was culturally assumed to be private: bodies, thoughts and the most 'intimate' rooms of a house.

The stillness of many participants lives was embodied in the many hours they (and subsequently we) spent sitting in their houses. For me, this sedentariness was emblematic of a heightened focus on themselves, especially their bodies, minds and emotional states. The embodying of a distinctive subjectivity within these settings was evident in what I came to recognize as Gerald's 'oratorical stance': sitting calmly in his chair for hours at a time, eyes fixed on the middle distance between us, an enigmatic smile occasionally playing across his face. The revelation of his identity as a 'Angel of the Apocalypse', together with the many bizarre events of his life — his life-long love of the 'kindergarten girl', his attempted disembowelment, his interactions with various historical figures such as Hitler, and the recent discovery of his uncle's corpse in the house that they shared — were all presented with the same deportment, gestures and detached emotional tenor as our talking about the weather or what was currently showing on television. It was this revelation of unexpected perceptions and beliefs contained within an undistinguished suburban home which made our encounters with Gerald so extraordinary (see Chapter 2) and his experiences so uncanny. It was the spectacular 'inappropriateness' and surreality of these experiences in the most ordinary of settings which highlighted the taken-for-granted relationship between setting and subjectivity through its transgression. Again, this very extraordinariness could be said to be a quality which emerged from conflating the ordinary and the bizarre, or from juxtaposing what was mundane (and therefore not requiring an explanation in practice) with what was unprecedented and inexplicable.

REFLEXIVITY

In their own bodies and homes participants confronted and questioned what was otherwise taken for granted in the relationship between corporeality, subjectivity and physical space. Participants' heightened awareness of the subtle and otherwise un-remarkable features of daily life — together with their motivated and intentional fixation on them — could be said to raise what was taken for granted into consciousness, making it an object of consciousness and of discourse (see also Parish 1996: 195). In particular, participants' focus on the body, its movement and dispositions confounded the 'economy' of 'intention' which Bourdieu says the *habitus* allows by way of 'dispens[ing] with close analysis of the nuances of someone else's conduct or with direct investigation of his intentions ("What do you *mean*?")' (Bourdieu 1973: 70). On the contrary, working out what the other means — and what the other means for the self, as well as what one's own experiences mean for the self — was a primary preoccupation for many of the people with whom I worked. "What do you mean?" was a question which was put to me often, and it could refer not just to my words but to the placement of my limbs, to the tone of my voice, or to my clumsiness in negotiating the clutter of objects in a living room. Equally, most participants were vitally interested in the meaning of their own mental, emotional and bodily states; they objectified these in various ways (for example, as forms of language, as a 'code', or as the manifestation of in-dwelling spirits and devils) and they used these objectifications for reflection and self-regulation. It was their homes which both accommodated and facilitated this multiplying of reflexivity.[28]

As physical structures which accommodated eating, sleeping, washing, and hosting guests (in this circumstance, the researchers), participants' houses were unremarkable. As 'refuges', 'sanctuaries', or 'shrines' (see Chapter 3) they sheltered subjectivities which were uncommonly sensitive to change, movement, intrusion, bodily dispositions and emotional states. It was this conjunction which substantiated schizophrenia's uncanniness. Houses also revealed participants' distinctive mode of involvement, less with other people and things than with their own minds and bodies, and an abiding concern directed toward delineating and finding meaning in their experiences.

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Participants' experiences mediated what was ordinary and extraordinary — mundane and unprecedented — in their lives. It was experience, and its specific refraction through schizophrenia, which they insisted had to be understood. Having identified this domain as being of heightened significance to participants, the question arises of how to gain access to such experience. The following chapter outlines the procedures by which participants' experiences and their meanings might become available to the researchers. These methodological concerns are framed by a broader question concerning intersubjectivity: that is, of how the meaning of those experiences which participants associated with schizophrenia could meaning something to me as well.

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[28] A broader context for this generation of reflexivity is examined in detail in Chapter 5, below.

Chapter 2

INTERSUBJECTIVITY AND THE CONDITIONS FOR KNOWING SCHIZOPHRENIA

The central problem for this research was to establish intersubjectivity, such that whatever participants' experiences meant to them could also mean something to them and me together. It was not simply extraordinary experiences that were at issue here, but those everyday contours which shaped what it was to live with schizophrenia: diagnosis, ongoing interaction with the psychiatric profession, welfare dependency and perpetual medication use. None of these were part of my experience. The fact of my not hearing 'voices', of not having a diagnosis of schizophrenia, and of never having resided as an in-patient in a psychiatric hospital all raised questions of how I could come to understand what such experiences meant for participants.

This problem of establishing intersubjectivity in respect of people with whom one does not share a common set of assumptions, experiences or traditions is at the heart of anthropological fieldwork (Rabinow 1977: 155). Fieldwork, which necessarily involves more than one subject, inevitably confronts the potential breach between what is shared and what is common. In mediating at least two cultures or lifeworlds — that of the researcher and that of each 'informant' — fieldwork is situated 'neither quite here nor quite there' but is itself a 'liminal culture' through which researchers and research participants try to communicate (Rabinow 1977: 154-5). The resulting knowledge, constructed over time, produces a world-in-between (ibid: 155).

Taylor (1979) has clarified the attributes of 'shared' and 'common' which are crucial to intersubjectivity as an exchange, negotiation, or 'interplay' (Benjamin 1995: 29; Jackson 1998: 6) between self and other:

> We can speak of a shared belief, aspiration, and so forth when there is a convergence between the subjective beliefs [and] aspirations of many individuals. But it is part of the meaning of a common aspiration, belief, celebration, that it be *not just shared but part of the common reference world* ... sharing is something we do each on his own, as it were, even if each of us is influenced by the others.
> ... *Intersubjective meaning gives a people a common language to talk about social reality and a common understanding* of certain norms, but only with common meanings does this common reference world contain significant common actions, celebrations, and feelings. (Taylor 1979: 51; emphasis added)

Convergence happens when something is shared, 'but what is required for common meaning is that this shared value be part of the common world' (ibid; see also Merleau-Ponty 1962: 354). This doubly problematic requirement — that 'sharing be shared' — is what was at stake in this research. For, according to Taylor (1979: 52), common meaning and intersubjectivity are 'intertwined'. They are not the same thing, but work together in a social setting: 'the result of powerful common meanings is the development of a great web of intersubjective meanings as people live in community' (ibid).[1] Equally, these two components may 'grow apart', as evidenced by 'dissensus', 'cleavage', social fragmentation, and by the 'different languages of social reality' (ibid). In the case of participants' extraordinary experiences, this language could be very 'different' indeed. These were, after all, people who have been deemed 'ununderstandable' (Jaspers 1963: 577ff), to embody 'different ways of being human' (Laing 1965: 66), to have repudiated the social world and negated the 'human role' (Shulman 1968: 190), and to be 'outside the human community' (Rümke 1990: 336; see also Glass 1989: 3).[2] For some

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[1] See also Glass (1989) who emphasizes that this 'community' is not merely an entity defined by political and administrative structures, but a condition for the self's engagement with others. It represents a 'consensual world' which offers the possibility of a trusting relationship with another human being; 'it is also to participate in a communal setting that transcends private need, preoccupation, and fantasy' (ibid: 2).

[2] It was the confounding of the basic urge to make contact with others — the weakening of what he called the rapprochement-instinct — which Rümke (1990: 336) declared to be the fundamental phenomenon in schizophrenia. The investigator 'cannot find the patient', who is 'absent' even though present before him.

commentators, schizophrenia is the 'essence of incomprehensibility itself' (Sass 1992a: 19). Historically, it has epitomized a point of failed intersubjectivity (see Barham 1993; Wulff 1993). This is implicit in Cameron's characterization of schizophrenia's incommunicability:

> Ultimately one will find that the disorganized or scattered schizophrenic has somehow managed to get himself isolated from the common social environment. He has become unable any longer to share genuinely in the attitudes and perspectives of those around him, to take their roles when mutual misunderstanding arises, and so to be able to assume their point of view, grasp their difficulties, and modify his own behavior to meet them. On the other hand, his own asocial development has brought him to a point where no one else seems able to take his role and share his perspective, either. (Cameron 1964: 50-1)[3]

It was in the face of participants' own acknowledged communication difficulties (see Chapter 6), and against this background of characterizing schizophrenia itself, that intersubjectivity became a central pragmatic issue for the research process. In this chapter, I am concerned with the presumption of an intersubjective breach, and with the anthropological and psychiatric approaches which might allow it to be explored. The chapter thereby sets out the structures and procedures which shaped whatever intersubjectivity was possible between me and the research participants, as well as between the researchers themselves.

The aim of the research was to effect a movement from sharedness to commonality: bringing the 'individual worlds' of both researcher and participants closer together, developing relationships as a way of constructing an often tentative and experimental social reality, and finding mechanisms which allowed a joint exploration of that reality.[4] The research process was used to propel what was merely shared (our being together, our talking, our mutual interest in psychiatric disorder, our knowledges of the society and

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[3] Although Cameron does not cite George Herbert Mead in this instance, his characterization recalls Mead's (1934: 175-8) distinction between the 'Me' ('the organized set of attitudes of others which one ... assumes') and the 'I' (a source of initiative and 'something that is never entirely calculable') which, 'taken together', constitute the self as a social process. Doubt (1996: 39ff) has recently revisited the issue of role-taking in schizophrenia, utilizing the work of Mead and its adaptation by Rosenberg. For a recent reanalysis of schizophrenia employing Mead's categories of 'Me' and 'I' see Scheid (1998).

[4] This image of movement echoes Dilthey's account of the way (subjective) experience is 'transposed' (1976b: 226) and 'transferred' (1959: 213) into (intersubjective) understanding.

culture in which we lived) toward what we could know in common (in this case, an understanding of the experiences associated with schizophrenia). It sought in this way to construct a 'common reference world' (Taylor 1979: 51), no matter how 'partial and thin' (Rabinow 1977: 154).

In addition to the particular issues of subjectivity occasioned by mental illness, the research process also reflected the living conditions and circumstances of people in a contemporary metropolitan city. It was shaped by the physical and cultural constraints of distance and separation which suburban life entailed. It was structured in particular ways by its various settings (especially the hospital, university and private homes), by the requirements of ethics committees and funding bodies, and by the tensions (both disciplinary and hierarchical) which existed between the researchers. The resulting knowledge was shaped by the limitations and possibilities of this web of relationships. The research also reflected the concerns of fifty disparate participants, the differing places in which they lived their lives, and the various ways in which we engaged with them (cf. Rabinow 1977: 92-105, 155-61). This chapter sets out the fragmented, multiplicitous and mobile strategies of the research process (cf. Gupta & Ferguson 1997a). In part, this fragmentary process echoed historical constructions of schizophrenia and reproduced some of the abiding experiences of participants themselves.

THE RESEARCH PROCESS: CONSTRAINTS AND POSSIBILITIES

STRUCTURED PRECONDITIONS

The research was facilitated by a Research and Development Grant from what was then the Australian (Commonwealth) Department of Health, Housing and Community Services (DHHCS). The grant proposal — written by Dr Rob Barrett and myself — was accepted after a series of negotiations with the Department, as well as consultations with a number of academic 'experts' in mental health who advised its research committee. The original proposal had included a comparative component, using data generated from a study of schizophrenia in Malaysia to which our sample was to be matched. This was excised to obtain a greater Australian focus. An 'intervention' component (focusing on educating participants about schizophrenia) was added to make the study more directly relevant to what the health bureaucracy saw as 'consumer' needs. In part, changes to the original proposal were meant to ensure the project's rigour, especially in respect of outcome measures, and compliance with Commonwealth priorities concerning the prevention of mental illness. The research was thereby shaped in significant ways by government initiatives and concerns.[5] However, the freedom of its conduct — embodied in the engagement with participants in their own homes — resulted in us pursuing many unanticipated issues. Also being unanticipated in the original proposal, this dissertation continues the exploration of participants' lives at some remove from the priorities and demands of government (and in this way reflects the stance of many participants themselves).

The research plan which finally won approval and financial backing represented a mix of anthropological and psychiatric methodologies, combining the quantitative measurement of psychopathology with qualitative participant observation in 'the community'. By way of attending to participants' understandings of schizophrenia and by eliciting the 'coping strategies' that were specific to their everyday circumstances, the proposal argued that ethnography could generate novel insights into how people might successfully live outside of hospital settings. Such a method emphasizes social relationships. Ethnography is predicated on establishing relationships with people as a means to understanding and sharing in their social life. In this way, relationships are also a primary way of

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[5] Cf. Bennett (1998: 6) on the positioning of cultural studies within the university as simultaneously entailing a positioning within the realm of government. Bennett cites Bourdieu (in *The State Nobility*) on the way in which 'agents engaged in the university field' are often blind to the role that their own activities play in sustaining the hierarchies of the social structure: '... to write of cultural studies as if it were somehow outside of or marginal to institutions, and to speak of 'institutionalisation' as if it were a looming external threat, shows just how vulnerable it is to Bourdieu's ... critique' (ibid: 3).

establishing intersubjectivity. The ethnographer 'enters into genuinely meaningful and lasting relationships with individuals and learns from those relationships the nature of "relating" in that society' (M. Mead 1977: 4). These relationships are presumed to entail both friendship and the making of 'practical or political commitments of one sort or another' (Lederman 1990: 88). Such personal, political and ethical concerns can be difficult to reconcile with the objectivity and measurement that psychiatric research methods could offer as ways of guaranteeing the project's rigour. The research proposal nevertheless argued that a combination of these approaches was required.

This combination of methods was itself only relevant in the context of recent changes to the provision and administration of mental health services at both a national and state level — changes which privileged community tenure, multi-agency support and social integration for people diagnosed with a mental illness (see Chapter 3). In this context it became possible to propose methodologies not traditionally associated with psychiatric research. Such an 'innovative' approach (for that was how the research proposal was argued and accepted) could only be supported, however, because psychiatric legitimacy, especially diagnostic expertise, was its counterweight.

DISCIPLINARY TENSIONS: ANTHROPOLOGY AND PSYCHIATRY

The research was thereby structured as a dialogue and a tension between the disciplines of psychiatry and anthropology. The tension reflected the demands of a national health bureaucracy as these had emerged through the granting process and found its expression in a series of stresses between qualitative and quantitative methodologies, meaning and measurement, participation and intervention. The researchers' backgrounds and roles reflected the same dichotomy. On the Commonwealth-funded project, Dr Rob Barrett was the Chief Investigator; I was designated a Co-Investigator and Megan Warin was a Research Assistant. Dr Barrett was a specialist psychiatrist with a PhD in anthropology. Megan Warin had a background in nursing and a recent Honours degree in anthropology.

I brought a range of experiences in anthropology and ethnography to the project, but no medical expertise. Anthropology united us, but was cross-cut by professional training, by competing disciplinary orientations, and by our differential experience of medical settings. The format of the grant proposal had also imposed an implicit hierarchy among us — from Chief Investigator to Co-Investigator to Research Assistant — which affected our interactions even as we attempted to subvert it.

Health bureaucrats were not the only assessors to raise doubts about the project. When I subsequently proposed to use the research as 'fieldwork' for a higher degree in anthropology, some anthropologists objected that the project was especially non-anthropological. There was no 'community' as such. I wasn't learning a new language. Why didn't I live with them? Some declared that a disease was not an anthropological subject, as if schizophrenia were only a natural (or unnatural) entity and not a phenomena of the human or social world. There was a polemic at stake here. It has been articulated by Jenner *et al.* as follows:

> If schizophrenics are such a strange and different people they must necessarily belong to another reality, one which has to be dealt with cautiously and detachedly through scientific and objective methods of enquiry. Such a reality cannot be known and understood by means of human involvement and dialogue but only explained by some natural causes. (Jenner *et al.* 1993: 39)

For a discipline so often associated with the exotic, schizophrenia was too strange altogether. Some anthropologists seemed fearful of the power of psychiatric authority and of 'hard' science to subvert the study, as if in the face of something so implacable as schizophrenia I would be unable to do anything but reproduce psychiatric ideology. Was I doing anti-psychiatry? That at least sounded like critique. Perhaps such critics were unaware of the strong hermeneutic and phenomenological traditions in psychopathology, exemplified by Jaspers (1963: 301ff) and formulated with explicit reference to the work of social theorists such as Max Weber and Dilthey (ibid: 301). Or they were unfamiliar with the adaptation of these traditions to anthropological analysis by Corin (1990).

The same disciplinary tension was mirrored in the institutional location of the DHHCS-funded project. Its resources were based in an academic department of psychiatry associated with a public teaching hospital. This was commensurate with the formulation and clinical practices which have historically shaped the very concept of schizophrenia. Our methodology and interests meant, however, that we sought to elicit peoples' experiences without presuming them to be 'symptoms' of psychiatric illness and to this end were focused on developing relationships and allowing participants to construct their own narratives. This tension was often accommodated by splitting the researchers' responsibilities and foci, each us developing our own set of interests and analytic bases within the project as a whole. As a consequence, Dr Barrett pursued an interest in thought disorder, Megan developed a concern with gender and privacy, and I came to focus on experience. The tension also shaped the interactions between researchers, structuring our own intersubjectivity and thereby influencing how we came to know and work with the participants.

PSYCHIATRIC FRAMING

The research was framed by psychiatry in very tangible ways. We physically left the Department of Psychiatry to drive out to participants' homes, returning to it later to begin the time-consuming tasks of tape transcription and notation. The role of Rob Barrett as psychiatrist and Chief Investigator highlighted this framing, which was subsequently amplified when he became my post-graduate supervisor.[6] The research team was thus hierarchically structured from junior to senior, the gradation encoding differential power that was the expression of both specialist medicine and supervisory control. Our disciplinary orientations overlapped, but our tasks were differentiated along several axes of

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[6] This level of supervisory presence within a post-graduate project was, I suspect, unusual; in part it was mediated by our prior working relationship and ameliorated by my having conducted anthropological fieldwork in other settings. See Ottenberg (1990: 139-40) on the intrusive and infantilizing presence of his supervisor via letters, as well as the more general vagaries of this relationship.

power and responsibility. Rob Barrett, for example, was accountable, both to the university and the Commonwealth government, for the 'proper' conduct of the project.

Aspects of this organization were probably never perceived by most participants, but generated conflicts among us as to how the research should proceed (in respect of the impact of medicalized approaches or interpretations, for example). A common understanding of what we were doing — the intersubjectivity demanded by joint research — was not always possible under these circumstances. Dr Barrett is a high-profile clinician with an extensive web of connections throughout the state mental health system. Especially at the beginning of the project this meant that he was a valuable source of contacts and insider knowledge. Several participants remembered him from when he had treated them as in-patients and agreed to work with us on that basis. In respect of our desire to establish relationships of trust with participants, however, his professional identity also meant that he embodied aspects of psychiatry's power — such as the ability to detain people if necessary — of which some people were afraid. This meant that several participants implored Megan and I not to reveal some of the things they told us to Dr Barrett. We acquiesced to such demands, on the basis of an ethical commitment to the loyalty and trust which we believed to prevail between informant and anthropological researcher, but this also diminished the amount of information which the research team held in common.

There is no doubt that participants also came to the project with preconceptions about us and about the task at hand. A community nurse introduced us to one participant as "Dr Barrett and his team", as if Megan and I mirrored the mental health worker's own role in a multi-professional 'treatment team', and our research team replicated the organizational structure of deinstitutionalized services.[7] Some participants indicated that they never

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[7] We did in fact identify as a 'team', but I at least was uncomfortable with the implicit reflection of professional psychiatric organization. The key worker's quip thus unmasked a disturbing analogy which was usually reserved for joking amongst ourselves. See Barrett (1996: 71ff) for an ethnographic account of treating teams in a local hospital, since closed, where some participants had once been

viewed us in that way. Whenever we arrived at Aiden's front door, for example, he would call out from inside, "The anthros are here!".

Psychiatry also marked the beginning and end of the formalized research process which was framed by our introduction of the project and concluded with the administration of a Present State Examination (PSE) as a quantitative psychiatric research instrument aimed at 'measuring' each participant's mental state. Some participants acknowledged this framing by producing a metaphoric sigh of relief when the PSE was over and inviting us to get back to a more personalized exploration of their idiosyncratic experiences (a process over which they had much greater control). Others saw the PSE assessment (of which all participants had some prior experience, in some cases many times over) as an appropriate point of closure. This framing again reflected the institutional setting of the research and the expectations brought to it by participants, as well as the disciplinary tensions between its objectives and personnel.

CREATING A DISTANCE FROM PSYCHIATRY

Without the association with psychiatry, I would have found it impossible to work in this highly structured field. In particular, it provided a means of entrée to an elite professional realm and to a quantum of 'insider' knowledge which allowed me to manoeuvre within that realm. Psychiatry also provided me with a vital means of access to people who were or had been treated as patients, together with frameworks of engagement which were understandable to them. Conventional anthropological methods of making contact with people (such a mere 'being there', in a circumscribed setting or place) were not sufficient without the institutional framing of psychiatry. This was a measure of the privacy, restrictions and ethical constraints which surrounded mental illness. I was not free to place myself in a hospital setting without first negotiating with psychiatry in its gate-keeping

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patients. Unlike such teams, we did not have the legal power to detain, or the medical power to prescribe or change medications.

role. Most importantly, I could not enter participants' houses without an appropriate framing of my interests and intentions.

Having gained such access, however, I felt compelled to escape a variety of presuppositions concerning what it was appropriate to do there — assumptions which were held by participants and clinicians alike. In part, this compulsion was fuelled by my anthropological critics, but also by my own commitment to anthropology as a distinctive discipline: I was not interested in (or capable of) merely reproducing what psychiatry saw in such settings. A psychiatrist once confronted me with the proposition that all I was doing was taking psychiatric case histories in a highly convoluted, unstructured and (by implication, since she knew I was not trained in psychiatry) undisciplined manner. At the time I merely pointed out that our talking together with participants might serve purposes other than 'case' construction; I have subsequently elaborated the grounds for this assertion in Chapter 6, below.

In fact, we made a conscious attempt to eschew procedures which would replicate the taking of a psychiatric history. Barrett (1996) has demonstrated how this history-taking constructs 'the case' as an object of clinical practice with its own distinctive spatial and temporal dimensions. These dimensions are themselves isomorphic with the institutional structure of the hospital and its work (ibid: 39). The location of a current 'problem' in a developmental history and its projection forward as a causal trajectory have implications for how patients are defined as appropriate cases for hospital admission. Barrett (ibid: 127-33) has shown how a segmented account of the person and his or her illness — reflected in such divisions of the record as the History, Presenting Complaint, Mental State and Diagnosis — is produced by way of 'forced choice questions', the use of technical idioms, and the temporal delineation of symptoms (see also Wilce Jr. 1995). One of the effects of this recording is to excise ambiguous meanings and thus separate a person from their experience as idiosyncratically expressed:

> In the transition from intermediate typification to technical term and then to diagnosis — from 'voice' to 'hallucination' to 'schizophrenia' — the patient became separated from his psychiatric illness. The illness was rendered into a language that was remote from the way Paul articulated his experience and that did not allow him to control how it was defined. (Barrett 1996: 132)

In these assessments, the passive 'patient' is rendered distinct from schizophrenia and becomes a suitable object for psychiatric work.

The fieldwork techniques of the present study attempted to reverse most of these features of psychiatric assessment in order to generate narratives of experience which were not necessarily constrained by the imperative to diagnose and verify 'cases'. Interviews were informal and questioning was open ended.[8] Use of technical language was minimal as I had employed a conscious strategy of *not* learning DSM-III-R or any other diagnostic criteria for schizophrenia, either before or during fieldwork. This strategy forced me to attend to participants' own descriptions, especially the vocabulary which they used to account for themselves and their medical status. It required frequent negotiation of what they understood by 'chronic', 'paranoia', 'dopamine', and even 'schizophrenia' when they employed these terms. I could have presumed that the language of psychopathology provided a common set of tools with which to explore such ideas. But neither the participants, nor I, could be sure that we were using these terms in the same way that psychiatry did. Instead we had to work to build up a joint understanding of what such apparently technical and unequivocal words actually meant for each of us. No particular trajectory for schizophrenia was presumed. There was no attempt at separating symptoms from biography: indeed, it was clear from many accounts that people themselves were not making this distinction, and that the interpretation of 'symptoms' was often inseparable from other personal, biographical or philosophical concerns. The personal and the

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[8] In this the research techniques were not so different from a psychiatric ideal, although pursued to different ends. The open-ended question is a technique taught to medical and nursing students who are encouraged to use it at the beginning of a patient interview, at least for the first quarter of an hour or so. Its purpose is to gain an understanding from the patient's point of view before proceeding to various checklists and diagnostic criteria. Our use was different in that it formed the primary form of engagement with participants. Instead of proceeding to a checklist of symptoms we would follow up topics which participants identified as significant: events which dominated their accounts, ideas and images which were emphatically presented, and assertions of what was 'really going on' in their lives.

idiosyncratic were precisely what I was most interested in.[9] Ambiguous meanings and difficult experiences became the foci of my engagement with participants.

The construction of people as 'cases' was avoided in both time and space. We worked (as much as possible) outside the hospital, in peoples' own homes or in spaces of their choosing. In terms of time, we offered as much or as little as participants wanted. This allowed a theme or a story to develop in ways which (some people said) had never happened before. The contrast with a psychiatric interview was noted by several participants. What was especially significant to them was that they did not have to limit their talking to a (euphemistic) 'psychiatric hour': the maximum length of time that they normally had with a treating psychiatrist. As Adam commented:

> "I thought the [hospital] system was inadequate. It doesn't deal with the content of experience. They only deal with the fact of complaint ... It's usually 'Are you hearing voices?', 'Are you eating well, sleeping well?', 'Have you put on any weight?', and five minutes later you have finished the interview. There's no content, and I think that the reality is the content."

To some extent this element of unrestricted time enabled participants to control both the duration of any encounter and their total number. In this way most of our meetings were qualitatively different from a psychiatric interview and were no longer recognisable as such by either participants or the few clinicians who became aware of them.[10] Their purpose was to move from a psychiatric frame (in which we had first contacted people) into a different mode of knowledge construction, one which mediated between institutions and immediate subjective experience to generate a new way of knowing which emerged between us (see Chapter 6).

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[9] Cf. Jaspers (1963: 675): 'There is a fundamental difference in meaning between depicting a patient as a particular case of some general disorder and describing him as his unique self... [I]f I direct my attention to the individual, I try to represent to myself the whole of his life; the general elements serve as a means of grasping and presenting the matter but they are not my target... Case-records are related to generalized knowledge while biographical study is always directed to the individual.'

[10] Jimmy was one participant who requested copies of the transcripts of our meetings. When, by chance, I met Jimmy's psychiatrist one day he said that Jimmy had shown him this material, which included some of my contextual notes. The psychiatrist said that he was "intrigued" by their detail, especially the "little things" that he himself had never thought to record or had not previously noticed. He gave, as an example, my notes on the difficulty of making appointments with Jimmy and our oft-repeated experience of turning up to find him not at home. He felt that this might have a bearing on whether or not Jimmy was able to return to work.

ENGAGEMENT AND INTERSUBJECTIVITY: THE CONFLUENCE OF PSYCHIATRY AND ANTHROPOLOGY

Such attempts to focus schizophrenia through the cultivation of intersubjectivity are not new, although they have been significantly shaped by historical conditions and institutional configurations. Methodologically, intersubjectivity represents a point of convergence by which both psychiatry and anthropology might construct a knowledge of schizophrenia. In it lies a potential common reference world for both disciplines.

Nineteenth century psychiatry and twentieth century medical anthropology share a grounding in the personal encounter with 'mentally ill' persons. Psychiatric categories were themselves constructed out of the meticulous observations which took place in nineteenth century asylums, using emerging documentary forms such as the case history, the life history and the *Klinisches Bild* or 'clinical picture' (see Peters 1991: 60; Barrett 1996: 186-9).[11] The category 'schizophrenia' exemplifies such knowledge construction, its distinctive characterizations of chronicity and degeneracy having emerged from the accumulation of 'cases' in the Heidelberg Hospital for the Insane where Emil Kraepelin first described dementia praecox and developed his classification of psychiatric disorders from a study of their longitudinal course (Barrett ibid: 204-7; Boyle 1990: 43-59). The diagnostic criteria of late twentieth century psychiatry (such as the neo-Kraepelinean DSM-III) identify disease entities — codified, classified and made amenable to statistical analysis — which originally emerged from intense interpersonal relationships between clinicians and patients in particular institutional settings.

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[11] Boyle (1990) demonstrates the persistence of these categories despite there being no reliable way in which the diagnostic status of Kraepelin's (and Bleuler's) asylum populations can be checked against those potentially very different populations which are called 'schizophrenic' today (ibid: 65-71).

The relationship between clinical formulations and personal experience is even more explicit with Eugen Bleuler, who theorized and named 'schizophrenia'. Taking up a position as medical director of Switzerland's Rheinau mental hospital in 1886, Bleuler

> ... lived in the hospital and spent all his time with his patients, from early morning till late at night, taking part in their physical treatment, organizing work therapy, and achieving a close emotional contact with each of his patients. He thus attained a unique understanding of mental patients and the most intimate details of their psychological life. From this experience he drew the substance of his future book on schizophrenia and his textbook on psychiatry... During the twelve years that he spent at Rheinau, continuously living with a great number of ... patients, he not only talked with them in their own dialect but made every possible effort to understand the meaning of their supposedly 'senseless' utterings and their delusions. (Ellenberger 1970: 286-7)

This endeavour, it has been suggested (Cox 1996: 311), was politically motivated by the marginalized position of the local language in the canton of Zurich where all important posts were occupied by Germans. Bleuler thus 'resolved to become a psychiatrist who would speak and understand the same language as his patients' (ibid: 312) — in this case a regional dialect, rather than High German.

Minkowski similarly developed an 'existential' psychiatric method out of close personal interaction with a patient with whom he lived for two months in 1923:

> I was with him continually, night and day. It is not difficult to imagine the annoyances that such a symbiosis can cause, but on the other hand it creates special conditions for the observer. By allowing him to constantly compare the patient's psyche with his own, it gives him the opportunity to note certain details which usually escape attention. (Minkowski 1970: 180)
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> ... I had the possibility of observing him from day to day, not in a mental hospital or sanitarium but in an ordinary environment. His manner of reacting to normal external stimuli, his ability to adapt to the demands of daily life, the variability of his symptoms and their particular nuances are set out more clearly under such conditions. This circumstance is accompanied by another. We cannot maintain a medical point of view 24 hours a day. We react to the patient as do other people around him. Compassion, gentleness, persuasion, impatience, and anger appear in turn. Thus ... I not only observed the patient but had the possibility of projecting his psychic life on mine at every moment. (Minkowski 1970: 182)

According to Havens (1987: 143ff), this technique of 'holding close to the patient', of eschewing withdrawal into professional objectivity or neutrality, and of being emotionally entailed in the patient's experience, was revolutionary. The confrontation and 'emotional explosions' of Minkowski's relationship with his patient provided a new means of 'contact' with, and understanding of, schizophrenic experience, while at the same time highlighting both the limits of intersubjectivity and the patient's capacity to be more than simply 'crazy' (ibid: 145).

Havens' (1987) history of the major psychiatric 'schools' — objective-descriptive, psychoanalytic, existential and interpersonal — is centred on their various 'technologies' (ibid: 5) for 'approaching the patient and losing fear of him [*sic*]' (ibid: 8). In this can be read an analogy with anthropological approaches — beginning perhaps with Henry (1965) and developing with Estroff (1981) into the more recent ethnographies of mental illness — which are explicitly concerned with the settings, degrees and stages of coming into relationship with people diagnosed with schizophrenia, and which employ this relatedness as a means of understanding.

Psychiatry and anthropology also share a number of interpretive and humanist concerns, the reflection of common epistemological tensions. The 'interpretive turn' in the social sciences (Rabinow & Sullivan 1979) had its parallels in psychiatry, where the same epistemological debates concerning explanation and understanding can be found (see Jenner *et al.* 1993). This was made explicit in Binswanger's technique of *Daseinsanalyse*, which developed as a critique of Freud's *homo natura* and the 'natural science' basis of psychoanalysis through the deployment of Heidegger's ontology and Husserl's phenomenological method.[12] In his Introduction to *Schizophrenie*, Binswanger distinguished two ways of coming to know the 'sheer, dazzling, multitudinous plenum of historical, psychological, and biological data' which comprise a clinical 'case' of schizophrenia:

> The clinician ... seeks an order in these cases, an order, however, based on purely clinical concepts and modes of thought that, based as they are on a

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[12] See Binswanger (1963: 155ff). His critique was extended to 'every psychology' — including that of Bleuler and Pavlov — that 'makes man ... into an object' and thus creates 'a rift, a gap' with human being as such. It was fundamentally concerned with questions of knowing and of intersubjectivity.

> naturalist-reductionist dialectic, transform all such data into *symptoms of illness*. The order that we strive for in daseinsanalytic communication with the patient is of quite a different sort. It lies on this side of the concepts of healthy and sick, normal and abnormal, and is only attainable by the kind of interpretation that sees all these data as distinct modes of existence ... (Binswanger 1963: 250; original emphasis)

The latter 'order' — to be arrived at by understanding (*Verstehen*) — is of a 'purely phenomenological nature'. Binswanger sought an analysis which would admit no favoured frame of reference for the task of understanding psychiatric phenomena, but would reveal what made it possible for phenomena to be phenomena for the patient.

Such methods of phenomenological or existential psychiatry begin with the questioning of presuppositions in order to reveal experience in its own light. To illustrate the method Kuhn (1960) uses the example of a woman hearing 'voices' coming from a teapot. The first question concerns the meaning of things — in this case, the teapot — and about the possible meanings that it might have for all of us. He elaborates the enormous complexity of this simple object, the meaning of which is different for its manufacturer, its seller, its user, its collector, and so on (ibid: 65). A second set of questions then concerns the hearing of 'voices'. These questions seek to clarify this experience phenomenologically: What do the 'voices' say and under what circumstances do they appear? Are they loud or soft? Do they speak fast or slowly? Are they the voice of a certain person? How does the hearer react to them? Such questions seek to uncover what the experience is for the patient, and how this might differ from what is common, 'natural' or taken for granted (ibid 68).

Drawing also on the phenomenological method principally associated with Husserl, existential psychiatry eschews the presupposition of illness, symptoms, aetiology and therapy — indeed, of the entire conceptual system of psychiatry and psychoanalysis as empirical sciences:

> When a human being hears 'voices' the psychiatrist recognizes the 'symptom' of an 'illness,' which he calls 'Schizophrenia' ... Phenomenology on the other hand is the method of 'letting the things

> themselves speak' … Hallucinations then are not conceptualized as the symptom of an illness, but the question is asked what hallucinations as such mean, and what they indicate, 'they' as such and not [as] 'scientifically' connected with the psychiatrist's system of concepts. (Kuhn 1960: 63)

Such concepts are what the psychiatrist 'silently implies when he goes about to examine the patient psychiatrically in order to reach his goal' (ibid: 64), which is diagnosis, therapy and cure.

Being free of diagnostic or therapeutic goals, I, as ethnographer, could avoid the prejudicial construction of what psychiatric symptoms were and could therefore explore the meaning of participants' experiences within both wider (cultural) and narrower (personal) frameworks. In the present study, no prior assumptions were made about the nature of schizophrenia as an illness separate to how it was manifested in participants' lives. Toombs (1987: 219) has pointed to the disparity of understanding which potentially exists between physician and patient: a failure of communication resulting not from inattention or insensitivity but from a fundamental disagreement about the nature of illness, represented by the absence of a 'shared reality' between them, or what Taylor (1979) has designated a 'common world'. In contrast to a collection of signs and symptoms which are 'thematicized' into a disease process, Toombs suggests that patients experience the effects of illness (and thus the illness itself) in terms of its impact on their everyday lives.[13] Rather than being a typical example of disease, the patient attends to the personal impact of illness in its immediacy and 'for its own sake' (Toombs 1987: 219). Neither perspective is more 'correct'; they merely reflect different experiential locations in, and involvements with, the world. It is to the patient's construction of meaning that phenomenology and existential psychiatry both look for an understanding of being ill, an understanding wrought in the relationship between patient and physician, as between two human beings.

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[13] Here recalling Bourdieu's (1990b: 60) criticisms of the 'theory effect' — a 'theoretical vision … without anything practical at stake' — as well as Schutz's (1962a: 36) identification of the 'cognitive' rather than 'practical' interests of a disinterested observer, scientist or clinician. See also Chapter 7.

Ethnography's focus on engagement similarly demands an attunement to those meanings which schizophrenia had for participants themselves. Like Bleuler's identification with his patients at Rheinau, the anthropological encounter with 'madness' aims to construct knowledge of this perplexing human phenomenon by way of proximity and dialogic engagement, although pursued to alternate ends and fulfilling other institutional criteria. Kuhn (1960) notes that what is taken for granted in the clinical exchange is that psychiatrist and patient will understand each other: that words will have the same meaning for each of them, and that the patient is willing and able to explain both normal and abnormal experiences. This presumes not only that intersubjectivity is possible, but that a common reference world is already in place. Like existential psychiatry, ethnography seeks to unmask the presuppositions 'from which the psychiatrist proceeds as from something self-evident' (Kuhn ibid: 63), and to explore the conditions which would make such intersubjectivity possible. Its aim is likewise to 'contact the patient in the patient's own world, speak out of the patient's world, and use words with the meaning they have in the world of the patient' (ibid: 66).

An assumption of the possibility of relationship is central to anthropological epistemology. It presumes that a relationship between self and other, ethnographer and informant, is possible, despite the many apparent gulfs. It posits that understanding is predicated on both researcher and research subject each having a relationship to some sort of culture and therefore possessing a means of discovering or creating a relationship between them on that basis, however circumscribed. For anthropology,

> … the understanding of another culture involves the relationship between two varieties of the human phenomenon; it aims at the creation of an intellectual relation between them, an understanding that includes both of them. The idea of 'relationship' is important here because it is more appropriate to the bringing together of two equivalent entities or viewpoints than notions like 'analysis' or 'examination,' with their pretensions of absolute objectivity. (Wagner 1981: 3)

Such a position reflects some of my own presuppositions on beginning this study. I assumed that each participant 'belongs to a culture' (ibid: 2) just as I did and that in this equivalence was to be found a common basis and the possibility of understanding.[14] I emphasize an anthropological framework because it is my background and experience — my own 'culture' in Wagner's terms. Other disciplines converge on the same point, including phenomenologically informed psychiatry (Binswanger 1963; Mendel 1974), psychology (Sass 1990, 1992b), and nursing research (Anich 1997; Walton 1995).

I highlight the common themes in these various approaches, not in order to claim that I am doing existential psychiatry or philosophical phenomenology —I understand myself precisely to be doing ethnography — but to highlight the confluence of interest in meaning, the everyday world, and the questioning of taken-for-granted assumptions which arises in each. This joint interest seems to emerge especially when the focus of attention is on psychopathology, and schizophrenia in particular (see Davidson 1992). It is as if schizophrenia confronts those who experience it, as well as those who attempt to analyze it and treat it, with a profound challenge to understanding, and a questioning which elevates the interpretive response in ethnography, philosophy and psychiatry itself.

RESEARCH PRACTICALITIES: DECENTRED AND MOBILE

In many ways, the research defied conventional attributes of anthropological fieldwork. It lacked the 'basic frame of reference' which oriented classic 'realist' ethnography: namely shared values, shared identities and a shared 'culture' in which the anthropologist becomes enmeshed in reciprocating relationships and which can be mapped, literally, onto a delineated geographic location (Marcus 1995: 110; see also Gupta & Ferguson 1997b). The question of what was shared — among participants themselves as much as between participant and researcher — was a central problematic of the research process. Its locales

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[14] Just as Walton (1995: 84), from the perspective of phenomenological nursing research and on the basis of clinical practice, presupposed a relationship with her participants on the grounds of mutually recognized imperatives toward 'care', 'need' and 'support': 'I considered that human relationships were important for people with schizophrenia, and that even when it was difficult to understand what people said when acutely unwell it was important to communicate a willingness to try to relate to them'. See also van den Berg (1982: 164): 'The patient ... is neither a stranger nor is he akin to us. He is a stranger in kinship with us.'

were many and of disparate scales, encompassing monolithic institutions (such as the hospital and university) as well as individual houses scattered across a wide metropolitan area. This too defied the spatial centring of traditional anthropological fieldwork and highlighted the ambivalent category of 'visiting':

> 'Villages,' inhabited by 'natives,' are bounded sites particularly suitable for intensive visiting by anthropologists. They have long served as habitable, mappable centres for the community, and by extension, the 'culture.' After Malinowski, fieldwork among 'natives' tended to be construed as a practice of co-residence rather than of travel, or even of visiting. (Clifford 1992: 98)

As a consequence of transgressing the presumptions of sharedness and co-residence, my analysis conforms more to Marcus' characterization of an 'experimental' ethnography which is occasioned by the conditions of modernity:

> The connotations of solidity and homogeneity attaching to the notion of community ... [have] been replaced in the framework of modernity by the idea that the situated production of identity — of a person, of a group, or even a whole society — does not depend alone, or even always primarily, on the observable, concentrated activities within a particular locale. The identity of anyone or any group is produced simultaneously in many different locales of activity by many different agents for many different purposes... It is this process of dispersed identity construction or mobile, related representations in many different places of differing character that must be grasped as social facts. (Marcus 1995: 110)

This decentred perspective is particularly apt for an examination of schizophrenia, I suggest, given the contradictory discourses by which it is defined (Rümke 1960; van Praag 1976) and the processes of deinstitutionalization which have dispersed those diagnosed with it throughout the wider 'community'.

The research was not conducted in a faraway place, but in the same city in which I lived (which was, paradoxically, unrecognisable in some of its aspects — see Chapter 3). It was conducted in my own language, but like Okely (1996: 23) I had to 'learn another language in the words of my mother tongue'. It tested and sometimes confounded the positions of power and authority which structured relations between the researchers, as well as those which usually pertained in a medical field, with a psychiatrist working outside the hospital and anthropologists infiltrating a clinical sphere. Likewise, there was no one centre (a hospital, a treatment program, a boarding house) at which the research was conducted. Individual encounters were had with disparate individuals in the discrete spaces where they conducted their own individual lives. What could be generalized from their situation was confounded by unique biographies and incomparable experiences.[15] The knowledge we gained of schizophrenia by way of the fifty participants was thus fluid and decentred — a reflection, perhaps, of how many of them saw schizophrenia itself.

This research strategy was not without its dangers. Approaching schizophrenia from the meanings which it had in individual lives risked individualizing the phenomena itself, ramifying its referents (literally hundreds of representations of schizophrenia were identified during the course of fieldwork) and rendering peoples' experiences incommensurable (thereby reinforcing participants' isolation and marginalization). This could also have resulted in the failure to find any commonality in the phenomena being investigated. There was an inherent tension in the research materials between the specificity of individual accounts — where experiences were embedded in a particular biography which was necessarily idiosyncratic — and the more abstract themes and common elements which emerged when one story was compared with many others. I suggest that bringing this tension into view and maintaining it, however, serves to deepen an understanding of schizophrenia as a multi-faceted symbol which operates at many levels, both personal and social. It also serves to highlight these lives as a pre-eminent site at which institutional knowledge (schizophrenia as a clinical construct) mediated subjective experience (schizophrenia as a lived reality) via the vicissitudes of intersubjectivity.

A car was essential to the research. It was the principal means of accessing 'the community', which in psychiatric parlance meant a variety of locations away from hospitals and treatment centres (see Chapter 3). Pragmatically, this meant travelling to

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[15] Kapferer (1986: 191) argues that this tension between what he calls the Universal and the Particular is a dialectic which is always entailed in the relationship between experience and culture — a dialectic which is also the basis of intersubjectivity.

parts of my own city that I had never visited before (and sometimes never heard of) in order to gain access to those private spaces in which participants lived. The car was also the principal private space of the researchers: a place of anticipation and rehearsal on the way to a meeting, and a space of speculation, cathartic laughter, or stunned silence on the journey back. Since most of the details emerging from the research were strictly confidential, the car was often the only space in which some forms of knowledge could be shared and certain types of responses could take place between the researchers. Both of these were crucial mechanisms in the research process. Some encounters were so perplexing that talking about them was the most immediate form of reorientation, by which means the bizarre and the extraordinary could be appropriated to an everyday mode of interaction (and thereby rendered less disorienting and potentially understandable). Such encounters often initiated in us the same imperative to interpret that we noted among participants. Our sometimes irreverent responses to people and situations were actually a beginning analysis of how to confront the strangeness of schizophrenia. At the same time, this does not convey the whole truth. Many encounters were entirely mundane, and this quality was equally important in coming to understand participants' everyday lives.

Such interactions between ourselves highlighted one value attached to the team approach as it developed throughout this research. It was often as essential to enter into a dialogue amongst ourselves as it was to enter a dialogue with participants in order to test points of common reference. "Is that schizophrenia?" was my frequent query to Rob Barrett after an initial meeting, more as a way of hanging on to what we were meant to be doing than as a pedagogic enquiry about psychiatric categories. In our joint quest for understanding it was also helpful to have a group of researchers of different ages, who had varying biographical resources on which to draw in order to interpret a range of cultural references (say, in popular music or film), or different life experiences which encompassed a range of settings and historical events (the Vietnam War or the Beatles tour of Adelaide in 1964, for example).[16] Another value was that the team afforded a gender division. Each of us, at different times, felt constrained or threatened by the sexualized nature of some encounters. Our having male and female researchers work together diffused this to some extent, allowing one researcher to withdraw if that seemed appropriate.

ESTABLISHING GROUNDS FOR UNDERSTANDING

MEETING WITH PARTICIPANTS

Most initial meetings were held in participants' homes. The majority of these were private or publicly-owned houses, although five participants resided in hostels which provided varying levels of professional care and/or supervision. (Participants' place of residence is set out in figure 2.1 of Appendix 1.) Some initial meetings took place in other settings of participants' choosing.[17] In each case the purpose of this meeting was to introduce the researchers, obtain the person's formal consent to participate, and talk about the aims of the project. (For further details on recruitment to the project see Appendix 1.) These formalities over, each participant was asked simply to talk about themselves: their personal history, their experiences, or whatever it was they thought we needed to know if we were to have some understanding of their circumstances. This approach resulted in a diverse range of accounts, from a chronology of hospitalizations or a pivotal past event, to life

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[16] In a largely ignored suggestion, Nadel (1951: 50-1) advocated anthropological teamwork in recognition of the fact that '[social] science cannot in any respect be "private"' and as a means of 'overcoming the limitations of the [fieldworker's] personality', especially in the study of 'widespread groups and complex civilizations [where] the old technique of single-handed observation becomes sadly inadequate'.

[17] Three participants requested an initial meeting in a hospital setting, indicating that this was where they felt most comfortable. Two of these initial meetings were held in the anonymity of a university teaching department and the other occurred in a psychiatric ward of a public hospital. Kate, who requested the latter meeting, was not a patient at the time, but had spent long periods on the ward and this was clearly the setting in which she felt most able to talk about psychiatric illness — it was her habitual place of disclosure. Two of these participants (including Kate) were subsequently met with in their own homes. The third lived a semi-itinerant lifestyle, moving from house to house, spare room to couch, during the course of the project. Enticingly, he had lived in two other participants' houses, where we would hear about him and sometimes encounter him. He eventually agreed to participate himself, but always came to the university department to meet with us.

histories which did not mention schizophrenia and did not canvas symptoms at all.[18] Three participants stated emphatically that they did not have schizophrenia, which led to a detailed discussion of what their experiences had been and why they thought others had misconstrued those experiences in terms of psychopathology. This way of initiating discussions was designed to minimize interference from our own preconceived ideas about schizophrenia, its onset, its course, and its meaning for the person so diagnosed. As much as possible, each participant was encouraged to tell their story in their own way.

Subsequent meetings and activities were usually undertaken by me and Megan Warin. This facilitated our escape from psychiatric and supervisory control, and created another sort of distance from the project's psychiatric frame. For me, at the time, these activities represented what I thought of as the most 'anthropological' of our encounters (in this case framed by the tropes of participation, intensity, and distance from my own everyday world) — see Gupta and Ferguson (1997a: 5ff). In them we tried to avoid anything approaching an interview format. Through them we took on various roles as sympathetic listeners, confidants, allies, or co-investigators of perplexing subjective states. Some of these roles were attributed to us without our conscious knowledge at the time, their meaning only emerging over the course of our developing relationships and our growing familiarity with the styles of life engendered by schizophrenia. These meetings generated particular forms of knowledge: biographical details, information on social networks and daily activities, representations of schizophrenia, and the meanings attached to medication use and treatment paths. In this way we maintained contact with some participants for several months, and for over two years in the case of three participants. Based on the often intimate knowledge which had already been disclosed to us over that time, these relationships were pursued by way of 'keeping in touch', knowing what was going on in people's lives, and monitoring the various projects in which they were engaged (such as

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[18] Clark (1995: 86) noted that using open-ended interviews focused on life history did not direct participants to 'share the experience of the illness in any particular way'.

writing, painting or pursuing formal education). We sometimes went out with participants to witness a particular problem or situation which they wished us to experience or explore with them. More often, our being together was merely an opportunity to be sociable. Such occasions could be entirely uneventful, a case of being with a person whose main occupation was talking, watching television, or moving about the city in an attempt to keep themselves from being bored.

After a variable number of such meetings, Dr Barrett, in the role of specialist psychiatrist, would see each participant again in order to administer a Present State Examination (PSE) — a detailed, structured psychiatric assessment in questionnaire format aimed at eliciting quantitative research data (principally diagnostic, symptomatic and outcome measures). This was also an externally imposed requirement of the research to ensure (for the purposes of peer review and academic critique) that the participants did in fact have verifiable schizophrenia. The assessment was positioned as one of the last formal meetings, rather than at initial contact. In this way we hoped to avoid structuring participants' accounts into a standardized format which focused on the chronology of symptoms and disability. This was, however, always a narrative resource available to participants themselves, several of whom structured even our initial conversations in precisely this way.[19] It was also a format that was privileged by the research itself, which was framed by a prior diagnostic assumption that the participants did in fact have schizophrenia. Our positioning of the PSE aimed at having the psychiatric assessment conducted only after firm working relationships had been established with participants who might then be expected to be more comfortable with the task and therefore willing to expand on their experiences. By this time as well, the researchers had a greater store of

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[19] See Estroff *et al.* (1991) who found that approaching the study of schizophrenia from a life-history perspective did not mean that persons will describe their illnesses from that perspective; they are just as likely to employ derivatives of a 'medical model' which in itself can be 'normalizing' — alluding to the fact that mental illness is widely distributed among the population and asserting a claim to belong to this larger, 'normal' group.

knowledge about each individual participant by which to interpret responses to the psychiatric schedules: we had, hopefully, moved closer to a common reference world.

Our having prior knowledge from a range of meetings and sources meant that we were able to compare participants' accounts from at least two different contexts: the informal, open-ended dialogue and the formal psychiatric interview. Contradictions between what we learnt in each of these modes were also the starting point of new work toward understanding some participants. It was only after the formal PSE assessment that we negotiated with participants to get access to their hospital case notes. These added a third perspective on how a person's experiences could been viewed, since such notes principally encoded the opinions of treating staff and the clinical representation of participants as cases.

Many of our conversations during these meetings were tape recorded and later transcribed. Only two participants requested that a tape not be made during a particular encounter, but both allowed (and even requested) tape recording on other occasions. In a number of instances people would ask anxiously if we had brought the tape recorder with us, and then insist that it be turned on. It was clear that, for some participants, such recording accorded authority to the task at hand. It validated the importance of the story that was unfolding and marked participation in the project as a 'serious' research undertaking on their part, as well as ours. Such recording was also a means of objectifying extraordinary experiences, according them a 'documentary' relevance and legitimacy which meant that they were not so easily dismissed as mere 'madness' or delusion. This was the most practical expression of participants' strategic attempts to have their experiences re-valued (see Chapter 4).

The temporal sequencing of these meetings reflected the oscillating tension between psychiatry and anthropology as this was structured by the facilitating research grant and by the project's institutional setting. Meetings were a context in which the research team would alternately come together, disarticulate and then re-group in varying combinations: first, all three of us would present ourselves to each participant; then Megan and I would pursue a variety of meetings and activities; Megan and Rob, each with medical backgrounds, would usually conduct the PSE; then Megan and I would pursue more informal and opportunistic engagements with those participants who welcomed ongoing contact. Strikingly, this shifting process of identification with, distancing from, and encompassment by psychiatry reflected much of what I came to understand about participants' own everyday strategizing to both utilize and escape psychiatry. It was in this way that a reflexive awareness of our mutual relationship to, and distance from, institutional frameworks became a basis for intersubjective understanding.

ACTIVITIES: CONTEXTS FOR PARTICIPATION, PRESENTATION AND EXPLICATION

Beyond interviews and their resulting texts, the research process involved joining with participants in a variety of everyday activities. Whilst they provided important contextual data on participants' lives, such activities were more valuable for introducing me to the demands and possibilities of various situations in which participants commonly found themselves and where some of their extraordinary experiences took place. They were privileged opportunities to be in certain settings — a crowded bus, the shopping mall, an out-patient waiting area — to witness participants' responses to those settings, to experience them myself, to have problems or difficulties pointed out while they were occurring, and to engage actively in the interpretation of phenomena to hand. Like the ethnographic technique of participant observation, and like Goffman's placement of himself at the very site of social interaction, these activities provided access to 'the most fleeting and elusive, and very often the most decisive, aspects of social existence, such as the furtive strategies that are engaged in the most banal and therefore least observed moments of ordinary life' (Bourdieu 1983: 112).

Such activities provided an education of the senses, as new significances were attached to previously unnoticed sounds, to certain visual effects in art and advertising, the aural properties of radio and telephone, or to the effects of closed and heavily curtained rooms. These activities were also an exercise in educating our attention, as neglected or previously undisclosed relationships were established between people and everyday objects, unveiling alternative readings of speech or television imagery, of posters and newspaper headlines. This heightened attention was often generated for both researcher and participants, as our very interest caused some participants to reflect on and therefore to objectify such phenomena in order to bring them to our attention. Rabinow (1977: 118-19) has noted that fieldwork is contingent on such an effect: that an informant's perception and experience must necessarily change in response to questioning and scrutiny, becoming self-conscious and objectified in the process.[20] The resulting knowledge is an 'interpretation' and a 'translation', both of which are mediated by the history and culture which each party brings to the task (ibid: 119; see also Dilthey 1976b: 191ff).[21] It is in this way that presentation, objectification, and education can be identified as the specific mechanisms by which some measure of intersubjectivity was established in the present project. Many participants played an active and enthusiastic part in these processes, instructing us, pointing out and taking us to sites of anomaly, finding illustrative objects and settings, and explicating these for us. Shaun eagerly scoured the shopping mall for examples of the objects and activities which would demonstrate his concerns to us; Tony arranged for us to film the spirit 'voices' which emanated from him in particular settings; while waiting at the bus interchange, Brian solicited and debated each of our responses to

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[20] This reflects the interpretive tradition which flows from Dilthey, who made objectification an epistemological condition for understanding human beings: '... in so far as [human life] becomes something we understand, it contains the relation of inner to outer throughout. Accordingly, this objectification is always related, in understanding, to experience in which the person becomes aware of his own inner life and capable of interpreting that of others.' (Dilthey 1976b: 192)

[21] Ethnographic fieldwork is thus 'doubly mediated' by the researcher's own presence and by the 'second order self-reflection demanded of informants' (Rabinow 1977: 119).

the bus ride we had just shared, thus setting up the intense reflexivity of our subsequent journeys that day.

Such situated learning had the effect of changing (however temporarily) my own thought processes so that, for example, coincidences appeared heightened and were interrogated for their meanings, and I could begin to play with the possibilities of connectedness.[22] Many of our interactions were contexts for displaying the distinctive attunement in terms of which participants appreciated their everyday worlds from the perspective of schizophrenia; sometimes being involved in such an attunement affected my own subjectivity.[23] What I witnessed and learnt during such activities provided a basis in my own experience from which a dialogue with participants about *their* experience became possible, thus moving each of us closer to an intersubjective world-in-between (cf. Rabinow 1977: 153-4).

Some sense of these activities has already been suggested — such as in the bus travel with Brian described in Chapter 1 — but here I describe a number of others in order to convey their scope and tenor. On another occasion Megan and I accompanied Brian through a large suburban department store, playing what he described as a game of "cat and mouse". He had wanted us to witness the behaviour of the store's security guards (whom he thought were singling him out for attention) and to engage us in a debate about this perceived surveillance. With another participant, Peter, who was ostensibly homeless, we visited the reserves and suburban parks where he spent a large part of his time and thereby

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[22] One participant, Roland, was concerned that he had the potential to induce schizophrenia in us by suggesting ways in which we might become aware of certain thought processes, significances and connections (thereby also identifying what he saw as the specific medium of our intersubjectivity). He said: "It's in your thoughts. I don't know if you listen to your thoughts, but, I don't want to turn you into schizophrenics, or induce something in you that might cause that". He also implied in this way that what is labelled schizophrenia is a potential state of consciousness and reflexivity which is available to everyone and not just a chronic, pathological condition.

[23] Cf. Wagner (1981: 4): 'In experiencing a new culture, the fieldworker comes to realize new potentialities and possibilities for the living of life, and may in fact undergo a personality change himself. The subject culture becomes "visible," and then "believable" to him, he apprehends it first as a distinct entity, a way of doing things, and then secondly as a way in which he could be doing things.'

became aware of the highly structured nature of his vagrancy. We learnt about the safest places to sleep, where to store minimal equipment such as blankets, and which rubbish bins promised the best food (this turned out to be out-of-date produce dumped by a local supermarket). In Aiden's living room we viewed the video tapes which he said captured the "anomalies" — non-sequiturs, editing mistakes, out of focus shots, indeterminate action sequences, enigmatic subtitles over foreign films — which had precipitated his elaborate quest for understanding; they were part of the "Great Archive of Anomalies" which would prove the interaction between his mind and electronic media. Such viewing was a regular activity for Aiden, whether alone or with others who could be cajoled into sharing it. Individual scenes from these tapes were viewed over and over again, as Aiden interrogated our reactions and interpretations. Of particular interest was a dream sequence from a Greek film of which he said:

> "It reveals the secret of the whole thing [referring perhaps to the film, to his schizophrenia, to his life as a whole, or perhaps to all three at once]. It represents the cause, the middle and the result of my experiences. The cause is represented by the smashed doll [replicating an image in a dream which he says initiated his schizophrenia]. The middle is the fire, which is the destruction, which is the psychosis. And the end result is represented by the boat, which is the wreckage, which is death."

A lot more viewing and much more discussion were required before these multiple levels of signification could be teased out. The viewing and the talking were equally important to the process of coming to appreciate the experiences which Aiden represented so enigmatically.

We met some participants in cafes at irregular intervals, where the noise of cappuccino machines, scraping chairs, and other people's conversations would disguise our talk of mental illness or troubled relationships and create an intangible screen around our deliberations. More often, however, such topics were conspicuously *not* discussed outside the privacy of a person's home, and the conversation in such settings revolved around current events, films and television programs — the usual ephemeral talk of public sociality. Such activities highlighted the juxtaposition of ordinary and extraordinary experiences, as well as participants' senses of the appropriate location of these along a public/private continuum.

On one occasion we were invited to share the special intimacy of the monthly lunch that Wynn had with her son — the only child who, at the age of five, had been removed from her care, a consequence of the marriage break-up which had accompanied her first hospitalization. The meeting was a consciously managed confluence of the people and issues that were singularly important in Wynn's life: her son (then aged twenty) figured prominently in any discussion of her identity, but he had been brought up by somebody else; they were discovering each other again as two adults and this entailed a careful and methodical introduction to the life of a person diagnosed with schizophrenia. Wynn's participation in the project was itself part of a broader commitment to 'speaking out' about a stigmatized subject. She had, in the past, been an advocate for the rights of the mentally ill, a public speaker, and was at the time of the research a member of a national mental health advisory body, in which role she sought to influence government policy. She had grown used to talking about schizophrenia in public forums, but it had been harder to broach the subject with her son. Here, then, was a context in which Wynn sought to present and objectify schizophrenia in much the same way as she had done with us; except the focus of this exercise in establishing rapport and understanding was not us, but her son. The two tasks of explication approximated each other, even though her purpose in each was different. The lunch was a doubly mediated exercise in reflexivity which reproduced the circumstances by which we had come to understand Wynn, while we joined with her in undertaking the same task with another party. Our presence at the meal and our already established rapport with Wynn were in some way a validation of her as a person and of her self-appointed role to teach others about schizophrenia. The lunch provided a 'safe' context in which to pursue this task with the one person whose understanding and respect she wanted most of all. We were also recruited to the task of conferring authority. As "researchers from the university" — as she introduced Megan and I — we added value to her experiences, and this supported her aim of cementing a relationship with her son.

MAKING AND MAINTAINING CONNECTIONS: MEDIA OF ENGAGEMENT

Over the course of the research project, a distinctive pattern of engagement emerged with the majority of participants. This comprised three main components. First, there was the invitation to empathise with the emotional content of their stories, life histories and current situations. Second, there was an invitation to intellectual engagement through debate of the various theories and philosophies (especially popular and widely available ideas emerging from the 'new physics', quantum theory, mysticism, and elements of the 'New Age' movement) which some participants sought to use in order to interpret their experiences. Third, some participants intentionally sought to make connections with us through a common knowledge of books, films, contemporary popular culture, historical events, or other personal and professional interests, once these became known. They sought out shared interests in music, or our knowledge of films, for example, and these became markers of the connection between us (as well as the focus of our social interactions). In some cases, these connections developed into a lending of books, videos and music tapes. Suggestions for reading and viewing went both ways in these exchanges. By this means some participants highlighted what we shared as a way of intensifying what we might come to know and understand in common: that is, some participants actively worked at increasing the bases for our intersubjectivity.

Several people asserted a connection through biographical and historical contingencies — being in the same places at the same time, knowing people in common, or sharing particular aspirations (such as writing about the experience of schizophrenia or achieving academic success). The case of Oscar is illustrative. When he was asked about how he felt talking to us, Oscar reiterated what several other participants had said: for the purposes of research which may educate others, including medical practitioners, he was happy to talk. But he also outlined a more personal agenda. He emphasized our shared participation in an academic task (which was how he construed the research project). He commented that we were all graduates — he had a hard-won Bachelor's degree, completed between hospitalizations — and on this basis shared a common orientation to the world, one that valued knowledge, learning, books and debate. Oscar made it clear that we were doing something which he valued and in which he could participate on an equal footing. This also reflected how he viewed himself: even if (as he said) he was suspended in an impoverished lifestyle with limited resources and opportunities, he too was a scholarly and discerning person who had something to offer others. Participation in the project afforded him a sense of value which was in accord with the way in which he liked to think about himself. If his own aspirations for enrolment in a higher degree had been thwarted, at least he could participate, however vicariously, in someone else's. The telephone rang while we were sitting in Oscar's "study" one day. It was a friend wanting him to come over. He told her that "Rod and Megan are here from the university", using only our first names and stressing our institutional allegiance. Both the familiarity and the institutional association were clearly important to him and valuable also if they could be conveyed to other people in his world.

Ongoing contact with a number of participants provided invaluable glimpses into their lives over time that highlighted the many difficulties, discontinuities and false starts which they faced. For example:

- We first met Roland when he was living in a small religious community, lost track of him when he went into hospital for several months, and then began visiting him when he was back living with his parents. The latter setting was not conducive: it lacked the freedom which he said he required to pursue his various researches into mysticism and alternative medicine, and it lacked the privacy he required for talking about his experiences. He took to visiting us at the university, 'dropping in' for a coffee whenever he was in the city, usually once a week. A fledgling massage business had failed to take off and he was drifting, thinking about travelling in Europe again (he put a deposit on a plane ticket, then gave it away to a friend). We knew that conflicts with his father were escalating and it was hardly surprising when he turned up one day having spent the previous night in a men's shelter and stating that he was looking for a flat to rent.

- Similarly, we followed Shaun through a period of relative stability, when he seemed to be enjoying his freedom to wander the city streets or read for hours in the public library, then through a period of heightened anxiety when he rarely left his flat (which was becoming crowded with found objects and every available surface was covered in delicate paper 'sculptures'), to a brief stay in hospital. When he was discharged, I was the only 'friend' available to drive him home.
- We had worked intensively with Tony for over a month when a change of medication caused a sudden and dramatic depression. Our exploring the effect of these changes with him was in itself extremely valuable — he was able to meticulously map the "fading away" of various beliefs and symptoms which had preoccupied him for some years — but his energy and enthusiasm were gone, his speech was altered, and even his physical composure had changed. In contrast to his previous avid documentation of his experiences, Tony sat almost inert in his tiny house or slept most of the day. Another change of medication (the introduction of an anti-depressant) precipitated a sudden move to another capital city, where he got a job in his former trade. Three weeks later he was back having "panicked" at the onset of, as he put it, "minor symptoms". He was resigned to not working, but he was happier, more lively, and beginning his numerological investigations again.

Such glimpses into the lives of people diagnosed with schizophrenia provided another means of going beyond what could be learnt using more formal techniques or from the mere elicitation of their experiences. Intermittent engagement represented a mode of social interaction with which they seemed comfortable and over which they had greater control.

Several participants found the telephone a communication tool, providing access to others without entailing them in a threatening or overwhelming physical presence. The telephone was thus a medium for maintaining both distance and connection. For one participant, the telephone had a particular affinity with other aspects of his experience: Adam characterized himself as a "heavy telephone abuser", because, he said, "it's just like the voices in some ways". Shaun had (quite literally) elevated his telephone to the status of a "shrine". It was raised on a series of up-turned metal bowls and decked about with fresh flowers that he gathered from neighbouring gardens. He reasoned that even if it didn't ring very often at least it performed a decorative function.[24] Later, Shaun repositioned his telephone so that it sat inside an open attaché case which was also decorated with dried roses and coloured writing papers (see Plate 1): he reasoned that this too was a beautiful object, and if the

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[24] Its silence prompted regular calls to the telephone company to request that it be tested.

Plate 1. Shaun's Telephone

phone offended by its silence he could always close the lid of the case so as not to be constantly reminded of his social isolation. The apprehension of the telephone as a sympathetic or mediated vehicle of communication meant that several people sustained ongoing contact with the project via this medium. They would ring up regularly — weekly or monthly — for a 'chat', which usually entailed a review of their current activities and concerns, casual accounts of what they had done in the intervening period, and polite queries about where we were at in the research schedule. The telephone allowed these participants greater control over their interactions, since it was they who determined when they rang and how long they spoke.

The connections which we made with participants and the relationships which we entered into during the course of this research reflected participants' abilities and willingness to relate (together with their strategic purposes in doing so) as much as it did the structured possibilities of the methods or the capacities of the researchers. The ability to enter into relationships with participants may have been constrained by the medical or psychiatric framing of the research, but equally, this was also the frame which circumscribed the participants' views of themselves and their relationships with others. To have denied or ignored this framing would have meant that we were disattending to one of the most powerful defining contexts of their lives. This was the field in which they normally operated (see Chapter 3). Their relationships with other people were constantly inflected and refracted by the presence of mental illness (whether they accepted it as an accurate diagnosis or not), as well as by the institutions which had determined their 'condition'. We could only relate to these people and come to understand them by being fully cognisant of the real consequences which this institutional context — condensed into a psychiatric diagnosis — had for them.[25] We entered into relationships with them by entering the entire field of relationships in which they lived, including those with their psychiatrist, the

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[25] For an example of a marginalized fieldwork practice (by Radin) which similarly emphasized the 'institutional conditions of [its] intellectual production' see Gupta and Ferguson (1997a: 23).

staff of psychiatric hospitals, the bureaucrats who handled their case records, the CSI[26] workers who came to clean their houses, the parents who had been forced to re-negotiate their own relationships in the context of mental illness, and the friends and lovers who also had to factor mental illness into their knowledge of the person concerned (cf. Estroff 1989). We entered into relationships with participants on the basis that they had been diagnosed with a psychiatric illness: this was the starting point of all our relationships, wherever they went after that. No matter how much I (or they) wanted to create a distance from psychiatry, it remained important to those relationships and to my understanding of their context. The only rigorous way forward was to attend meticulously to that context, its circumstances and consequences.

OTHER PARTICIPANTS: RELATIVES AND FRIENDS

Additional meetings were convened with a variety of relatives or friends — people whom the participants nominated as being important to them in some way, or who they believed had a good understanding of their experiences. These were mostly parents and siblings but also children, spouses and friends. Sometimes these meetings were conducted with the participant present, but more often without. I had hoped in this way to gain additional perspectives on the core of people we were meeting. I had presumed that with them I could develop a productive rapport: many of them had long-term contact with psychiatric illness, had been affected by it themselves, and could reflect on its meaning for their own lives and that of others; like me, they were vitally interested in schizophrenia but were not diagnosed with it themselves. These were the bases, I thought, of discovering a 'world in common' which would illuminate what schizophrenia meant in a human and social sense.

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[26] Community Support Incorporated, a non-government brokerage organization which provided a range of services tailored to individual 'consumers' or 'carers'. These included home support (e.g. personal care, overnight care, housekeeping, laundry, shopping), respite services, recreation, home maintenance, home modification, transport and information services. They were available to 'those people with psychiatric disability whose continued community tenure may be at risk if they are not provided with adequate support to meet their identified needs. Carers of these consumers, who themselves are at risk, are eligible also to receive respite and support ...'

For the most part, however, these expectations were not met, which raises important questions about processes of empathy and identification within the project.

Witnessing or being drawn into the relationship between a participant and their relative could sometimes provide important clues as to how I might conduct my own relationship with the former, thereby building a closer intersubjective engagement. Such an opportunity was afforded by Zöe's brother. My relationship with Zöe was always difficult: she espoused a hatred of men (for all that they had "stolen" from her); the colour of my shirt offended her; and she attributed significances to the inflection of my voice which I did not intend. Our meetings often resulted in her expressing hostility toward me. I would try to avoid this if possible and negotiate the situation when it inevitable arose since I deemed such antagonism to threaten our being together at all. She always declined my offer to leave. Such a withdrawal would have dissolved whatever intersubjectivity was possible between us; Zöe's commitment to the project was such that she and I continued to work on a mutual understanding of the situation despite its difficulties (see Chapter 6). Notwithstanding intimated threats of violence against members of her family, Zöe was pleased to facilitate a meeting with her brother. In his presence I saw a very different side to Zöe. Observing his interactions with her provided clues for how I might conduct my own, as well as providing insight into the dynamics of their very intimate relationship. With him she was warm, conciliatory and physically demonstrative. He in turn was calm, attentive and supportive, which did not mitigate against the eruption of several voluble disagreements. Throughout these interchanges he never got angry himself, never raised his voice, and never stopped listening to or engaging with her. It was instructive to see her brother reinforcing Zöe's interpretations of people and events but never shying away from asserting his own interpretations as well. In particular, he was able to challenge some of her views (about men, for example) without questioning her integrity or undermining her right to opinions which were embedded in her own experiences. I found this admirable. Negotiating Zöe's belief system was often difficult for me, because I as a man was implicated in it to a large degree. I did not want to offend or antagonize her let alone assert a sense of superiority, authority or rationality, but I was never completely sure of the bases on which she attributed me roles or interpreted my actions. Our meeting with her brother allayed some of my concerns, especially my fear of provoking in Zöe a distress or anger which might have consequences beyond the period of time we actually spent together and when such reactions could be negotiated to some extent. In particular, her brother was able to place some of Zöe's reactions into a broader context — he was able, for example, to explicate some of her past relationships — thereby allowing me to make some 'sense' of them. This, in turn, endorsed the stance of equanimity which I tried to assume in the event of her provocations.

My negotiation of the belief system of a relative was sometimes as difficult and disconcerting, however, as it was with a participant. Problems of empathy and rapport, disparities of value and limits to understanding were encountered here as well. One experience stands out in this regard. Thelma and Reg were aged in their early seventies; Reg had retired after a successful but undistinguished military career; Thelma was a housewife and proud grandmother. All three researchers met with them in their comfortable home in an ageing, middle-class suburb. After a brief opening conversation about the lack of recognition and support for carers, Thelma challenged each of us with a question: "Are you Christians?" While we each searched for a polite way to answer she went on: "If you say 'no' you probably can't realize just how I feel". Her qualification clearly established the framework within which she believed issues concerning her daughter could be explored. This opening gambit challenged our own presumed neutrality (as disinterested researchers) by signalling that the potential for understanding between us was contingent on *our* belief system. Our beliefs had been an issue for some participants — especially those who presumed that we represented the psychiatric profession — but it was rare to be confronted so directly with a demand for self-disclosure which would establish the ground rules of an interaction. What followed had a pervasive moral tenor:

their daughter, Francis, was a wicked, lying, deceitful, promiscuous drunkard, who wasn't theirs anyway: "You know she's adopted" blurted Thelma at a moment of exasperation. They construed schizophrenia in the same negative and distancing terms: "with our religious background we find the whole thing quite odious, but we live with it". After a sometimes uncomfortable conversation lasting several hours, it was almost a relief to retire to high tea in the dining room, where our competent manners and shared accomplishments in polite conversation shifted the focus onto family achievements and Reg and Thelma's standing in the local community. All this made it difficult to admit to them how much we admired their daughter and how much we enjoyed her biting wit, her sharply drawn caricatures, and her incisive social commentary. For me, the meeting with Thelma and Reg highlighted where my own sympathies lay. It therefore confronted me with the prejudices and partisan interests which were no doubt present on many occasions, but which I was rarely called to reflect upon so dramatically. It was to the participants diagnosed with schizophrenia that my sympathy flowed; it was with them, rather than their families, that I wished to establish empathy and dialogue as a basis for understanding.[27] The fact that many participants asserted that they were estranged from their families (especially parents) effectively precluded my developing the same empathy with the latter; to do so would have jeopardized the trust, rapport and understanding which I sought to construct with participants.

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[27] On the centrality of 'empathy' to understanding in the history of interpretive approaches to the social world see Rabinow and Sullivan (1979: 5), who note its derivation from Dilthey (1959, 1976c) and Weber (1978: 4ff). In this methodological formulation, empathy is neither intuitive nor 'mystical', but is predicated on the 'prior existence of the shared world of meaning within which the subjects of human discourse constitute themselves' (Rabinow & Sullivan ibid). Jackson (1998: 149) argues similarly that it would be a mistake to view empathy as wholly spontaneous or subjective, or to view it atemporally: '… intersubjective relations are continually modulated as circumstances change, and empathic and combative behavior are equally important modes of negotiating relative distance between self and other. At the same time, both empathy and enmity must be understood as cultural "acts" that are performed for practical and social purposes rather than simply expressed as a matter of private and emotional need'.

LIMITS ON ENGAGEMENT AND UNDERSTANDING

DIFFICULT RELATIONSHIPS

Like the issues of co-residence and shared spatiality, participants' circumstances and histories often confounded the anthropological presumption that relationships of trust could be established with 'informants'. Was it possible to enter into relationships sufficient for intersubjectivity to be achieved and confirmed? The institutional frame of the project, the identity of its personnel, and a number of distinctive features of participants' own experiences made the establishment and maintenance of some relationships especially fraught. There were clear barriers — such as isolation and mistrust — to an ethnographer participating in the participants' sociality. In particular, I was faced with the double problematic of how to enter into relationships with people for whom intimacy and the availability of one person to another were already the focus of intense monitoring and reflexivity. Most participants talked about the problems they had establishing, maintaining and managing interpersonal relationships. Lawrence, for example, talked about how he would rather lose himself in a crowd than subject himself to being "pinned down" by people whom he knew and, more importantly, knew him. He was self-reflexive about the paradoxical reinforcement which took place between his relationships and what he called his "paranoia":

> "One of the great paradoxes of schizophrenia is [that] the people you know so well are the people you trust the least, because of the fact that you know them and they know you. So somehow you invest that knowledge with all of the aspects of schizophrenia and delusions. That's why I would rather walk in a crowd than actually be one-to-one with another human being, because I can just dissolve into the mass of nothingness, as opposed to being pinned down, which I really don't like."

Most participants were highly conscious of these difficulties, which had also been codified in official classifications of schizophrenia as a mental illness.[28] Attending to the difficulties of my own relations with participants throughout the course of the project was

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[28] 'Impaired interpersonal functioning' is a 'characteristic symptom' of schizophrenia, involving either social withdrawal and emotional detachment, or intrusiveness and 'excessive closeness' (American Psychiatric Association 1987: 188-9).

one important way in which I came to understand this aspect of their everyday lives. Engagement in and reflection on these difficulties were sources of intersubjectivity for each of us, as well as a measure of its limits.

Some participants, while willing to engage in formal interviews and convey something of their experiences, were clearly not interested in pursuing a relationship beyond this most obvious aspect of the research. These were people who signalled that the PSE (the formal psychiatric assessment) finished their commitment to us. Several such people, when we met with them again in other settings (a hospital waiting area, the Schizophrenia Fellowship, or walking in the street), attempted to avoid our approach or were dismissive of any intimation of familiarity. I found this profoundly disconcerting, but I came to recognize it as a cycle of closeness and rebuff whereby some participants would seemingly disclose the most intimate details of their lives but fail to acknowledge what I felt to be the social entailment of such disclosure. I was left with a sense of responsibility for their emotions and stories — which I thought needed to be recompensed by ongoing social engagement — when they obviously felt no further need for connection, either with those stories, or with me. Perhaps this was a reflection of the institutional frameworks of disclosure with which many participants were *au fait*. Their treatment paths had been predicated on desperate, startling or bizarre confessions to psychiatrists, nurses, medical students, police officers and social workers. Such stories (or at least parts of them) had been offered and reiterated to many others, written down and transformed into numerous case notes and referrals. Participants did not 'own' these stories in the way that I thought they must, and the stories did not 'work' to cement relationships and understandings in ways that I had presumed. This too was a lesson about the limits of engagement.

It was not possible to live with participants in some sort of simulation of 'standard' anthropological fieldwork.[29] Apart from the obvious lack of space in most peoples' houses, it would have entailed a personal and psychological intrusion which was repugnant to many of them. This unavailability intimated a body of social codes concerning what it is to live in one's own home — that there are barriers to entry and to observation — and the cultural practices by which privacy and personhood are structured in Australian society (see Benn & Gaus 1983; Stivens 1985: 30). To have breached these barriers would have, in itself, violated cultural rules, and would thereby have removed some essential features of the situation from analysis and reflection.[30] These were all people who had secured some measure of freedom from the surveillance of their 'mental state' and who were not about to compromise that freedom by having an anthropologist 'shadow' them. This capacity to avoid or reject surveillance was an important index of their social situation and identities. Participants' ability to invite us when it suited them, or to not be home at a time for which an appointment had been made, was intrinsic to how they controlled their social interactions and thereby constituted themselves as agents in respect of the research itself. Relative inaccessibility was crucial to some participants' everyday lives. It maintained distance from unsympathetic others (including family members), decreased psychiatric surveillance, and facilitated the sustenance and elaboration of idiosyncratic belief systems. Acknowledging distance and separation was as intrinsic to my understanding of participants' worlds as were access and disclosure.

The lack of space to accommodate researchers betrayed a more general lack of resources available to many participants (this is considered in more detail in Chapter 4). Many people were severely restricted in their ability to conduct the types of exchanges which I

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[29] See Reynolds and Farberow (1981), an account (largely in diary form) of an anthropologist living in a 'patient's' apartment for one month, following him everywhere in a technique called 'shadowing', and recording his family interactions for the purpose of studying the 'stress of being an outpatient'.

[30] It is in this sense that the 'field' of the present study is intrinsically and necessarily distinct from the 'field' of boarding houses and half-way houses studied by Hannan (1990), the community out-patient team studied by Estroff (1981), the residential shelter studied by Desjarlais (1997), the 'nonplaces' (empty lots, abandoned tunnels, transport terminals, parks, the no-man's-land under bridges or highway abutments) inhabited by the homeless mentally ill (Lovell 1997), or the jail of Clark's (1995) study.

took for granted as comprising everyday sociality. Their economic resources could be significantly strained by the supply of cups of coffee (let alone biscuits) to two or three additional people. When visiting people with whom we had developed ongoing relationships we commonly took a small jar of coffee which we left behind with our host — a token of thanks for their hospitality, but also an acknowledgement that their need was greater than our own.

Most participants were aware of their differential command of even basic resources. For instance, Shaun rarely appeared to have any food in the house, apart from the occasional packet of biscuits which he would inevitably consume at one sitting. On arriving at his flat one afternoon, Megan and I were ushered into the kitchen to view his new "pantry". This was a commercial display stand consisting of wire baskets attached in tiers to a metal frame (see Plate 2). It had been given to him by a local shop owner who no longer required it for its former purpose of displaying packets of potato chips. Shaun highlighted this association with what he saw as gastronomic plenitude. He had decorated the stand with bunches of flowers gathered from neighbouring gardens. Over several more months of visiting there was never any item of food on Shaun's pantry shelves. For me, the pride and decoration which Shaun directed toward these shelves only highlighted their perpetual emptiness.

Commensality, in which sharing a meal expresses both commonalty and relationship, was difficult for similar reasons of restriction on participants' resources. It was rare that we actually ate with a participant. Domestic budgets did not stretch to feeding additional people. But there was more to this than just finances: many participants never ate with another person. Even in households where they lived with others, they often cooked for themselves and ate alone. Our visits were usually timed so as to avoid being present at a (conventional) meal time — or rather, to avoid the presumption or social obligation that we should be offered a meal. Even when we went to cafes with people, it was rare that they

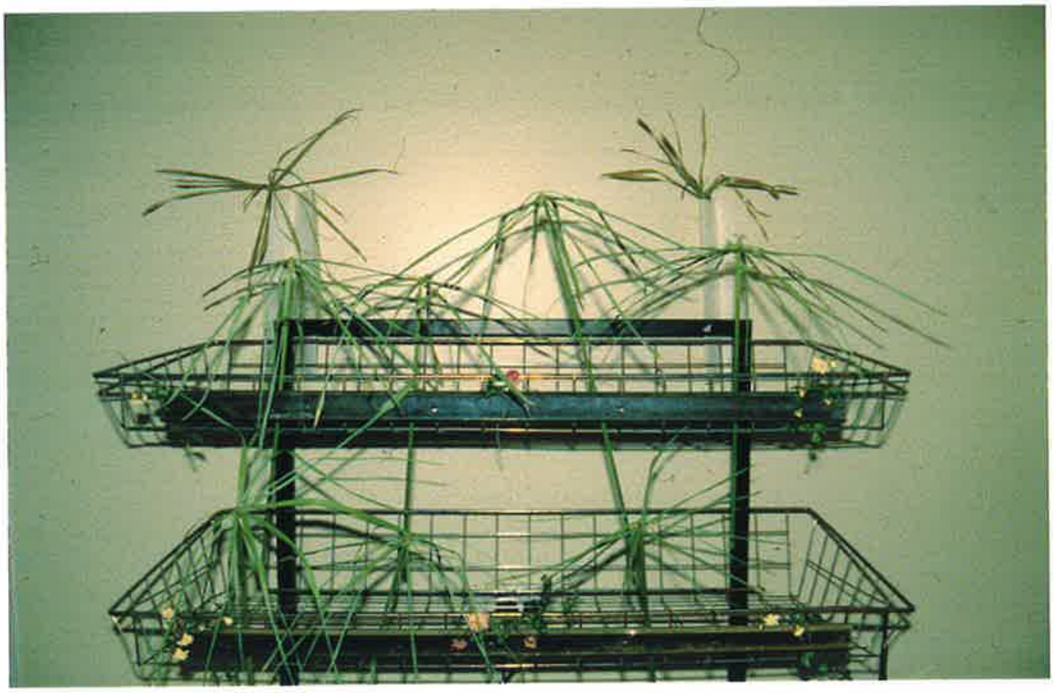

Plate 2. Shaun's 'Pantry'

would eat (the lunches with Wynn being a notable exception). It was surprising, therefore, when Brian suggested one day that we go to his "favourite" restaurant for lunch. We walked up and down the main street of a beach-side suburb for some time as Brian tried to locate this establishment, in the end unsuccessfully. Finally, we opted for a small cafe in which there was only two other diners. Brian perused the menu for some time, seemingly unable to decide. After half an hour he declared that he was not hungry, but proceeded to eat off both Megan's and my plate. Throughout our time in the restaurant, Brian appeared awkward and uncomfortable: his movements at the small table were 'jerky', threatening the arrangement of plates and cutlery; his laughter was often exaggerated, given the setting, and he was clumsy with the sugar. It struck me that Brian was profoundly unfamiliar with this type of social activity; the restaurant required styles of deportment, conversational registers and physical skills which he had rarely had cause to learn or practice.

TEMPORAL DISSONANCE

One of the obvious constraints on building a common world with participants was a kind of temporal dissonance which distinguished researchers from participants. My experience of time was largely shaped by the research project itself, which meant that it was quite different from the circumstances which pertained in participants' own lives. The scheduling and time constraints of the research process were not the same as those temporal structures which patterned participants' own projects — here also confounding the anthropological assumption that a researcher simply attunes to the temporal cycles and rhythms of a community or culture. In part this dissonance reflected the tempo of psychiatric institutions, in which there is often a disjunction between staff movements (changing shifts, personnel who enter and then disappear on 'rotation') and the more restricted movement of in-patients. As one participant commented:

> "... that's another thing I found about [the hospital] — there's a staff turnover. [He names the several different psychiatrists who treated him there over the course of only two admissions.] The chopping and changing of the medication

> and the chopping and changing of the doctors doesn't imply any consistency at all, and it's the major drawback to the system of treating mental illness."

Our appearance in, and subsequent disappearance from, participants' lives must often have looked like this aspect of the 'medical system', of which participants had wide previous experience. This was something which we shared, but its meaning for (and apprehension by) each of us was incomparable.

Throughout the period of research we were constantly recruiting and meeting with new participants. Developing these relationships often detracted from the amount of time that we had available to maintain contact with people with whom we had already worked. The project also had its own momentum and timetable, which were predicated on progress and closure: processing the material and writing reports necessitated our withdrawal from regular contact with participants. In addition to completing the project in line with the requirements of funding bodies and the conventions of academia, each of the researchers became involved in other projects, including my writing of this dissertation. By contrast, many participants' lives appeared remarkably static. Their circumstances and conditions did not change as rapidly. Most remained unemployed, their income was fixed, they did not move house, and they expressed consistent concerns year after year (as I was to discover when I occasionally encountered or went to visit various participants after the period of formal interviewing had been completed). Often their personal projects were much the same a year or two years after we had first met them: Gerald was still hoping for a singing career, but two years of singing lessons had not produced much in the way of improvement; Tony was still meticulously documenting the 'occultic' phenomena which had tormented his body for much of the previous decade; three years on, Aiden was still at work on his monumental novel.[31] Such stasis made it difficult to maintain relationships because of the disparities it highlighted and the reticence it caused between us, there being a social value attached to progress and change — achievements which are presumed to be

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[31] Change was, however, much more a feature of the lives of some younger participants: three men aged in their twenties, for example, had begun (or returned to) tertiary education; Jane had recovered from a massive drug overdose, resumed her writing and won a local literary prize.

inhibited by schizophrenia as a 'chronic' illness. These disparities were only measurable and meaningful in relation to the structured demands of the research itself: I was forced to move on, report and 'produce'; participants, on the other hand, were for the most happily ensconced in their own lives and their own temporality. Participation in the same research project generated different experiences of time for each of us, further highlighting the difficulties of establishing a common world between us.

WRITING (AWAY) STRANGENESS

Writing is integral to ethnographic practice (Geertz 1973: 19; Clifford 1988: 25, 1990: 53).[32] Most meetings with participants resulted in some form of written account. In addition to transcripts of our conversations, these accounts included detailed notes of where people were sitting in a room, what they were wearing, and the various non-verbal inflections which guided our conversations, such as demeanour, eye contact, hesitancy, discomfort, laughter and irony. The writing up of our encounters thus combined what Sanjek (1990) distinguishes as 'fieldnotes' and 'fieldnote records'. The former — developed from 'headnotes' and 'scratch notes' made at the time — served the purpose of description, especially of the spaces (living room, bedroom or cafe) in which particular conversations took place, the general physical and emotional attributes of the participants, their appearance and behaviour, the gestures they used, my reactions, and any explanations and interpretations which occurred to me at that time (see Minocha, cited in Sanjek ibid: 97). These fieldnotes were organized sequentially by date; over time they began to incorporate cross-references to other participants, comparable settings and interrelated themes. The 'fieldnote records', which also became a part of this corpus, were the transcripts made from our tape recordings: the purpose of these 'texts' was 'to secure

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[32] But see the critique of writing (and the textual production of ethnography generally) in Tomas (1992).

the informant's precise words *during* the fieldwork encounter, as they were spoken' (ibid: 104; original emphasis). Such records were not just a way of letting the research subjects speak for themselves — thereby providing a means for establishing the authority, persuasion and 'descriptive rhetorics' of the ethnographic exercise (see Clifford 1988; Rosaldo 1986) — but were part of a conscious research strategy to subvert the tendency for these people's words to be ignored or turned into symptoms — see Chapter 6.

Writing also took on another valence in this context. It is a particular response to psychopathology in clinical settings (Barrett 1996: 126) as much as in everyday life (Keitel 1989). Many participants had long engaged in writing as a way of recording and reflecting on their experiences. My response to the fieldwork encounter with schizophrenia reinforced this strategy, with writing (like talking) as a means of reasserting orientation as well as distancing myself from the uncanny strangeness encountered in familiar environments. Writing was thus a way of composing my own subjectivity, as well as a means of reflecting on the effort (and occasional failure) of intersubjectivity.[33]

The fieldnotes, which focus on context and description, have often proved to be as important to this analysis as the record of what participants actually said. It is in them that the 'flavour' of an encounter is best recorded: a sketch of sights, sounds and responses which are truly evocative, which can take me back to the feelings of strangeness and disbelief (or, on rare occasions, mundane boredom) which accompanied our meetings.[34] Some encounters were literally 'shocking', producing a dislocated, disorienting effect that

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[33] On these often undisclosed uses for writing during fieldwork, see Okely's reflections (1996: 33ff) on Malinowski's diary.

[34] Cf. Favret-Saada (1990: 192): 'My notes were obsessively precise, so that I was able later to re-hallucinate the events, and because I was then no longer "caught" in them but became "caught" in them again, I did eventually understand'. I find this image particularly apt because some encounters were hallucinatory in themselves and a simple transcript of what had occurred or what had been said did not register this effect. Writing about such encounters immediately afterwards, however speculatively, was a fervent attempt at personal orientation and understanding. On the centrality of evocation to ethnography, see Tyler (1986: 125) who asserts that ethnography must similarly evoke 'an emergent fantasy of a possible world' in the minds of both reader and writer.

could last for hours or even days. Our first meeting with Gerald was one of the most dramatic. The following is adapted from notes written at the time:

> *This was another truly fantastical meeting, on par with our first encounter with Zöe. I recognized the same sense of shock and dislocation afterwards, although this time it was probably less traumatic precisely because I had experienced such reactions before … Megan and I were both talking compulsively about Gerald the next day, turning over the images he had provided us with, but more fundamentally expressing our own disquiet and confusion. The shock of this encounter comes from the dramatic juxtaposition of the mundane and the bizarre: here was the most ordinary-looking middle aged man, someone you would pass in the street without noticing, who could serve you in his shop without creating any sort of impression at all, but who, when he spoke about his private world, produced a flood of the strangest images and ideas. I sense that my feeling of dislocation comes from a particularly vivid encounter with a truly alternate reality… Gerald appeared to be talking in perfectly clear consciousness, and this in itself heightened the strangeness and the sense of dislocation which resulted. It was not so easy to dismiss him, or bracket what he said, as being somehow the result of a mental state which had been altered by some recognizable technique or drug. It was the very ordinariness of his looks, his demeanour, and the rendition [of his story] which made the contents even more bizarre and heighten his narrative's dissociative power.*
>
> *I was struck by the disparity between the very ordinariness of the man, the mundane setting [his lounge room], the plain language that he used, the form of the narrative itself [a simple chronological unfolding by way of a biography], and the hugely elaborate web of references, associations and identities which he spun. Megan suggested, more perceptively, that it was a conflation of the ordinary and the bizarre which was so disconcerting. The fundamental categories which I assume to constitute time, space, biography and even 'reality' itself were not so much juxtaposed as collapsed. So, for example, he is both Gerald and [the legendary] Achilles, King Arthur, and perhaps others besides. His narrative encompasses 4000 years … traverses world geography — Africa, continental Europe, Britain and Australia — and identifies sites of historical, biographical and even cosmological significance: the Garden of Eden, Stonehenge, the city of Troy, a [local, named] strip-joint. The account was also peopled by the most disparate of characters: mythic Greeks (Achilles), mythic Europeans (King Arthur), major historical figures (Genghis Khan, Adolph Hitler, Stalin), movie stars (Jacqueline Bissett), socialites ('Mrs Smith'), and a local stripper ('Big Pretzel'). What was*

> *even more surprising than their mere evocation was the connections which Gerald has built between these characters. This was epitomized for me by the conflation: little girl at kindergarten/Helen of Troy/daughter of Hitler and Eva Braun. For me these associations were 'hallucinatory'. The boundaries of my own sense of reality began to blur in the course of Gerald's 'explanation' of these connections. The images and their 'explanations' created a dream-like state in which the ordinary and the extraordinary mingled — a state in which the commonplace was suddenly revealed to be either miraculous or absurd.*

My responses to subsequent meetings with Gerald were similar, as he continued to expand on the meanings which connected the various people, events and experiences in his life into an elaborate, almost cosmological, plan. No amount of familiarity with his way of making sense of these experiences completely eliminated their strangeness for me, even as I came to understand the 'logic' and emotional resonances which they held for him.

Writing about such encounters as soon as possible afterwards became a ritual of my own, driven by an imperative both to record the strangeness of these situations and also to achieve some distance from them if they were particularly disturbing. I found writing up fieldnotes to have a cathartic effect at the same time as it allowed my experiences to be fitted to some sort of framework (doing research) and an academic purpose (the production of this dissertation, another distancing device).

Gerald posed a particularly vivid example of what Schutz has called 'the world of the insane' (1962b: 232) — a 'sub-universe of reality' or a 'finite province of meaning' which is incompatible with the meaning of everyday life. For Schutz, everyday reality (the 'natural attitude') is premised on a world of shared experience which is historically given, pragmatically negotiated, and intersubjectively interpreted. My everyday world of work (exemplified, at the time, by the research project itself) did not provide sufficient clues for how to operate in scenarios such as those generated by the encounter with Gerald. The latter profoundly challenged my assumption of a common world. Some elements of our meetings were unproblematic because they partook of my taken-for-granted knowledge, such as the protocols for visiting or knowing how a suburban space works.[35] Other aspects of these encounters were frighteningly strange (such as being attributed a role in his apocalyptic 'revelations'), or simply uncomfortable (being locked in his house for the duration of our meetings). Schutz (ibid) noted the shock which accompanies the passage between alternate realms of meaning. My shock was caused by the compelling evocation of surreality and strangeness which Gerald could achieve just by what he talked about and how he talked with us in his lounge room. The power of his story resided precisely in the fact that its contents were 'everyday' for him, but not for me.

Such encounters confronted me with a hierarchy of 'realities' — participants', my own, the psychiatrist's diagnosis — some of which by external force, authority or logic could be represented as more 'real' than others and which therefore raised issues of competition and power. There is a coercive power attached to some 'realities', and more to some than to others, by which means they are able to be represented as the 'most real' (see Berger & Luckmann 1967: 98). Participants commonly reflected on the hierarchical location of their 'everyday' reality of experience in just these terms, knowing (as Gerald said) that they would be labelled 'sick' if they voiced some of their beliefs and concerns to 'doctors', for example. This was one of the reasons why Gerald had rarely spoken before about what he considered to be his 'real' life. My reactions (such as 'writing up' difficult encounters) were more indicative of the restitutive and remedial force and power of my own everyday world in the face of such failed intersubjectivity. Writing was the only means I had to deal with these strange expressions and this became the focus of my own coping with anomalous experience. Such writing also marked an ongoing process in which intersubjectivity is always a potential, if partial, achievement.

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[35] Examples included assessing whether to wander into the kitchen while Gerald was preparing coffee or stay seated in the lounge room; enacting protocols for using the toilet; and negotiating access to a photograph stored in his bedroom.

CODA: EXPERIENCE, FIELDWORK AND INTERSUBJECTIVITY

Participants' apprehension of the extraordinariness of their experiences was the effect of their own recognition that these did not fit with what other people experienced, or with what they understood other people to have experienced, or with what they had previously experienced for themselves. The experience of others was implicated in each of these disjunctures. In this way, intersubjectivity — as a simultaneous recognition of the non-self, and of the self as reflecting or otherwise being in relationship with other sentient selves — was the condition of extraordinariness as I have defined it in Chapter 1. Intersubjectivity provided the very basis of familiarity and strangeness by which extraordinariness and uncanniness were measured for both self and other.

This chapter has outlined the procedures — informed by both psychiatry and anthropology — by which some measure of intersubjectivity was established with the research participants. This intersubjectivity was not only a source of commonality in the social interactions we shared, but was equally the very basis of their extraordinariness. These encounters and their emotional impacts were not unidirectional. The research process was influenced by the participants as much as by its formal design and execution. That I was also affected by them, emotionally and intellectually, was the result of whatever relationships I was able to form for the purpose of exploring what schizophrenia could mean for each of us. My changing perceptions, which repositioned our being together from strange to extraordinary, were indicative not just of familiarity, but of the growth of intersubjective understanding in a site of mutual production. My only chance to clarify the ambiguous meanings of extraordinary experience was through an intense and extraordinary engagement with participants themselves.

Both the disciplines of psychiatry and anthropology have the potential to view people diagnosed with schizophrenia as so radically other and different as to preclude intersubjective understanding. As a corollary, both disciplines have the capacity to treat such people as unable to account for themselves in any meaningful way, or as lacking the agency to define their own lives. The research methods outlined in this chapter were conceived to test these propositions, especially by way of facilitating a movement toward common understanding through dialogue and negotiation. A detailed case study of the possibilities and limits of this movement is set out in Chapter 7. The following chapters elaborate on the circumstances, conditions and structures which shaped participants' experiences, as well as my capacity to grasp the meaning of those experiences.

PART II

STRUCTURING THE FIELD

INSTITUTIONS, AGENCY, HABITUS

Chapter 3

SITES OF POWER
PUBLIC INSTITUTIONS AND PRIVATE HOMES

This chapter examines some of the principal social and geographic sites which structured what it was to live with schizophrenia. These structures had their abstract codification in legislation and bureaucratic procedures which determined how psychiatric illness was defined and where it was to be treated. The principal expression of this determination was a new attributed location for psychiatric illness — in 'the community'. For people diagnosed with schizophrenia, this had resulted in a particular setting — the private home — being constituted as the 'appropriate' focus of their lives and experiences. These were also structures which could be seen in practice: they were displayed in public events which coalesced around the concept 'schizophrenia', and thereby defined it in certain ways.

The chapter begins by outlining the international and national frameworks which had, in the years immediately preceding the study, reconstituted public discourses and 'dominant ideologies' (see Baumann 1996) of psychiatric illness by way of legislative reform, national inquiries and government policy. These changes were reflected in treatment practices which had shifted the locus of mental illness from the old segregated asylums to the general hospital through a process of 'mainstreaming' and integration — a programme which, in South Australia, was termed 'realignment'. This process had been underway for some decades, but had achieved a new momentum with the release, in 1992, of a *National Mental Health Policy* (Australian Health Ministers 1992) and, locally, with the closure of a dedicated psychiatric hospital in 1993. The chapter then continues with an analysis of those individual houses to which mental illness had been shifted again through deinstitutionalization.

The institutions I highlight in the first part of the chapter are those which had a major role in designing, delivering or commenting upon mental health services. These included the parliaments (at both state and Commonwealth level) which had provided the legislative frameworks; the public health administration which had re-shaped service delivery; the professional staff who were re-organized into mobile treatment teams and deployed from decentralized offices in the suburbs; the Churches which had added their support to the framing of mental health as a social justice issue; and the non-government organizations that advocated for changes in funding, servicing and public perceptions. This constellation of organizations and forces was also the source of public discourses — forms of knowledge, media images, addresses delivered to gathered audiences — which sought to represent what it was like to live with a diagnosis of schizophrenia in this city at this particular time.

During the course of the research there were a number of events held in a range of settings, to be described in this chapter, which were organized around schizophrenia. These, in turn, endowed schizophrenia with particular meanings and shaped how it was understood. I am concerned here with the institutions which were on display in such events. These, I argue, constituted the institutional framework for a local 'field' of schizophrenia. I define this field, following Bourdieu, as a configuration of relations in which agents and institutions were determined by their mutual location within structures of power (Bourdieu & Wacquant 1992: 97). I analyze a particular event — the 'Vigil for Justice' held during Schizophrenia Week, 1994 — as an expression and a practical formation of the new field of schizophrenia which had emerged from institutional realignment.

In this setting of sweeping institutional changes, a struggle for power was manifested as a contest to control the definition of schizophrenia, its 'natural' location (in bodies, institutions and homes), and its appropriate treatment. Barrett (1996) has shown how the competition between professions over how to define and treat a ‘case’ of schizophrenia was integral to clinical work in the psychiatric hospital. Here I suggest that such competition was a feature of the wider field within which the hospital itself operated: what it meant to have schizophrenia was defined not only by the psychiatric team, but was reinforced, amended or contested by the state, by the churches, by ‘carer’ organizations, and even by those people who attracted it as a diagnosis.

THE LOCAL ‘FIELD’ OF SCHIZOPHRENIA

DEFINING THE FIELD

I employ Bourdieu’s concept of ‘field’ to characterize the complex configuration of knowledge, institutions, interests and representations which confronted me when I sought to grasp what ‘schizophrenia’ was in this setting. It provides a way of bringing into view the multiple sites which organized (and were organized around) the concept of schizophrenia.

A ‘field’ is defined by Bourdieu as,

> … a network, or a configuration, of objective relations between positions. These positions are objectively defined, in their existence and in the determinations they impose upon their occupants, agents and institutions, by their present and potential situation (*situs*) in the structure of the distribution of species of power … as well as by their objective relation to other positions (domination, subordination, homology, etc.). (Bourdieu & Wacquant 1992: 97)

A field is relational and contextual, shaped by those elements of power and capital (including symbolic capital) which are effective within it as a ‘quantum of social force’ (ibid: 230). It is manifested as a ‘struggle’ between individuals and concrete institutions (ibid), each of which are defined in terms of their relations to the field as a whole (and not as pre-constituted social units). The analytic task is to account for the form and legitimacy of power within a field, the conditions under which their contestation is effective, and the consequences of that contest for social differentiation (in the form of distinctive social categories and groupings). A field also entails a specific *habitus*, the structuring mechanism which operates from within agents by way of practices which are themselves structured by the field.[1] This *habitus* — comprising dispositions, actions, bodily states, schemata of perception and 'socialized subjectivities' (ibid: 126-8) — is deemed to reproduce a field by way of homologies and analogies with the system of categories which already pertain there (Dreyfus & Rabinow 1993: 38).

In this and the following chapter I establish the pivotal role of identity and experience in mediating participants' responses to the field in which they operated. Because these introduce specific issues in relation to the conceptualization of the field in Bourdieu's terms, consideration of the interrelationship between *habitus* and the field of schizophrenia is deferred until Chapter 5, and returned to again in the Conclusion.

The concept of a 'field' directs attention to the play of forces *between* institutions and settings. This interstitial focus reflects my own location within the study (see Chapter 2), just as it is an apt rendering of how participants lived their lives in the interstices between institutions — that is, between hospital and home. Bourdieu expressly employs the concept of field to 'break with … substantialist modes of thinking' (Bourdieu & Wacquant 1992: 229) which would seek, for example, a dominant class in an 'actual population of holders of this tangible reality which we call power' (ibid) or the 'realist' location of power and where it comes from. While schizophrenia would seem to be substantiated as an illness by over a century of psychiatric theorizing and treatment, the concept of 'field' allows me to avoid presupposing what it was — that is, of applying either a psychiatric or a sociological reduction of it to (among the many possibilities) a neurological malfunction in the brain or an epiphenomena of distorted family relationships. Rather, I was interested in how various agents constituted and contested it in practice.

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[1] Cf. Bourdieu and Wacquant (1992: 127): 'the field structures the habitus, which is the product of the embodiment of the immanent necessity of a field'.

Moreover, the field of schizophrenia was not synonymous with those institutions which were professionally and bureaucratically responsible for treating schizophrenia as a psychiatric illness, although it included them. All participants had personal maps of the health care system in which they were enmeshed, but these maps did not necessarily correspond with organizational charts of how state mental health services were structured. Hospital and health bureaucracies were not the only sites at or through which schizophrenia was constituted. Likewise, the fluid and relational properties of a 'field' as proposed by Bourdieu allows me to avoid any simplistic juxtaposition of 'psychiatrist' and 'patient' as pre-constructed (and therefore 'given') positions of dominance and subordination within the mental health system.

The 'social space' of a field is abstract and metaphorical: 'social space is to the practical space of everyday life … what geometrical space is to the "travelling space" of ordinary experience, with its gaps and discontinuities' (Bourdieu 1984: 169). It is a topology, 'constructed on the basis of principles of differentiation or distribution constituted by the set of properties active within the social universe in question' (Bourdieu 1985: 724). Insofar as these significant properties are differentially distributed then social space is also a 'field of forces' (ibid). The differentiation of this social field is fundamentally a product, as well as an expression of, the categories through which it is perceived — those significant properties which are at stake in any practical struggle for power:

> …this work of categorization … is performed incessantly, at every moment of ordinary existence, in the struggles in which agents clash over *the meaning of the social world and their position within it, the meaning of their social identity*, through all the forms of benediction or malediction, eulogy, praise, congratulations, compliments, or insults, reproaches, criticisms, accusations, slanders, etc. It is no accident that the verb *kategoresthai*, which gives us our "categories" and "categoremes," means to accuse publicly. (Bourdieu 1985: 729, emphasis added)

Thus, to struggle and to classify are integrally related as a fundamental social dynamic. Moreover, just as categories are contested, so they form the basis for significant symbolic distinctions ("natural' distinctions" for which legitimacy is claimed): 'The social space, and the differences which "spontaneously" emerge within it, tends to function symbolically as *a space of life-styles* or … of groups characterized by different life-styles' (ibid: 730, original emphasis).

Contested classifications and differentiation on the basis of lifestyle were strikingly apparent in working with people with schizophrenia. Most participants were eager to debate the consequences of diagnosis for their material circumstances, their capacity for work, for socialization, and their general well-being. Oscar, for example, attributed his poor physical health to a "coffee and cigarette lifestyle". He had also purposefully chosen a "stress-free lifestyle" of inactivity: "I've rested and rested and rested [in order to] ease the factors that are associated with schizophrenia". Brian observed that life on Social Security in itself made him "insecure": "They threaten you with an unstable lifestyle if they were to withdraw financial support — it's an insecurity that's not conducive to getting better if you have a mental illness". Shaun scoffed at the community nurse who suggested that he get a kettle and a working refrigerator; he was angry that so many people had the capacity to dictate a "proper lifestyle", or felt able (even duty bound) to comment on how he should live.

The most ubiquitous source of contention throughout the research was not over the category of 'schizophrenia' as such. This existed objectively in psychiatric diagnosis and was made manifest in all of the practical consequences (hospitalizations, regular medication use, unemployment) which flowed from that. Its force was apparent to most participants, evidenced by the high compliance rate in taking medications which we found amongst them. Rather, they contested what the category of schizophrenia meant and what contents it should rightfully encompass. Illness, brain malfunction, trauma, spirituality, heightened perception and existential dread were just some of the 'properties' of schizophrenia which they canvassed. Participants debated the legitimacy of these meanings and what consequences each of them had for their own identities and lifestyle. Participants sought to contest the priority of meanings attributed to schizophrenia by psychiatry, suggesting others which they saw as more pertinent to their phenomenological and social experience. They did not reject categorization as such, but insisted that such categories should reflect their perceptions of what was significant in their own lives. It was *their* knowledge and *their* categories of experience which participants sought to have recognized — that is, to achieve legitimacy as 'common sense' and as 'natural distinctions' of the social field (Bourdieu ibid: 730), the 'normalizing function of common sense' being what is at stake in mental disorder (Mishara 1994: 134-5).

RECONSTITUTING MENTAL ILLNESS: INSTITUTIONAL 'REALIGNMENT' AND THE EMERGENCE OF A NEW FIELD

The struggle over classifications and lifestyles was heightened during the period of research because it coincided with significant institutional change and legislative reform. These were conscious and managed attempts on the part of governments, professional bodies, carers and 'consumers' to create new structures for the delivery of mental health services. The pervasive rationale of these changes was to effect new ways of viewing mental illness, making it public and accessible by way of altered perceptions and physical locations. These changes highlighted schizophrenia as a field of institutional innovation and contestation.

The research was conducted in the wake of an exhaustive national inquiry into the social, legal, medical and institutional frameworks of Australia's mental health system (Australia. Human Rights and Equal Opportunity Commission 1993).[2] The scope of that inquiry had brought the mental health system throughout Australia under unprecedented scrutiny. Its advocacy of sweeping reforms had, via television and print media coverage, made mental health a topic of public debate. It had also recast the terms in which that debate took place.

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[2] Conducted between 1990 and 1993, the Inquiry was chaired by the Federal Commissioner for Human Rights, Mr Brian Burdekin. The resulting two volume report (popularly known as the 'Burdekin Report') canvassed a full range of issues relating to the provision of mental health services, but was most notable for its focus on discrimination in the areas of housing, employment, education and training, and on the needs of vulnerable and disadvantaged groups. Its many recommendations followed from this emphasis on human rights and community responsibilities.

In the immediate post-Burdekin years, issues of psychiatric illness and its treatment were subsumed by a discourse on respect for the 'human rights' of individuals:

> People with mental illness are human beings with human rights. This simple and fundamental point, which unfortunately still needs to be stressed, has been one of the fundamental tenets of this Inquiry … [The] rights recognised in the various international human rights instruments are required to be respected and ensured to all individuals 'without any discrimination'. It is clear then, as a matter of international law, that individuals with mental illness are entitled without discrimination to the full range of human rights. (Australia. Human Rights and Equal Opportunity Commission 1993: 21)

In this period there was an emerging optimism for using the provisions of international law to improve the social circumstances of the mentally ill.[3]

A national strategy of change and adjustment had been set out in *The National Mental Health Policy* and *Plan*, which was ratified by all Commonwealth, State and Territory governments and launched in May 1992. A central component of the *Plan* was the introduction of additional services to facilitate the transfer of patients to community-based care, involving greater use of crisis intervention, outpatient clinics, mobile treatment teams, domiciliary services, rehabilitation schemes and living skills programs (Australian Health Ministers' Conference 1992: 22). 'Mainstreaming' was a cornerstone of the *Policy*; mental health services were to be co-located with general health services, leading to the reduction or closure of segregated services such as psychiatric hospitals. This was what deinstitutionalization meant in a practical sense. Across Australia, the number of psychiatric in-patient places had declined from 281 beds per 100,000 in the early 1960s to 40 beds per 100,000 in 1992 — an 86% reduction (Australia. Human Rights and Equal Opportunity Commission 1993: 166).

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[3] McNamara (1996: 33) argues that discrimination against people with mental illness is entrenched in Australian society and that "anti-discrimination laws … are an important preventative and proactive tool in a project of eliminating that discrimination". In Australia, such laws were premised on an international formulation of human rights derived from United Nations conventions such as the International Covenant on Civil and Political Rights (1966, to which Australia became a Party in 1980), the Declaration on the Rights of Disabled Persons (1975), and the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991, not formally incorporated in Australian legislation, but endorsed by the National Mental Health Policy of 1992).

Media images were widely employed as part of this national strategy to diminish the mystery and stigma of mental illness and bring it out into the open. Television commercials produced in conjunction with the *National Mental Health Plan* depicted 'ordinary' Australians seeking to perform various roles (salesperson, clerk, baker, musician) when a question of their mental health was raised by a potential employer; after a freeze-frame shot each commercial ended with the person's successful incorporation into the setting or workplace. The same 'successful' images were used in posters and on city billboards. The ostensible message of this campaign was that people with a mental illness were already participating in a range of everyday activities 'in the community', were indistinguishable from the general population, and to this extent were deserving of tolerance and acceptance, as was their right. This implied a redefinition of the person as depicted in public discourses. An asylum patient had typically been denied rights, autonomy and self-determination — a curtailment of the self which Goffman (1961: 43ff) glossed as 'mortification'. In this new era dominated by media images, the mentally ill person was an autonomous individual (all characters in the advertising campaign bore a Christian name) who, most importantly, demonstrated their agency by successfully winning a job or pursuing some other activity of their choice. The apparent dismantling of centralized administrative structures and the movement of treatment resources into the community was thus accompanied by images of the new type of person who was able to take advantage of those changes.

At the state level this was also a period of accelerated change to the bureaucratic structure and scope of mental health services. In South Australia this process was termed 'realignment', the term itself conveying an image of how psychiatric illness was to be re-positioned in and between a range of institutions. It signalled the 'weaving' of the South Australian Mental Health Service (SAMHS) into the 'fabric' of the general health system by way of establishing formal links between general hospitals, universities, support services, non-government agencies and local councils (South Australia. Realignment Project Team 1995). The philosophy behind these changes reflected broader re-definitions of what was entailed by mental health care, including the identification of the type of person who was to be its recipient:

> In addition to international and national initiatives, the South Australian State Government's Social Justice Strategy provides a further framework for reform of public services with an emphasis on access and equity, rights and consumer participation as well as improved outcomes for consumers. (SAMHS 1993: 3)

The first principle of the State's realignment programme was to treat 'consumers as citizens' (South Australia. Realignment Project Team 1995: 8). According to the policy document, consumers were accorded rights to equity, access and advocacy, entailing the mental health service in reciprocal responsibilities for responsiveness, integration, inclusion (of consumer representatives in decision-making, for example), and accountability (ibid).

The changes initiated by these policy developments caused considerable ferment and uncertainty, especially about such issues as the 'continuity of care' afforded patients, as well as the provisioning and resourcing of services. It was a recurring feature of the research that mental health workers would voice their disenchantment with 'the system' every time we visited an out-patient clinic or a treatment team; in private homes we would be confronted by concerns on the part of both participants and their relatives about the future shape and availability of services. Increasingly throughout 1995 and 1996 there was widespread media coverage of bed shortages in the state's only public psychiatric hospital, televised protests by the parents of patients who could not find stable accommodation in the public system, and industrial action by mental health nurses — see Figure 3.1. Conditions in the state's mental health service were debated frequently in Parliament throughout those years.

Those who used mental health services were also increasingly critical of the changes which were taking place during these years. As individuals with rights which had been championed by the Burdekin Inquiry, consumers and their supporters had an increasing number of forums and outlets to air their views. In an 'audit' report on the state's mental

Mental patients sent to hotel

By Political Reporter
LEANNE WEIR

Mental health patients are regularly sent to a Hindley St hotel, it has been revealed.

The Health Minister, Dr Armitage, made the admission after documents from Glenside Hospital were shown to Parliament yesterday.

"crisis" patient,
sent to the
was nowhere to
in emergency accommo-

a mental illness who can live in society. This is not a mental health crisis, this is an accommodation crisis. The situation is tight, but there are acute beds available all the time."

However, he said mental health teams regularly sent patients to the Plaza Hotel because of the limited restrictions and services supplied by the hotel.

Plaza Hotel staff refused to comment on the matter.

A member of the nursing staff at Glenside Hospital said: "We are sending a lot of people to highly inappropriate places in the

'Dangerous' $5m mental health cut predicted

By Political Reporter
LEANNE WEIR

A further $5 million
be slashed from the
mental health system
year, despite claims
already in crisis, the Opposition's health spokeswoman, Ms Lea Stevens, said yesterday.

Ms Stevens said she
ceived information fr
Health Commission
would need to cut the $5 million from its 1996-97 budget.

The cuts would further en-

Patient 'told to sleep under trees'

By Medical Writer
BARRY HAILSTONE

A mental patient was allegedly given a pillow and blanket and told to sleep under trees at

clined in the past few months, and a crisis point has been reached.

Some of the letters received by *The Advertiser* are from senior employees, who say they fear speaking out publicly because of disciplinary action

- Fears of upsurge in violent incidents and suicides
- Facilities 'inadequate' for thousands of patients

Mental health crisis

SPECIAL REPORT

Figure 3.1. LOCAL NEWSPAPER HEADLINES (*ADVERTISER*, 1995-96)

health system from 1991 to 1995 — the period of most rapid change in which one of two dedicated psychiatric hospitals was closed and services were 'realigned' — a group of consumers and welfare workers expressed considerable dissatisfaction with the changes, especially the provision of services and support:

> There is a need to shift the emphasis of the majority of resources into direct contact with consumers. Staffing structures need to include a large number of care workers who provide one-to-one intensive support to people whose level of functioning in the community is most impaired. There is no doubt the people need psychiatrists, social workers and therapists however, these people only have minimal and sometimes only transient contact with consumers.
>
> The push to move much of the responsibility on to the non-government sector for helping people to rebuild their lives in the community is disturbing. There is no doubt that there is a strong case for a non-government sector role to add diversity and choice in the system for people with a mental illness. However, the potential for the mental health services to abrogate their role in linking people to community services and other community supports is enormous. (Marion-Brighton-Glenelg Health and Social Welfare Council and Disability Action Inc. 1995: 16)

Following what it identified as a period of 'disruption, uncertainty, promises and frustration' (ibid: 2), the report itself served as a vehicle by which people with a psychiatric illness could realize their right to voice concerns in a public way. It was also a means by which people with a psychiatric illness claimed ownership of 'public' services and facilities on the basis of being equal members of a single civic 'community': 'Services for people who have a mental illness are owned by and are accountable to the whole South Australian community' (ibid: 17). These were services which all citizens were entitled equally to consume. Moreover, such consumers were individuals, who should be treated 'one-to-one' and 'served where they lived' (ibid: 7).

BEING IN 'THE COMMUNITY'

'Community' is a term which dominated the *National Mental Health Policy* (Australian Health Ministers 1992). It can be found on virtually every page of the document, yet nowhere is it defined. From the context of its use the following meanings can be deduced:

- The existence of an 'Australian community' is assumed; in this usage 'community' implies the populace of the nation as a whole, a geopolitical abstraction.

- 'Community' is a non-specific location for the conduct of 'care' and 'participation'. In noting the movement away from segregated and custodial systems of psychiatric treatment the Ministers stated: 'This shift in the pattern of care has meant that most people with mental disorders are able to be cared for in the community and continue to participate in the life of the community' (ibid: 7). In the new 'realigned' system a major 'avenue' for this participation is involvement in decision-making about the development of psychiatric services and about the individual's own treatment (ibid: 13).
- 'Community' is a (non-localized) setting for the exercise of (unspecified) civil, political, economic, social and culture rights (ibid: 12) — that is, the background conditions for involvement in the State's political life.
- More specifically, to be 'in the community' is to partake of the 'mainstream health system' (ibid: 18) — that is, the structure of facilities and services which the State provides to all members of a civic society. This 'community' is thus a 'marketplace' of health care services, made up of the 'consumers' and suppliers of these services.
- In addition, 'community' is a set of 'linkages' to other services and facilities provided by the State: housing, accommodation support, income security, employment and training opportunities (ibid: 19). Again, this is a reflection, writ large, of the State's own bureaucratic structures for the provision of welfare services.

Overwhelmingly, this 'community' was a non-specific, non-localized reflection of the (abstract) State; more concretely, it was this political entity substantiated through the institutions and services of a bureaucracy. The concept also marked a distance from certain types of formal organization, such as the 'segregated' and 'custodial' psychiatric hospital of former times. In this it was simply defined negatively — a type of non-place (cf. Augé 1995) in which consumption and civic participation is presumed to take place. In this context, then, 'community' was a ubiquitous but 'empty' category.[4]

Other parts of the field generated other meanings for the term 'community'. Certain types of 'non-government organizations' — another negative designation — saw themselves as embodying 'the community' and were identified as such by the state (ibid: 26). In the

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[4] Boyer (1986) identifies 'empty categories' as elements of discourse which pervade disparate domains, but which often cannot be grasped or defined by speakers themselves; they are 'opaque' and 'unexplicated' because there is no overt discourse about them. Typically they are religious concepts such as *mana* (ibid) or, more accurately, the Fang notion of *evur* (Boyer 1988). Quintessentially they are about ineffable power. In a secular field like health care, the concept of 'community' had accrued considerable power: it was used to reconfigure complex institutions and services and provided a moral rationale to support those changes.

context of realignment, 'community' meant organizations such as Clubhouse[5] and the Schizophrenia Fellowship, which were now construed as 'partners' in health-care delivery. Although they were subsidized by the government[6], such organizations maintained an aura of independence and were free of direct bureaucratic scrutiny or control. They were managed by elected boards whose personnel were deemed to be representative of 'the community' at large, but who were predominantly health care professionals, academics, church representatives and industry leaders. They were located in buildings which were physically remote from hospitals and from the centralized office which housed the state health administration (the 'Health Commission'). In the case of Clubhouse, the main centre of activity was a deconsecrated suburban church where people with schizophrenia (who, in this context, were designated 'clients' of the health care system) learnt and practised the 'living skills' which would render them indistinguishable from their neighbours.

By facilitating education and support for parents and relatives of the mentally ill, the Schizophrenia Fellowship imbued the concept of 'community' with another set of meanings with were social rather than spatial: 'community' meant a set of intimate relationships, especially those which were presumed to exist within the family. From this perspective, to be in 'the community' was to be encompassed by kinship and its attendant obligations of 'care' and 'support'; this also intimated broader constructions of 'community' as a set of norms and values signifying mutuality, co-operation and identification (Gilroy 1987: 234), as well as interpersonal warmth, shared interests and loyalty (Baumann 1996: 15). This representation was, however, contentious in itself. Both participants and their families attested to the many ways in which core aspects of kinship — reciprocity, dependence and independence, attachment and distinctiveness,

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[5] Like the north American organisations on which it was modelled, Clubhouse SA Inc. offered a site-specific rehabilitation programme based on a structured day, the taking of responsibility for running a self-help centre, and return to mainstream employment for people with psychiatric disabilities.

[6] For example, according to its *Annual Report* for the 1996-97 financial year, the Schizophrenia Fellowship of South Australia Inc. derived 59% of its income from state and local government grants.

inclusion and separation (cf. Medick & Sabean 1984) — were rendered problematic by schizophrenia. Many parents pointed to ways in which what Goody (1958) has described as the developmental cycle of domestic groups — the creation of indebtedness, the fulfilment of obligation, and the establishment of autonomy — was confounded by a child who nominally fails to grow up, establish independent relationships, or replicate the parental family by establishing a self-supporting domestic unit of his or her own. Many of these parents suggested that reciprocity for the emotional and material investments of parenting had not been forthcoming, or not in the manner that they might have hoped for prior to the diagnosis of schizophrenia for their child. As I have indicated elsewhere (see Chapter 2), there could be considerable contestation between people with schizophrenia and their relatives as to the nature of their relationships and obligations, rendering this attribution of 'community' especially problematic from many participants' point of view.

For many people diagnosed with schizophrenia, including the majority of our participants, being in the 'community' meant living in their own home, whether this was a house or a flat (apartment), or accommodation which was shared with a spouse, parents or friends. In this usage the term was both specific and localized. It referred to particular inhabited places as the locus of participants' experience in both ordinary and extraordinary modes. 'Community' in this sense had its grounding in the phenomenological 'emplacement' and embodiment of 'local knowledge' identified by Casey:

> Local knowledge is at one with lived experience if it is indeed true that this knowledge is of the localities in which the knowing subject lives. To live is to live locally, and to know is first of all to know the places one is in. (Casey 1996: 18)

Again this meaning was predicated on a distance: a private home, whether rented or owned, decreased the extent to which participants' activities were made available to psychiatric professions, or could be scrutinized by the health care system.

The 'audit' statement that consumers were both members of a wider civic society as well as individuals who could attract services to their own homes highlighted an unresolved tension between two constructions of 'community': one which reflected the structure of services; the other referring to a specific emplacement. Consumers were both members of a wider, impersonal, non-localized, non-spacialized 'community', and they possessed the right to be met with and dealt with individually at home. This disjuncture of referent occurred throughout the field.[7] That it was unreflected upon is suggested by the lack of comment on it in the 'audit' report which raised it most explicitly. As a result, the two referents tended to collapse into each other. Being in 'the community' often meant being in one's own separate house, without services, support or intimate social relationships. The principles of visibility and participation which were championed in the *National Mental Health Policy* were rarely met outside of the health care system itself. Contrary to the advertised images of acceptance which accompanied the *Policy*, one young female participant noted:

> "I try and get a job by being honest and saying I have schizophrenia. It's just the looks people give you, like you're going to kill them. Mental health doesn't have a very good reputation."

She had given up attempts to find work and only left her house on a weekly shopping trip.

From the perspective of participants in this study, therefore, 'community' could be restricted to their own home and the people who they could attract to it. It was in this setting that a fundamental tension between social categories — civic and private, institution and agent, citizen and private individual — was most apparent. It was a tension generated by the field itself.

PUBLIC EVENTS: THE FIELD DISPLAYED

During the period of research there were a range of public activities which coalesced around the category 'schizophrenia'. The most prominent of these was Schizophrenia Awareness Week which in Australia occurs annually in late May. It is coordinated at the

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[7] For example, the civic referent reproduced formulations which occur in the *National Mental Health Policy*.

state level by the Schizophrenia Fellowship and nationally by the umbrella carer organization, Schizophrenia Australia. It involves a week-long programme of activities, seminars, workshops, displays, film screenings and media publicity. The aim of the Week is to raise public awareness by way of education and the presentation of 'positive' images of 'living with schizophrenia'.

We attended seminars held during Schizophrenia Awareness Week as both observers and participants. The research team was requested to present material to mixed audiences of parents, patients (including some of our participants), mental health workers and members of the 'interested' general public. Such forums provided access to practical medical definitions of schizophrenia as research scientists addressed developments in neurological theory, or pharmaceutical companies hosted updates on the latest medications. They also provided an audience for the concerns of carers during a period of hospital closures and diminishing public resources, for the opinions of nurses and other workers in the hospital system, and for the views of those people with schizophrenia who had assumed public roles as advocates or activists for the rights of the mentally ill.

The juxtaposition of different forms of knowledge about schizophrenia was made apparent at one of these seminars when we shared a 'session' with a leading neurophysiologist. The latter presented her most recent research findings by way of elegant (although simplified) coloured images of neural transmission; her subjects were "schizophrenic brains". In the manner which we had developed for such occasions, each of us spoke separately: Rob Barrett outlining the project and Megan and I talking about areas of interest to us at the time. Our presentations included a lot of verbatim statements from various participants. (Two of those participants were in the audience, and we recruited a few more during informal discussions afterwards.) It would have been hard to design two more different presentations than these, given the disparities of our methodologies, our aims and the very different accounts of schizophrenia which were the result. Through such seminars I became aware of the range of paradigms and explanatory models which were available throughout the field; indeed, in this circumstance I was entailed in their production. Such juxtapositions were not unusual. On another occasion — a breakfast meeting for psychiatrists and general practitioners — we witnessed presentations by a flamboyant American 'carer'[8], a pharmaceutical company representative, and a clinician from the state psychiatric hospital who reported on a local Clozaril [Clozapine] trial which, he suggested, challenged the prevailing 'dopamine hypothesis' of schizophrenia.

In 1994, Schizophrenia Awareness Week included a 'Vigil for Justice' which started on the steps of Parliament House, followed by a march to a city cathedral and an ecumenical service. It was held to mark the end of Schizophrenia Awareness Week and, since it appropriated key sites in the city's centre, was the most public event of that year's programme. Megan and I walked the short distance from the hospital to the Parliament building, passing the university on our way. This triangulation of Hospital/University, Parliament and Church (see Figure 3.2) encompassed three of the most powerful institutions with the capacity to define how mental illness is understood and treated.

Having recently begun the research, this 'Vigil' seemed the ideal opportunity to witness an enactment and display of peoples' concerns about mental health. As happens in such circumstances, we became caught up in the rhetoric and emotions of the event and our presence became aligned with the group's purpose. A crowd approaching 100 people had gathered on the steps of Parliament in an air of excitement. There were prominent office bearers of the Schizophrenia Fellowship, people with schizophrenia, families, a number of doctors and academics who we recognized, and a television news crew. A small van pulled up to deliver ready-made banners and placards. Megan was fortuitously handed a

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[8] Being the mother of a son with schizophrenia had, she said, 're-focused' her professional interests and she had recently completed 100 interviews with relatives of the mentally ill, from which she read selected verbatim quotes. Her association with the National Alliance for the Mentally Ill (NAMI) was emphasized; it is not surprising therefore that 'Don't blame the family' was the explicit message for this audience of GPs and psychiatrists — see McLean (1990).

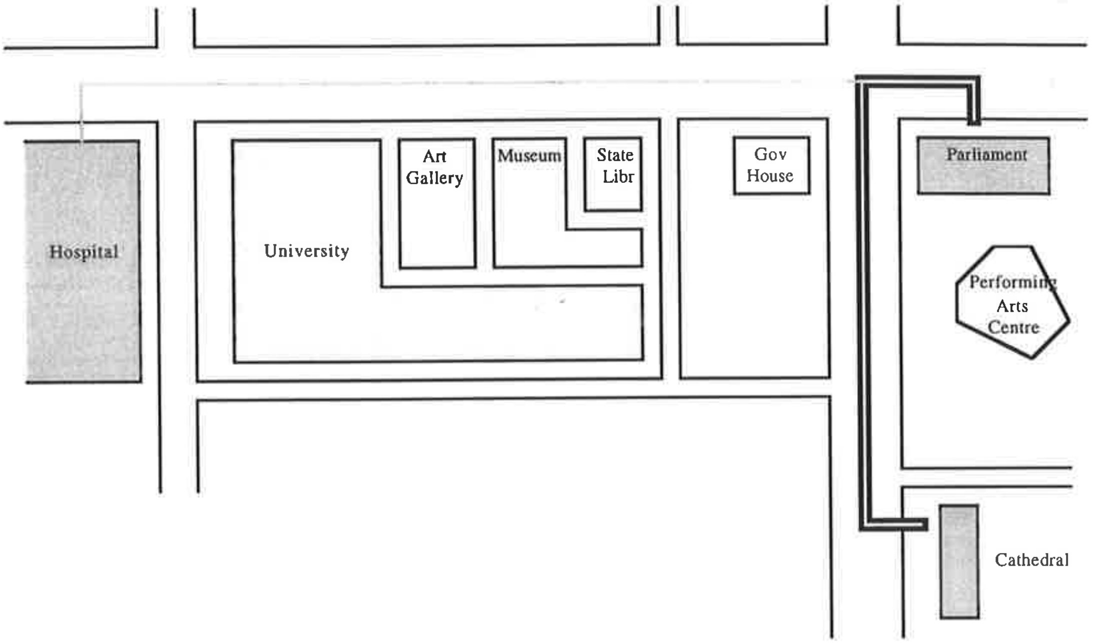

Figure 3.2. 'VIGIL' ROUTES

placard that read 'More Funding for Research' which she proceeded to carry aloft until reaching the cathedral. Other prominent messages included 'Hospitals Not Prisons', 'Remove the Stigma', and the somewhat ambiguous 'No Respite For Carers'. As dusk fell, florescent green chemical lights (in lieu of candles) were handed out, inducing an atmosphere more of reverence and solemnity than political protest. The Executive Director of the Fellowship addressed the gathering, followed by the city's Anglican Archbishop, gowned in purple. There were calls for more funding, better facilities, and greater recognition of people's human rights. The subsequent procession disrupted evening traffic on one of the city's main thoroughfares, with the flashing lights of a police escort augmenting the flickering chemical lights and hand-held torches. Several hundred more people came to the cathedral, ushered in by a 70-strong choir. The service included hymns, blessings, speeches, poetry recitations, and readings from Anne Deveson's book

Tell Me I'm Here.[9] Individuals, both lay and cleric, went forward to the raised podium to read prayers. These were printed in the program, and canvassed the gathering's concerns. They included a Prayer for Justice — 'We pray that today signifies the new beginning of the season of compassion and understanding, of the new time of tolerance and justice.' — a Prayer for Families and Friends Affected by Schizophrenia; a Prayer for People of All Races and Creeds Affected by Schizophrenia; a Prayer for those Missing, Homeless or Imprisoned through Schizophrenia; a Prayer for Improved Conditions and Removal of Stigma; a Prayer for Those Who Love and Care for Sufferers; a Prayer for Professionals Working with Sufferers; a Prayer for All Our Benefactors; and The Serenity Prayer. A woman identified as 'suffering' from schizophrenia spoke briefly and tearfully of friends who had suicided.

The cathedral architecture, its dimly illuminated stained-glass windows, a huge sculptured scene of crucifixion suspended high above the altar, the voices of the choir, and the emotive readings combined to create a powerful image of sadness and loss. Tragedy, suffering, and the rupture of human relationships were the abiding referents of schizophrenia in this context. There was a sharp contrast between the initial vociferous public assembly on the steps of Parliament and the more sombre, reflective and contemplative church service. Personal and emotional impacts were highlighted by having 'carers' and people with schizophrenia give short testimonies or conduct readings. The involvement of the church added moral weight to a post-Burdekin political agenda focused on human rights and social justice for people living with a mental illness. The Burdekin Report was mentioned first on the steps of Parliament and twice during the church service.

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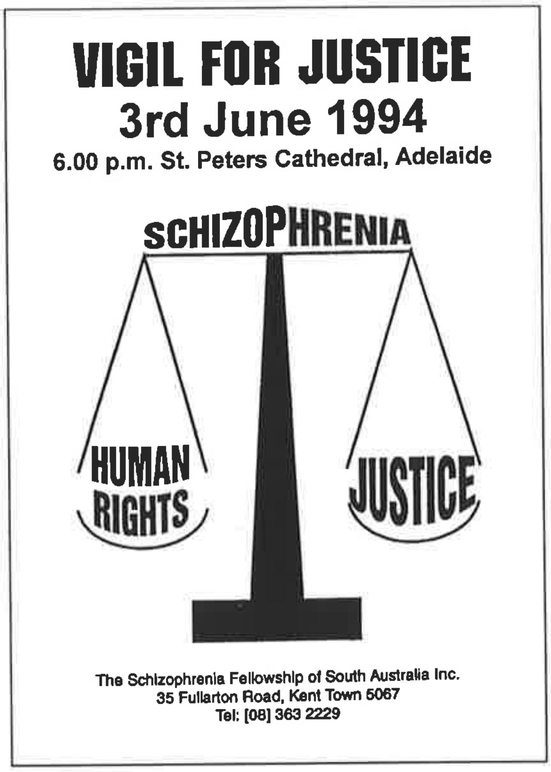
[9] This was the most well known of Australian texts recounting the experiences of a 'carer' — a mother whose son had suicided. The chosen passage contained some dramatic and painful images:

> We are the parents of the throwaway schizophrenics, the disposables, the ones who are the most difficult to treat; who are often, as a result of their disability, unable to ask for or accept help … Left without treatment they continue to suffer. Relatives must stand by and watch, unable to alleviate the suffering which in the main is ignored by the mental health care system until it is sometimes too late … We are the people who mop up the blood of our sons and daughters when they have killed themselves, released from hospital all too soon, or not considered sick enough to be hospitalised … We are left helpless and hopeless, alone in our struggle to save the lives of our children. (Deveson 1991: 244)

Advertising for the occasion intimated the 'Scales of Justice' (see Figure 3.3). The whole event was poignantly evocative of the emotional, moral, personal and institutional structures of the field which I had only just entered. Their resonances were to recur throughout the following two years.



VIGIL FOR JUSTICE

3rd June 1994

6.00 p.m. St. Peters Cathedral, Adelaide

The Schizophrenia Fellowship of South Australia Inc.
35 Fullarton Road, Kent Town 5067
Tel: [08] 363 2229

Figure 3.3. 'VIGIL FOR JUSTICE' FLYER

Throughout the period of research we attended a variety of these public events, including a solo art exhibition by one of our participants held in a 'Community Arts' facility. Another group exhibition (entitled 'Soul*sharing*') sought to highlight a distinctive aesthetic said to arise directly from mental illness. Exhibitors in this show were invited to annotate their works with an illness label ('schizophrenia', 'depression' and 'bi-polar illness' were the most common), as if these experiences were themselves being displayed on the gallery walls. We made another presentation at the inaugural annual general meeting of the newly incorporated Clubhouse organization[10] and participated in the making of a film for the Schizophrenia Fellowship which was screened on a community television channel during Schizophrenia Awareness Week in 1996. Both of these latter forums were focused on 'living in the community', which meant giving emphasis to the skills and strategies required for living outside of hospital in what was called a 'deinstitutionalized setting'. The 'qualitative' nature of our research project had attracted a certain amount of interest and a local reputation. We were called upon regularly because our work was seen by organizations such as Clubhouse and the Fellowship to provide direct access to consumers' viewpoints, which was itself a newly enhanced element in the structure of mental health services. We were increasingly co-opted by this structure to present views on 'the community' and to channel 'consumer' voices to various parts of it. In some way this was a ventriloquist's act, because it demanded that one part of the field — a small research team located in the university and the hospital — was attributed both the right and the capacity to speak for consumers themselves, often to other consumers. This contradicted the emerging image of people with schizophrenia as agents in their own right, with the capacity to speak for themselves. The way in which these activities focused on the need for people with schizophrenia to develop the requisite 'skills' for living outside of hospital also emphasized the extent to which they were viewed as somewhat deficient in the strategic management of themselves, their condition, and their social environment. In this way our own participation in various events embodied the contradiction of a field which advocated consultation, representation and the development of agency, but still relied on the expertise and authority which flowed from its traditional centres of power in the hospital and academy.

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[10] A typical constellation of institutional forces was exemplified by the affiliations of the inaugural board of Clubhouse SA Inc., which included a prominent 'carer', a business person, a Director of Social Work in the South Australian Mental Health Service (who was also a council member of a Bible College), a 'consumer' representative, and a nurse; patrons included a university chancellor, a supreme court judge, a Roman Catholic Archbishop, an Anglican Archbishop, a local mayor, an emeritus professor, the chairman of the College of psychiatrists, a journalist, a broadcaster and the Chair of an international company. Subsequently its board was chaired by a former senior health administrator.

All such events contributed to schizophrenia's new-found visibility: the making public of mental illness in a multitude of settings. They also made visible the way in which various interest groups — consumers, carers, health professionals, academics, politicians, the churches — were deployed around the concept of schizophrenia, and how the category 'schizophrenia' itself emerged in the process of that organization.[11] These loosely aligned groups were the various agents whose 'positions' created schizophrenia as a new and specific field (and who were simultaneously created as 'players' by it). This double creation — of a field and the agents who enact it by way of possessing a measure of the 'social force' which is effective within it — means that the field is self-generating in terms of its focus, its personnel and the scope of what it can legitimately encompass. According to Bourdieu (1984: 169), 'the question of this space is raised within the space itself'. To answer the question, 'What is the field?', is only to reveal those various positions which can have a bearing on its operations at any point in time. These 'positions' are both coordinated and perspectival: '... the agents have points of view on this objective space which depend on their position within it and in which their will to transform or conserve it is often expressed' (ibid). A field can therefore also be described as a 'space of positions' (Wacquant in Bourdieu & Wacquant 1992: 262) — that is, of those positions which embody it and provide its 'perpetual motion' (Bourdieu 1981: 307).

Public events such as those which occurred throughout Schizophrenia Week threw these positions into sharp relief and were characterized by a struggle to assert, conserve or transform the categories which had a force in this field. Catalogue notes produced for the 'Soul*sharing*' exhibition made this explicit:

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[11] McLean (1990) analyzes the role of the (American) National Alliance for the Mentally Ill (NAMI) in constructing specific types of knowledge about schizophrenia and in mobilizing political action around that construction, especially the diverting of federal research funding from family studies to biological research. She demonstrates how 'clinical knowledge [of schizophrenia] interpenetrates with the conditions of its production, for example: economic policies ...; cultural attitudes; competing demands of consumer groups; available clinical ideologies; struggles for ideological dominance within psychiatry; ideological content of medical categories; and the responsiveness of the state to particular ideologies' (ibid: 971).

> Via inclusion in the worlds of others the unusual becomes accepted; exclude it and it assumes a shadow of sinister 'otherness' … this exhibition and others by marginalized groups within society may be viewed as sites from which to work towards the … more insightful aim of dispersing power rather than consolidating it, and creating a society which actively embraces the variation within itself. ('Soul*sharing*', Exhibition Catalogue)

It was through such events that various institutions, knowledges and attributions of agency came into view by way of their mutually configured relationships and interests in defining schizophrenia.

This emerging field of schizophrenia was located between, and constituted by, several others.[12] The 'Vigil for Justice', for example, was framed by the field of law at the same time as it transferred an image of 'suffering' between religious and psychiatric fields. What was prominent here, as in many other settings, was the movement and transformation of the 'significant categories' — illness, suffering, creativity — by which schizophrenia was grasped. The 'Soul*sharing*' exhibition, for example, demonstrated how the 'unusual' and extraordinary experiences of psychosis could be extracted from a psychiatric realm and re-presented on an art gallery wall while, concomitantly, the category of 'patient' was interchanged with that of 'artist'. I argue below (see Chapter 4) that these 'unusual' experiences were the principal form of 'symbolic capital' which was tendered by participants in an attempt to have them re-valued, with a view to changing the field itself. Bourdieu states that there is no *a priori* limits to a field, because such boundaries ('dynamic borders') are always what is 'at stake' within the field itself (Bourdieu & Wacquant 1992: 100, 104). His formulation raises only 'recurrent questions' about the limits of the 'universe under investigation, how it is "articulated," to what and to what degree' (ibid: 110).

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[12] Cf. Bourdieu and Wacquant (1992: 127) on the intersection of fields.

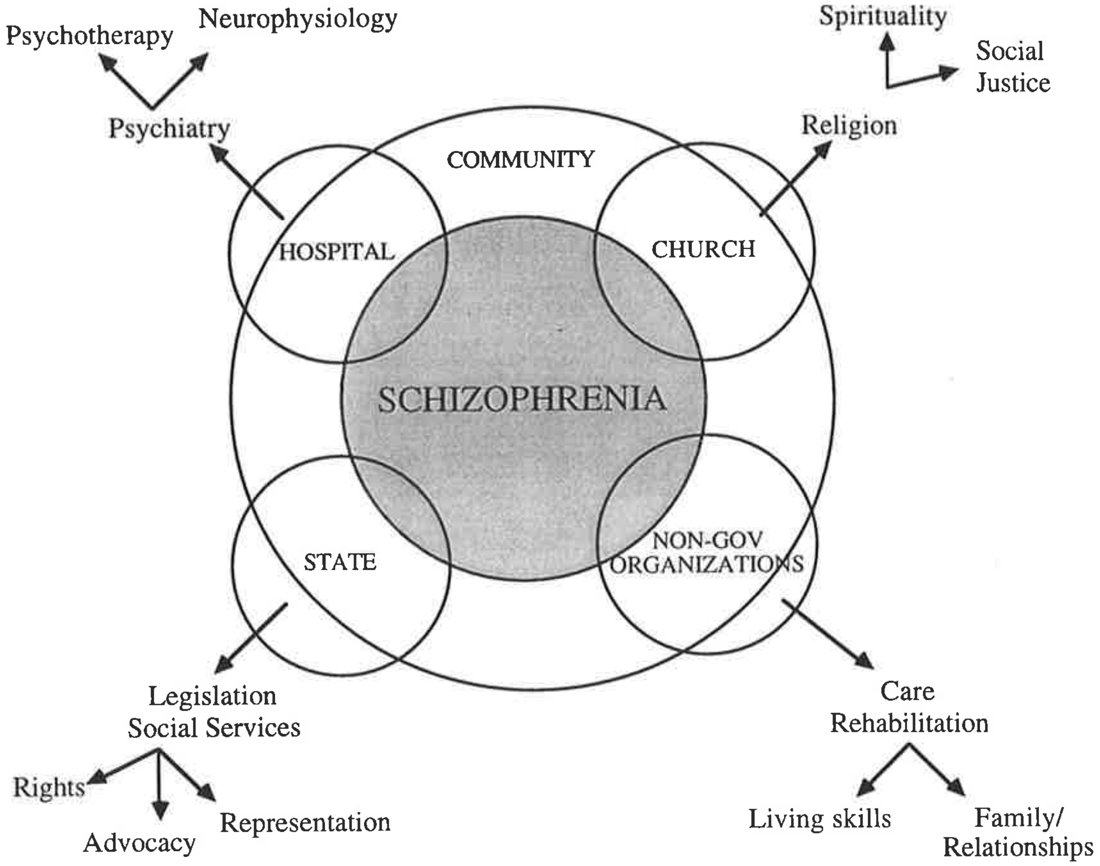

Figure 3.4. THE LOCAL 'FIELD' OF SCHIZOPHRENIA

The local field of schizophrenia is set out schematically in Figure 3.4. It highlights the most prominent institutions which comprised the field and which were articulated by it. As such it is only a sketch of the more obvious sites of power, together with the knowledges on which they were predicated. There were other institutions which could be added: the galleries which rendered psychotic experience into art, for example.[13] Nor were these institutional sites so easily demarcated in practice, as in the case of public

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[13] That this articulation was happening more widely is indicated by the use of a schizophrenic metaphor to describe the work of prominent Australian artist Brett Whitely on the occasion of a major retrospective exhibition at the Art Gallery of New South Wales, Sydney. While not diagnosed with a mental illness, his art was seen by one reviewer to convey the 'duality between pleasure and pain, calm and turbulence, beauty and evil, and a condition of schizophrenic fragmentation which he feared existed in himself' (B. Pearce, 'A Soul Set Free: Brett Whitely Retrospective', *State of the Art*, 14, 1995, p. 46). Also in 1995, the national carer organization, Schizophrenia Australia, launched an exhibition of paintings by 'artists who have experienced a serious mental illness' on the Internet ('Welcome to our virtual Gallery', *Schizophrenia Australia News*, 2, 1995, p. 3).

hospitals which were funded by and, to some extent, regulated by the state and which were also training institutions for various clinical professions. Each of the institutional components depicted could be further elaborated to reveal additional structures, substantive organizations, and sites of discursive power with the capacity to designate and delimit schizophrenia.

Figure 3.4 aims to convey the open and expansive nature of the field as presently constituted. Bourdieu has noted (1984: 169) that such graphic depictions of social space are 'an abstract representation, deliberately constructed, like a map, to give a bird's eye view'; they are, moreover, merely one point of view 'on the whole set of points from which ordinary agents ... see the social world' (ibid). The figure privileges a point of view from public institutions, and to this extent is entirely 'official' and hegemonic in Scott's (1990) terms. In particular, participants' own homes, as centres of resistant power, are absent in this representation. A different perspective on this same field — one which looks out from participants' homes — is examined in the following chapter.

There was no single name for this field, since its character depended on one's perspective or position within it.[14] The most obvious designations were 'psychiatry', 'mental illness', 'schizophrenia', or 'madness'. Participants suggested a number of others including 'affliction', 'disability', 'spirituality', or a combination of these, as in 'spiritual affliction'. I have opted here to use the designation 'schizophrenia' because it was the most ubiquitous, as well as the most contested by (and therefore of greatest interest to) participants. The choice of this designation — itself a diagnostic category — also reflects psychiatry's domination of this configuration. Despite the presence and claims of other institutions, psychiatry was the field's most powerful source of delineation, authority and legitimacy.

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[14] Bourdieu has noted (1985: 730) that, 'the same experience of the social may be uttered in very different expressions'.

Schizophrenia as an emergent field encompassed illness and art, neurophysiology and religion, grief and celebration, bureaucratic design and legislative reform.[15] In this way it created a distinctive configuration of institutions and knowledges which might otherwise have been considered disparate, even incompatible (as between neuroscience and Christian redemption, artistic creativity and parental suffering). The institutions involved (state, church and hospital) were some of the most powerful in our society, and the physical spaces which housed them (Parliament, cathedral, mental hospital) were some of the most prominent architectural features of the city. The forms of knowledge which they represented were amongst the most authoritative, as well as being discourses which are held to be the most penetrating of human existence and subjectivity. When I began this research (like many of the participants when they first experienced schizophrenia) I had only the vaguest knowledge of this field and, like them, I was daunted by its structural complexity, its multiple sites, its confusion of languages, and its disparity of levels (from the most personal expression of distress to the most impersonal of architectures).

AT HOME IN THE FIELD

The closure of dedicated psychiatric hospitals and the decentralization of mental health services meant that people diagnosed with schizophrenia were, of necessity, spending more time in what was designated ‘the community’ (see above). Although it was not specified in government policies such as the *National Mental Health Plan*, this meant, in practice, a greater proportion of time spent in various forms of supported accommodation,

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[15] Foucault has demonstrated that, historically, this same heterogeneous mix attended the development of psychopathology as an ‘object’ of knowledge. From the nineteenth century onwards, ‘medicine … became the major authority in society that delimited, designated, named and established madness as an object; but it was not alone in this: the law and penal law in particular (with the definition of excuse, non-responsibility, extenuating circumstances, and with the application of such notions as the *crime passionel*, heredity, danger to society), the religious authority (… that divided the mystical from the pathological, the spiritual from the corporeal, the supernatural from the abnormal …), [and] literary and art criticism (which … treated the work … more and more as a language that had to be interpreted …)’. (Foucault 1972: 41-2)

boarding houses and private homes. The majority of participants in the present study (43 of 50 individuals — see Appendix 1) lived in the latter, whether they owned these themselves, shared them with a spouse or other family members, or rented them either from the state or on the private property market.

It is in this context that 'home' was configured by the field itself to be the centre of participants' everyday lives and experiences.[16] As a consequence of realignment and deinstitutionalization, home was a specific type of place 'from which to look out on life, to grasp one's position in the order of things, to contemplate events from somewhere in particular' (Basso 1996: 56). Even though hospitalization had been a significant experience for almost all participants (as revealed by their biographical narratives), its definition and tenor was established in counterpoint to what it was to live outside of a hospital setting. Thus, participants contrasted the impersonality and surveillance which accompanied hospitalization with the privacy and lack of supervision which could be achieved in their own homes. For these participants, being 'at home' in 'the community' was to inhabit those places which substantiated those perceptions and possibilities — transforming the inchoate and abstract 'community' of public policy into the concrete and graspable place of individual houses (cf. Fernandez 1986).[17] Being in 'the community' in this way was also to control a particular type of 'free place' (Goffman 1961) or 'offstage space' (Scott 1990): these were social spaces of relative autonomy which facilitated the practical and discursive 'negation' of dominant ideologies concerning schizophrenia (cf. Scott ibid: 118). This is what made houses a site of power for their inhabitants, providing

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[16] I use the term 'home', following Rybczynski (1988: 62), to refer to the irreducible ensemble of material, social and affective meanings which denote house, household, place of attachment and site of repose. See also Jackson (1995: 120ff).

[17] Fernandez (1984) argues that *space* is transformed into *place* by its predication upon persons (so that space is apperceived by them as both differentiated and significant in specific ways), and the projection, in turn, of these qualities on to space. Basso (1996: 55) has expressed this 'dynamic' more prosaically: 'As places animate the ideas and feelings of persons who attend to them, these same ideas and feelings animate the places on which attention has been bestowed, and the movements of this process — inward toward facets of the self, outward toward aspects of the external world, alternately both together — cannot be known in advance'.

a specific resource with which to formulate, discipline and socialize patterns of resistance (ibid: 118-19).

HOUSES IN THE SUBURBS: AN HISTORICALLY GIVEN 'CULTIVATED SPACE'

Adelaide was one the last of the Australian capital cities to be established.[18] Its location and physical layout were the result of comprehensive planning. It reflected utopian and reformist ideals for the creation of a civic space which would remedy the perceived problems (especially 'slum' housing) of the nineteenth century industrial city: 'The basic attributes of city form — streets, spaces, buildings [and] functional areas … — were consciously perceived as having a social relevance and/or organizational meaning in terms of their operational characteristics over and above their time-honoured aesthetic and symbolic factors' (Hutchings 1986a: 3).

The central city was disposed in two grids, north and south of a small river. It included a dominating boulevard along which was arrayed the state's principal civic institutions: from east to west these included the public hospital, university, art gallery, museum, the Governor's residence, Parliament House and the railway station. Beyond an encircling ring of parklands[19] were further grids which, by the mid-nineteenth century, had become known as suburban sections; development over the next century filled and extended this wider grid to produce a continuous ribbon of houses, industrial and commercial properties which stretched 25 kilometres north and south from the city centre. Uniformly throughout this sub-urban spread, house allotments were relatively large, with backyards sufficient to allow people to grow their own vegetables and fruit. Participants' memories of childhood were dominated by recollections of these backyards (together with back lanes and quiet suburban streets) as safe and uninhibited play spaces.

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[18] The city was established as a municipal corporation in August 1840; Melbourne, for example, was incorporated as a town in 1842.

[19] The colony's first 'Lunatic Asylum' was located in these parklands on the very edge of the central city, sequestered in a corner of the Botanical Gardens.

South Australia was the only Australian colony not founded on convict labour. It prided itself 'as a place of opportunity and redress by liberals and nonconformists frustrated in the cramped conditions of nineteenth century Britain' (Bunker 1988: 229). It was settled as a conscious social experiment which aimed at balancing the availability of land, capital and labour, with private property ownership as 'one of the most important measures of respectability and independence' (ibid: 230). Influenced by theories of regional settlement planning, the laying out of new towns in the Americas, and a quest for 'logic and regularity in the creation of urban form' (Hutchings 1986a: 1), the city was quintessentially suburban:

> From the very beginning the pattern of development in the metropolis was one that sought to avoid the excesses of the Old World cities that the reformers attacked. To the freely attracted laborers, artisans and clerks who made up the bulk of the early settlers, the idea of each family having its own small estate was just plain good sense, given the contrast of the colony's vastness with the denseness of urban Britain. Thus suburbia, then a new experiment in the Old Country, was taken to the heart of the new colony. (Hutchings 1986a: 3)

If Australia was a suburban nation (Stretton 1970), then this city was its archetype (Bunker 1988: 228; Hutchings 1986b).

Private ownership of dwellings had often been higher in this city than in most other Australian capitals. After World War II the state itself (via a public housing authority, the Housing Trust) had embarked on a programme of making cheap house and land packages available for sale, thus providing a powerful incentive to home ownership. The Trust also offered identical dwellings for rent to low income families. It built mainly detached dwellings and did not replicate the high-rise urban renewal schemes which were undertaken by similar public housing authorities in other Australian states, notably Victoria (where, for example, large scale inner-city clearances had resulted in massive apartment blocks housing the aged, the poor, and other welfare recipients). The Trust's commitment to suburban living saw the development of a satellite town, 27 kilometres to the north of the city, in the 1950s and 1960s. Its design employed the British neighbourhood unit principle to purposely create and service an extensive area of low-density suburbia (Bunker 1988: 230).[20] Urban consolidation only became a question for housing policy in the early 1980s; the 'units' and 'townhouses' in which some participants resided were a response to this shift toward greater density. They were produced by both public and private developers, but maintained the earlier emphasis on discrete, independent and private dwellings which had long dominated the living spaces available to residents of the city.

As historically specific constructs, privacy, independence and separateness — as well as the progressive virtue and self-sufficiency attributed to suburban space — were thus materially embodied in built forms and shaped what is was to live in this particular city. It was this history — both material and ideological — which determined that so many participants were to be found dispersed over a wide suburban area, in discrete houses and medium-density townhouses or 'units'. A high-density concentration of cheap accommodation was simply unavailable to them. The city was also a 'cultivated space' in the sense that Baumann (1996) uses the term to describe Southall, a former borough of London. It was not a neutral space because present-day inhabitants found houses, roads, amenities and a defined geography already laid out. This physical environment 'set limits to any new cultivation of the space, yet these limits are often elusive' (ibid: 37). One such space of (re-)cultivation was to be found inside of participants' homes.

INTERIORS

The research was conducted by driving from the University of Adelaide Department of Psychiatry at the Royal Adelaide Hospital, in the centre of the city, to people's homes in the suburbs. This movement was also a journey inward to some of the most private and

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[20] Based on a physical design used in British new towns, each 'neighbourhood' comprised approximately a thousand dwellings, served by a centrally located retail centre and schools, and surrounded by buffers of open space. In an attempt to create a 'social mix', each neighbourhood contained a range of housing types and tenures (with roughly equal numbers of owned and rented properties).

inaccessible places of our culture.[21] The interior being sought was both the physical interior of individual homes and the inner realms of personal experience, emotion and belief.[22] Negotiating access to both of these was in itself a major source of ethnographic understanding, as it highlighted the availability of people to scrutiny, and the limits of what it was possible to say, do, or know as a guest in someone's house. Such restrictions emphasized the cultural meanings associated with this type of place and the particularity of practices which were centred there (cf. Silverstone, Hirsch & Morley 1991).

Thus, being guided by the places in which participants actually lived, I viewed this part of the field from a predominantly suburban perspective: small, individual houses occupying their own block of land, gates to be opened, windows covered by curtains, and closed front doors. These were places which one had to be invited to enter. This pertained equally to the higher density apartments, 'units' and 'townhouses' in which some participants lived; these could only be reached by crossing an intermediate space which separated public and private domains.[23] Shaun lived in a flat which was accessible only via an anonymous stairwell which he likened to a "battlefield" and a "no-man's land" — it was adorned with graffiti and often combined the smells of urine and cooked eggs; Shaun himself always traversed it as quickly as possible, as if escaping to the safety of his brightly decorated flat, or to the anonymity of the streets outside. Zöe lived in an award-

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[21] See Rybczynski (1988) on the history of the house in western European culture, especially the bourgeois creation of interior space and the emergence of a private domestic sphere which occurred first in the seventeenth century Netherlands and which, by the eighteenth century, had spread to the rest of northern Europe. Tuan (1982) constructs a similarly history by way of an extended comparison with China. M. Thomas (1997) examines the separation, independence, seclusion and privacy which are imposed by the layout of Australian houses, the cultural and psychological significances of which are highlighted when they are transgressed in everyday practice by Vietnamese migrants living in Sydney.

[22] Tuan (1982) proposes the parallel emergence of architectural differentiation within the house (exemplified by 'marked' spaces for eating, defecating and sleeping) and a reflexive self-awareness ('self-consciousness') which was made possible by the withdrawal into fragmented spaces. Also concerned with the 'interiorisation' of self-consciousness and of 'madness', MacLennan (1992) augments the social and economic history of domestic space with an emphasis on religious ideology and practice: both the self-examining discourses of Puritanism (which emphasized evidence of inner crisis as a condition of spiritual rebirth) and the longer history of withdrawal into monasteries where the skill of silent reading was developed, as recorded by St Augustine, the first autobiographer (ibid: 9).

[23] Biln (1991: 49) notes that the distance effected by the 'protective zone' which separates front doors from streets (and epitomized in the suburban front yard) is 'not strictly *metric*' but functions rather as a marker of social separation — a 'conceptual distance articulated spatially' — such that 'proximate neighbours are distanced in favour of constructed social networks'.

winning group of townhouses which faced inward to a common green space; each unit was staggered in relation to its neighbour, leaving individual front gardens to screen the entrances.

Living in a suburban house or an apartment had a particular valence after periods spent in hospital, and was especially welcomed by several participants who had previously lived in half-way houses, hostels or boarding homes. A number of participants attested to how, during periods of hospitalization, privacy was set aside and individual freedoms were severely curtailed. In such settings, time and space were regimented in entirely different ways to that which was obtainable in their own homes. Daily practices such as sleeping, eating, socialising and physical movement — together with the spaces in which these are conducted — effected different bases for the constitution of self and subjectivity.[24] One participant, Lawrence, reflected on the contradictory impetuses toward visibility, regimentation, and personal anonymity which he experienced in a purpose-designed psychiatric ward in one of the state's newest general hospitals (itself an embodiment of the realigned 'weaving' of health services). Here he found the patients to "mill like cattle":

> "You are very alienated in the institution — [it's] terrible ... The nurses' station is sort of elevated. It overlooks but it's completely separate from the Day Room. The Day Room is extremely large. When you are experiencing a psychosis sometimes you need a smaller space, but there was no smaller space. It was like being put in this *huge* [emphasis] holding facility ... It was Hell. They get you up at 7.30 in the morning. It's a very long day. I used to try to get as far away from the Day Room as possible."

Zöe reflected on her initial impressions of hospital: "The first time I was admitted ... there was this corridor with doors on either side, all the way down — I thought I was in a concentration camp". Shaun evoked the image of a firing squad when he said: "In hospital you are up against the wall". In the experience of people who had been hospitalized or

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[24] Cf. Goffman (1961: 148): 'Like the neophyte in many ... total institutions, the new inpatient finds himself cleanly stripped of many of his accustomed affirmations, satisfactions, and defences, and is subjected to a rather full set of mortifying experiences: restriction of free movement, communal living, diffuse authority of a whole echelon of people, and so on. Here one begins to learn about the limited extent to which a conception of oneself can be sustained when the usual setting of supports for it are suddenly removed.'

imprisoned[25], categories of private/public or inside/outside took on additional metaphoric referents in terms of autonomy versus constraint, freedom versus being 'locked up'. Being in their own homes added a specific valence to the categories of 'private' and 'inside' which was framed by these experiences of institutional reversal. Private homes embodied (materially and in practice) the rights to control and respect which were accorded inviolate individuals by public policy. Our access to private homes also highlighted the specific cultural categories of personhood and agency which such places embodied.

The physical space of a dwelling is not, of course, uniformly textured. There are differentiations and hierarchies within a house, with bedrooms being more 'private' than the comparatively 'public' space of lounge rooms. This was made apparent by the way in which we (participants and researchers alike) accessed and used the space of houses during the course of research. A marker of this privacy was the very few times we entered participants' bedrooms. The novelty of this (and its capacity to disrupt my expectations) was emphasized when our first meeting with Jane took place in just such a setting. Because (she said) the carpets in the rest of the house had just been cleaned, we followed her into the first room off the hall, which turned out to be her bedroom. All three researchers stood around helplessly for a few minutes wondering where to sit: there were no chairs, only a large double bed in the centre of the room. Jane disappeared to make tea and coffee. We waited, not knowing how to position ourselves. When she returned, Jane climbed up onto the bed, crossed her legs and took centre stage while we, her captive audience (or so it felt to me), were directed with a wave of her hand to positions at the end and along the sides of the bed. People and objects (such as the tape recorder or a notebook) were perched precariously in this way throughout the couple of hours we were there. Occasionally one of us would shift slightly, destabilizing each other's balance. Jane seemed very comfortable with the arrangement; it was undeniably her space and she commanded it adeptly. I found it unsettling — literally with the bed moving beneath me,

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[25] One participant had been incarcerated in the state gaol and he and several others had spent some time in the locked 'forensic' ward of the state psychiatric hospital.

and because I was uncomfortable being in such an intimate setting. This was not Megan's reaction, however; she felt "right at home", perhaps because of their shared gender and greater closeness in age.

Entry into another bedroom highlighted the behaviours and transgressions which were possible inside participants' houses. This occurred when Anselm, a young man living with his mother, took us into his bedroom to show us his prized possessions. At first he pointed out a stack of comic books and some illustrated children's books lying by his bed; next he showed us various pieces of weight-lifting equipment which were stored on top of the wardrobe; he then opened the wardrobe and started extracting his favourite clothes, asking me if I would like to try on his leather jacket. At that point his mother (whose house it was) came in and sternly directed Anselm back into the lounge room where she had prepared afternoon tea for us all, thereby reasserting what she saw as the 'appropriate' placement of guests and activities within her house. This incident highlighted how unfamiliar uses of domestic space — in this case a breach of the intimacy and privacy afforded by bedrooms, and the behaviours appropriate to that space — could in itself be a measure of strangeness, manifesting the extraordinariness which was sometimes my experience of schizophrenia.

In most suburban houses the bedroom epitomizes privacy (cf. M. Thomas 1997), and researchers would not normally have access to it at such an early stage in any relationship. By their actions, participants indicated that these bedrooms were spaces over which they had some measure of control; they were places to which we could retreat together to obtain privacy and intimacy, without being interrupted or overheard. This was especially the case when there were other people in the house. Thus, the first time we visited Brian at home we sat in the kitchen, regaled by his father's knowledge of local horse-racing history and plied with tea and biscuits by his mother; Brian hovered around the edges of the room, eating, listening, smiling occasionally, but contributing nothing to the engaging hospitality of his parents. His mother commented on his atypical appearance — "He never usually comes out of his room", she said — and added that he "never" ate with the rest of the family. On a later visit Brian took Megan and I straight into his bedroom where he played us tapes of his musical compositions, practised his guitar and read us some of his poetry. These were all accomplishments which had not been revealed previously over the course of several meetings. The place was integral to the revelation: relations with his parents were such that Brian would never have read out his poetry in the kitchen or the lounge room. Most of the bedrooms we entered (like Brian's) belonged to young adults living with parents. Jane, for example, was still a teenager, living in her mother's house.

These rooms were places of disclosure and display, especially of the person who occupied them: this was explicit in Anselm's exposition of his most valued possessions, all of which were housed in his bedroom. In other cases as well, the images and objects found there were pointed out as expressions of the self: an externalized display of identity, interests and allegiances. Even apparently 'neutral' objects such as books and CDs were gathered together and presented as a statement of personal interests and imagined possibilities for the room's occupant. Hence it was unexceptional — that is, resonant and common sensical — that albums by The Cure or Nick Cave and the Bad Seeds were propped against Jane's bedroom wall, a reflection of and a justification for her 'gothic' appearance. So too the pointed references to certain authors such as de Sade, with whose works she had a particular fascination and which were housed on the bookshelves next to her bed. Her very first question to us was: "Have you read Nietzsche?" Books, like popular music and collected or constructed objects (such as Shaun's delicate paper 'sculptures' — see Plate 3), were revealed as a source of identity which a person could use to anchor or project a particular version of the self. This sense of place as a position from which to view life (Basso 1996: 56) and as a 'scene for action and thought, feeling and expression' (Casey 1996: 38) was very much in evidence in Jane's room, where even her thoughts were literally inscribed in pen and pencil on the walls surrounding her bed. These augmented an assortment of texts (both her own verses and snippets cut from

Plate 3. Shaun's Paper Sculptures

papers and magazines) which were pasted on to the walls.[26] In conversation she referred to other visual images which were hanging there.[27] Thus the bedroom was singly appropriate to the disclosure of her perceptions and subjective experiences, a disclosure which was prefigured in the nature and the uses of the space itself. The same view of Jane, her interests and concerns, could not have been got in the house's living room, where we went once for an afternoon tea put on by her mother. It is also in this sense that a young person's bedroom might function in the same way that the more 'public' areas of a house or a flat may operate for an older person, or someone living alone.[28]

There was another aspect to domestic interiors which I became aware of over the course of the research and to which I responded with curiosity: this was a persistent darkness and stillness which seemed to pervade many participants' homes. What I initially perceived as a negativity (an absence of light and movement) I came to appreciate, however, as a source of control, intentionally achieved and maintained by some participants.

A sense of being closed off from the outside world was the first thing I noticed about Gerald's house. All the windows were covered with drawn roller-shutters — retractable metal screens which were advertised locally as security devices. On each visit I suspected that Gerald was waiting inside of the metal security screen which protected the front door, watching for our arrival. After greeting us over the front fence he would inevitably hold

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[26] The capacity for Jane's bedroom walls to retain and display her thoughts was in marked contrast to the walls of the building which housed the Station Street Shelter and a locked psychiatric ward described by Desjarlais (1997: 73-4). Those walls, being formed of sharp, rutted concrete set with stones and mineral fragments, were 'impersonal', resisting tactility, bodily contact and adornment. Jane's walls, conversely, were self-consciously infused and layered with expressions of her identity and subjectivity.

[27] These included a reproduction print of Edward Munch's *The Scream* and an etched image of a young woman lying in a hospital bed with a bandage around her head looking down at a crucifix held in her lap. Jane drew on both of these images to illustrate her experiences.

[28] Thus the bedroom (especially for a person sharing a house with others) was a limited case which drew attention to the various ways in which people used and augmented their homes to represent aspects of their selves. Hence Wynn's lounge room which was dominated by a large photograph of her son — similar portraits could be found in innumerable homes, but this one took on an added valence in light of Wynn's biography (she insisted that schizophrenia had been the cause of their separation), and reflected her abiding concerns about mothering and personal adequacy. In Oscar's 'study', books and framed certificates signalled a space which had been rendered serious and academic — qualities which he valued as part of his own identity and aspects of himself which he wanted to present to us (thereby justifying his capacity for 'collaborative' work on the research project).

the front door open and then dead-lock it after we had entered the house. The central hallway was hung with dusty Christmas decorations, a forlorn evocation of things out of time, which was how Gerald himself appeared in his cardigan and meticulously polished 'school' shoes, and which was also a key element of his experiences and his identity. Off this hall was the sitting room — it was immediately clear that we were to enter this room because light shone from its doorway and the rest of the house was always in darkness. The reason for the light soon became obvious: there was a fully drawn roller-shutter on this window as well. Once inside the room, which was furnished with old vinyl sofas covered in crocheted rugs and a 1960s 'radiogram', Gerald would shut the door and there we would stay for several hours at a stretch. The room thus produced a profoundly inward focus, adding to the intensity of what was divulged. The effect — firstly of the shuttered house, the locked front door and then the closed room — was a sense of space as closed off, secreted or defended. It was only in this space that Gerald talked about his love for a girl he had not seen since kindergarten, put forward his theory of a conspiracy being perpetrated in maternity hospitals, disclosed his attempts to operate on himself and drive nails through his hands in imitation of Jesus Christ, and 'confessed' to his encounter with Hitler. None of these things — all of which were central to his understanding of himself and his life — had even been hinted at during an afternoon spent at his place of part-time employment, or in the presence of his parents. It was as if the house, in its darkness and timelessness, contained and protected these extraordinary concerns. In its sense of closure Gerald's house was reminiscent of a number of others we visited, including Gillian's which was situated on several acres of land on the metropolitan outskirts, which could not be seen from the road, where there was no obvious entrance, and where all the windows (except the kitchen) were covered by heavy blinds and curtains.

This feature was consistent enough to become a topic of speculation among the researchers. Eventually I put a question directly to Aiden to see if he too recognized the phenomena:

> "*Just while we've got that tape still going, can I ask you — because we've been thinking about this in relation to other people's places — is there any particular reason why you have the blinds closed and things like that?*
> To keep the light out [laughs]
> *... because we've actually discovered this in many spaces that we've been in — they're very closed off and we don't know if it's significant or not.*
> Yeah, it is.
> *Many people seem to have this need, or -*
> You know why? ... The reason is because, if you sit in a room where nothing changes — there's no things moving around or anything like that — then you can deal with that. If it's all like this [taps the coffee table], you know — nothing changes except people and this sort of thing.
> *Yeah. It's solid and fixed.*
> Yeah. It doesn't change, it doesn't start talking to you or walking past and looking at you, or this sort of thing.
> *So you don't get changes of light or -*
> Oh, no. I hate sunlight as well, for some reason. Maybe I'm a vampire or something [laughs]. But, yeah I think it's just that — the fear of things changing, you know. If nothing changes, you do OK, because it's controlled.
> *And that enclosure — is that a sense of control — of keeping something fixed?*
> It's creating a boundary. Yes. The walls are the boundary. Nothing changes in that boundary. You know, you can separate yourself.
> *That makes good sense. I've just noticed it with many people ... this very [same] sense of enclosed space.*
> Yeah. That's why. I think that's a fundamental thing about schizophrenia is that openness. I really believe that's the key to the whole thing. That's where all the experiences come from, and all our beliefs and everything else that revolves around that. All these thought projections, thought insertions, that sort of stuff. It all revolves around that. Mm."

Other participants commented similarly on the sense of closure which was achieved in their own home. Lawrence, for example, contrasted his "need for a small space" with a terrifying vision of the streets and city outside of his house:

> "The other day I almost died on the train. I got on the train [and] I couldn't breathe. I was so agitated I couldn't breathe. I thought I was going to die. It's OK if it happens here [at home]. I feel I'm a little bit safer here. But if I'm out there and I can't breathe, it's — I was with my brother on the bus and he had a seizure. Yeah, so, scary stuff. I used to always think when I left the house that I wasn't going to get back to the house, that I was going to go out there and I'd get lost, and I'd never find my way back. So, I've got these fastidious sort of habits I have, with my ID cards and all these things in my little wallet."

Another of his 'fastidious habits' was to maintain a regular route — from bank to public library to art supply shop to coffee shop and home again, what he called a "pilgrimage" — on his fortnightly trip into the city. He said:

> "... there are paths that I go on ... It's a set pattern that's been going on for about a year — every fortnight I'll do that. I guess I've stopped changing. I'm just repeating myself over and over and over."

In the face of these terrors and their ritualized containment through "pilgrimage", Lawrence's home was a point of stillness. It could still be subject to intrusions, however: "… when I turn the radio on, then the radio makes the environment a public environment, or a social environment, and I find social environments very, very difficult". For Lawrence, the problem with such a 'public environment' was that he could not control it sufficiently; it was "unmediated — very raw, very open, very direct" in terms of "all the material that's available" for interpretation. Home was also a space which facilitated an intense reflection on his experiences and the transformation of those experiences into concrete artefacts via the media of canvas and paint. While restricting social interaction and screening various forms of unwanted intrusion (from radio and television, for example), the physical space of the house thus provided Lawrence — as it did Aiden, Adam, Gerald and many others — with a space of self-exploration and self-creation.[29]

ORDINARY SPACES RENDERED UNFAMILIAR

In participants' homes we usually sat in living rooms or lounge rooms; sometimes we sat in a kitchen. These were the domestic spaces which I associated with everyday social interaction — the entertaining of guests and friends, the setting for family tasks — except that it soon became apparent that participants rarely engaged in these types of activities. Those living alone rarely received visitors; many were estranged from their families. It was not always possible, therefore, to presuppose the valence of these rooms. Occasionally my taken-for-granted assumptions about them were radically challenged.

Some homes were comfortable because they conformed to my own schemas of movement, thoughts and perceptions relating to domestic interiors. To this extent, many homes were unremarkable. This was the case with my first visit to Shaun's flat. In the

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[29] In this, houses operated much like the 'free places' of the hospital identified by Goffman (1961: 230ff): bounded physical spaces in which surveillance and restriction were markedly reduced, where 'inmates' could engage in a range of 'tabooed activities' with some degree of security, and which were 'pervaded by a feeling of relaxation and self-determination' in which 'one could be one's own man [*sic*]' (ibid: 231).

lounge room there were fresh flowers in vases (later it transpired that he had picked them from neighbours' gardens especially for the visit), books on a bookshelf behind the door, paintings and collages around the walls, sculptures and lamps on small tables, a colour television set, a sofa and three (unmatched) chairs. With such trappings, together with the movements and deportments which they entailed, I felt 'right at home'. There were choices as to where to sit, objects to look at and talk about, and over time Megan and I were comfortable enough to get ourselves a glass of water from the kitchen when we wanted one. Ongoing changes to this interior became a point of particular interest: there was the addition of many more art works, the importation of a second television set (which played simultaneously with the first), and the construction of a bunk bed over the doorway to the lounge room which allowed Shaun to watch the two television sets all night if he wished. He related this (what to me was a) 'disordering' use of space to his 'creative' identity and to his increasing concerns about 'referencing' phenomena on the television.

In some participants' houses the use of rooms had already been rendered decidedly unfamiliar. Jeff and his wife Raelene, for example, lived in a red brick Housing Trust house on an austere post-war housing estate made up of identical houses, a few straggling trees and rusting wire fences. Their front yard (like most of their neighbours') was bare except for a rubbish bin. On our first visit Raelene looked out through the wire door as we entered the front gate, but did not come out to greet us. Jeff (who we hoped would become a participant in the study) called out for us to come inside. The front door opened directly into a dark lounge room, its only window covered by a heavy curtain. The room was tiny and there were not enough seats for all of us. Megan and Rob shared a dilapidated couch which they were warned was 'hard' because of a board which had been inserted under the cushions. I sat on the floor. The most striking first impression was of numerous paintings which had been positioned everywhere about the room. On two walls these formed two rows, one above the other, with several more paintings propped on the floor. Another covered the fireplace. Their sheer number and bright colour were startling.

Jeff said that he did not "do anything" except paint and sleep. He said that he "liked" schizophrenia because it meant that he didn't have to go to work: "I can paint and not worry about appointments". His painting was an "inspiration from God" and he attributed its products with magical powers and protective effects. There were a number of images of Christ around the room. Pointing to an image of the crucifixion, Jeff said:

> "That one is pretty involved in my life … I thought that because I was painting the crown of thorns that Jesus Christ was schizophrenic and that the crown of thorns represented the voices and the pains in his head … so as you notice I haven't painted a crown of thorns on that Jesus. I believe that I was with Jesus Christ and the crown of thorns because [He] looked like me."

It transpired that Jeff viewed these paintings (together with the tattoos which adorned his own body) as talismans — images of positive occultic or religious "power" — and the room itself as a sanctuary. After recounting stories of hostile relations with a number of neighbours and with his in-laws, Jeff observed that, "no-one comes to the house". He rarely left the house except, he said, to withdraw money at automatic teller machines in the middle of the night. He said that this house was the only place in which he truly felt safe.

Throughout the project we encountered some extraordinary re-workings of Housing Trust interiors. In a few cases these spaces and their decor could be explored in themselves as self-conscious displays of the self and its identity. Zöe's living room was perhaps the most arresting example. Its walls were entirely covered in drawings, posters, photographs and images cut from magazines. In front of these hung almost transparent veils of fabric in different colours, and several more were suspended loosely across the ceiling. These veils enveloped the room, except for the window which overlooked a luxuriant front garden (itself a screen to the public space beyond). There were more images and objects pinned to the outside of these veils. Wall lights shone eerily through the fabric. Incense filled the air. There was always music playing; when we were present Zöe would self-consciously put on a CD which, she said, evoked a particular mood for her or created an 'appropriate' ambience.[30] China, trophies, toys, books, records and CDs were stored in cabinets and on shelving units around the room. A religious icon (of the Madonna) was housed in its own small cabinet fronted by glass doors. The room's entrance was hung with a knotted 'ethnic' cloth and another shawl, decked in small bells, covered the doorway into the kitchen. A large green *flokati* rug defined the sitting area, which was bordered by two couches, an armchair and a television set. In the middle of these was a coffee table, the surface of which was covered in plastic to protect an assorted collection of photographs, postcards, handbills and invitations to art exhibitions. On top of these could be found jars of coloured pencils and pens, baskets of beads, costume jewellery and trinkets; sometimes there were containers of tablets (her medication) which, placed in this association, looked like small jewels. It was very difficult to negotiate a passage through this accumulation; I found that it was safest to keep as still as possible, sitting in the one spot, in order to avoid knocking something over or otherwise unsettling the display (something which men were bound to do, according to Zöe). The overall effect evoked images of a glittering cave, a harem, or a shrine. Certainly this room reflected an 'art of living' whose 'schemes of perception, thought and action' (Bourdieu 1977: 90) were distinctive and elaborate, and we spent some period of time exploring its layered meanings with Zöe. I remember thinking on walking into it for the first time that many of the portraits (of herself, Krishna, Marilyn Monroe, Annie Lennox, Joni Mitchell, Sophia Loren and David Bowie) were displayed like religious icons. It became obvious, after various attempts at exegesis, that Zöe conceived of the room as a shrine to herself — "it's all of my past", she said — or rather, to the various aspects of herself which she identified in others. This room enveloped her and clothed her identity. It was also continuously evolving, a work-in-progress: "I keep adding stuff, like adding to my wardrobe", she said.

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[30] Our conversations were often interrupted by her jumping up and finding a recording to illustrate a point she was making. She also played us a number of songs by famous recording artists which (she insisted) she had 'written' and which had been transmitted telepathically or been 'stolen' from her.

The dramatic conflation of place and identity in Zöe's living room recalled Heidegger's (1993) meditation on *dwelling* as the basic character of human Being, which he contrasts with a substantive building which merely houses people: 'The way in which you are and I am, the manner in which we humans *are* on the earth, is *buan*, dwelling' (ibid: 349). To be *in* the world means to dwell and be at home there — to be familiar with the meaningful structures that articulate people and things. Dwelling, in these terms, is both cultivation and construction (ibid: 350), as Zöe's living room was both an elaborate construction of almost infinite variety, materials and textures, but also the cultivation of a view (or rather, multiple views) of herself. As houses are for Bourdieu the locus of durable dispositions and schemes of perception created and reproduced through a 'practical mastery', so places of dwelling are the sedimentation of habit and custom for Heidegger: 'Building as dwelling … remains for man's everyday experience that which is from the outset "habitual" — we inhabit it, as our language says so beautifully …' (ibid: 349). Dwelling is also a 'growing accustomed to', and a being 'content'. It is a 'safeguarding', which means 'to set something free into its own essence' (ibid: 352). Thus Zöe was extremely protective of this place of her own invention, which housed and displayed her most intimate and 'true' self: images of Krishna and talismans such as *mati* (to protect against the 'evil eye') guarded its entrances. Zöe's lounge room was an homology for her self, but also an expression of that social 'art of living' which appropriates and makes meaningful the images, objects and persons of a wider culture, and which makes of identity a 'being with one another'.

Basso (1996: 54) similarly develops Heidegger's notion of *dwelling* in order to account for the multiple 'lived relationships' that people have with places and by which abstract space is rendered meaningful — see also Jackson (1995: 127). Focusing on places brings them forward in thought and emotion, together with the experiences which render them meaningful:

> … the self-conscious experience of place is inevitably a product and expression of the self whose experience it is, and therefore, unavoidably, the nature of that experience (its intentional thrust, its substantive content,

> its affective tones and colorings) is shaped at every turn by the personal and social biography of the one who sustains it. Hence … places possess a marked capacity for triggering acts of self reflection, inspiring thoughts about who one presently is, or memories of who one used to be, or musings on who one might become. (Basso 1996: 55).

It is when stepping back from the flow of everyday experience and attending self-consciously to places that awareness is 'seized' and 'arrested', emotional responses are heightened, and places are 'sensed' and encountered 'most directly' (ibid: 54). Certainly this was my response to some of those places in which participants normally dwelt. For many participants this 'sensing' of (and emotional reaction to) places outside of their own homes often had a negative cast: these were places of fear and disorientation, as the department store was a locus of Brian's "paranoid feelings" (see Chapter 2), the street was a place of "assault" for Zöe, and the hospital was a place of terror for many others. By contrast, participants' houses were their place of dwelling.

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Participants attested to and demonstrated how their homes reflected a privileged view of themselves. These were places of display (Zöe), protection (Jeff), exclusion (Aiden), and elaboration (Shaun) which were consciously arranged and self-reflexively maintained. In itself, this was not unusual: it is taken for granted in Australian culture that a house or a room 'reflects' its owner or occupants in some way; this was an aspect of the individuality (itself a quality of person) attributed to discrete residences. There was nothing unusual in Wynn having a large photographic portrait of her son on her lounge room wall, except for the particular way in which that image was tied to her identity as a mother and a person, and how she said it represented all of the losses she had endured as a consequence of schizophrenia. Jane's bedroom, with its CDs, posters and texts, was probably not dissimilar to that of many other teenagers, except for the extent to which she used it to externalize the tormenting visions and thoughts she associated with schizophrenia, and then used these to instruct us in how we might appreciate what such a life was like. The images which covered Zöe's walls were not simply an expression of fandom but a visualization of those aspects of her self which she believed were lodged in other people. Aiden's walls combined astronomical images and large, hand-drawn maps of imaginary worlds, a reflection of his being "off the planet", as he once quipped. While all interiors are consciously arranged to some extent, these took on an additional task of reflecting the particularities of identity and subjectivity which their inhabitants associated with schizophrenia. Moreover, since many participants' houses seemed to be rarely visited by others, the principal audience for such displays was often the person who constructed them; or their meanings as such were not obvious until their creators chose to disclose them.

The implications of this distinctive 'being at home' for participants' identity, and for their relationships to the wider field in which they were located, are the focus of the following chapter.

Chapter 4

"I'M JUST A BRAIN WITH A CHEMICAL IMBALANCE"

STRATEGIES OF IDENTITY

This chapter examines the resources which participants used to make sense of their everyday realities and identities. It also addresses the constraints which were placed upon such constructions, especially those which flowed from psychiatric diagnosis and restricted material circumstances. It focuses on how participants viewed the field of policies, legal reforms and institutions in which they were located, and how they acted within it to seek advantages in line with their own needs and projects. The chapter is therefore concerned with the capacity of participants to create and substantiate meaning for their lives on the basis of their extraordinary experiences, and with the structures and limits of that capacity. In the broadest terms, then, the chapter is an ethnographic exploration of 'the human power to shape universes within which to live', especially in the context of those 'contradictions, inconsistencies, ambiguities, and strains within and between systems which sooner or later require of some men and women that they be causes and not only effects, creators of categories and not only creatures of them' (Fernandez 1986: 244).

Participants' experiences could be construed as examples of psychopathology, or as evidence of extraordinariness, or both according to context. Participants tended to see psychiatry as laying claim to the first interpretation, while they emphasized the latter. This represented a fundamental contestation of the field's significant categories and authoritative knowledge. Moreover, each construal led to divergent constructions of agency, identity and personhood, but since each could be invoked in context they were also media of strategy and manoeuvre.

AGENCY, IDENTITY, PERSON

Agency is the capacity for persons and their actions to be taken into account and, to this extent, to have an effect in and on their world. Participants were already accorded agency as a consequence of their engagement with the mental health system: they were 'consumers' attributed the capacity to choose, advocate, criticise and protest, who were expected to have views about the services and treatments provided to them, and who could expect those views to be heeded. Equally, they were 'citizens' who were attributed rights which they could expect to have acknowledged (see Chapter 3). In relation to national policies and as a consequence of the locally realigned field, persons diagnosed with a mental illness were also accorded a specific capacity to be noticed: to be represented on billboards and on television; to identify themselves as 'schizophrenic' in art exhibitions; and to play a role in public events.

Bourdieu's concept of the field depends on this type of agency, agents and groups of agents being defined by their relative position *vis-à-vis* the institutions making up social space (Bourdieu 1985: 724). Agency is generated by the 'space of positions which constitute … a field of production' (Bourdieu & Wacquant 1992: 86). It is embodied in persons who are capable of 'position-takings'[1] which realize the 'social conditions of possibility' in any configuration (ibid). Equally, a field is nothing other than its enactment by such agents — those persons who are 'socially constituted as active and acting in the field under consideration by the fact that they possess the necessary properties to be effective, to produce effects, in this field' (ibid: 107). It is the situatedness of individuals within such a field of relations which gives them '… the roots of their singularity, their *point of view* or position (in a field) from which their particular vision of the world (and of

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[1] Position-takings are the structured stances, practices and expressions given to agents by the field in which they act (see Bourdieu & Wacquant 1992: 105).

the field itself) is constructed' (ibid; original emphasis). It is participants' point of view on the field of schizophrenia which I focus on here.

The phenomena associated with schizophrenia initiate a range of institutional processes, including scrutiny, recording, treatment and research. These are processes which, in themselves, confirmed the existence and agency of people so diagnosed: these were persons who possessed specific properties (especially their experiences, perceptions and behaviours) which had effects (including the historical emergence and institutionalization of psychiatry itself) and rendered them effective players (as the 'clients' of mental health services) within a field I have designated 'schizophrenia'. That such people also had the capacity to focus institutional forces on themselves and their experiences confirmed them as a specific type of social agent.

Such agency was evident whenever people identified as, or acted in the capacity of being 'schizophrenic', with psychiatry providing the label's institutional authority and justification. Moreover, as was evident by other labels drawn from law and economics ('citizen' and 'consumer' respectively), this agency drew on key structural elements of other fields, as well as the wider society. Defined in this way, agency was less a force of individual action than a dimension of historically formed institutional positioning.

Participants, however, drew on a range of other sources in order to attribute themselves identities and claim bases for action within their own lives. Here their agency was principally expressed by way of withdrawing from participation in dominant institutions and social relationships, of withholding information from doctors, researchers and family members, and by contesting the attributions and knowledge claims which were constructed for them and about them, especially by psychiatry. Their agency was constituted as much by refusal and 'doing nothing' (see Chapter 6), as it was by doing something.[2] Their identities were infused by their extraordinary experiences and informed by the various tropic devices by which these were apprehended and made meaningful (see Chapter 1). The meanings which informed participants' identities on an experiential basis — and which also shaped how they conducted their lives day-to-day — both contested and transcended the limits of agency and identity which were available to them by way of psychiatric management and mental health policies. Lawrence articulated this distancing from the hegemonic forces of the field when he said:

> "I'd like to hang on to what little control I've got over what I experience. Sometimes it's very, very slender, but it's still something. So … the word 'schizophrenia' — I don't take it too seriously. Some people make their illnesses a way of life, you know? It's very difficult to get out of that, sort of, proposition, that you've become a schizophrenic, whatever that is! But I'd like to think that schizophrenia is a lot of different things. In fact, the experiences a human being has can't be valued enough, and, you know, I have so much respect for any sort of reality … [Any experience] is a hook in the world and that's what we need in a universe which is basically cold and indifferent to us."

Psychiatry — through its authoritative clinical knowledge exercised in a constellation of institutions and settings — tended to predicate identity on pathology and to construe agency in terms of compliance to psychiatric regimens or consumerism (specifically, the consumption of psychiatric services). Participants predicated identity on their extraordinary experiences and their agency was an expression and sequelae of this perceived centrality. Each of these predications rested on alternate interpretations of experience: as pathology (from the perspective of psychiatry) or as extraordinariness (from participants' perspectives). This was a fundamental contrast from which numerous others flowed, including the attribution of a 'schizophrenic' identity by psychiatry and the assumption of various alternate identities by participants themselves. This basic disjuncture was the primary source of contestation and competition in this field.

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[2] Cf. Desjarlais (1996b) who emphasizes a concept of agency as the capability for motivated and consequential action (and hence for intentionality and free will): a 'being able to do otherwise' rather than simply a 'doing something' (ibid: 897n, citing Giddens 1979).

Contested bases for claiming and acting on identity were thus a feature of participants' everyday worlds. Their dual source is represented in Figure 4.1.

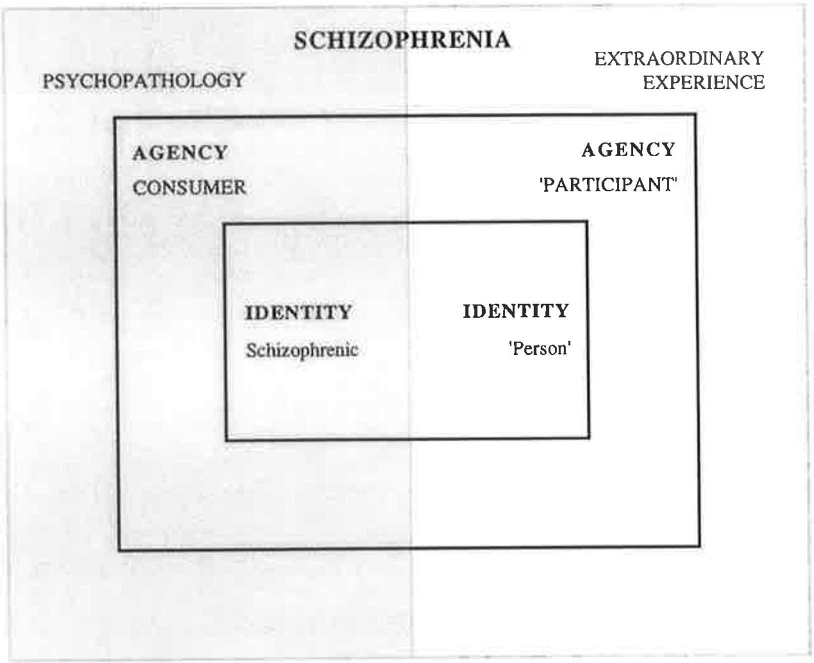

Figure 4.1

Contrasting claims in respect of these categories also had implications for how a person was construed in this setting. The clinical practice of psychiatry construed the person as an object of assessment, intervention and management.[3] This was the core of its work as a profession which also had implications for how the category of 'person' itself was constructed and attributed moral weight (see Barrett 1996).[4] Participants' representations,

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[3] This was a particular case of those 'practices of thinking and writing … that convert what people experience directly in their everyday/everynight world into forms of knowledge in which people as subjects disappear and in which their perspectives on their own experience are transposed and subdued by the magisterial forms of objectifying discourse' (D. Smith 1990: 4).

[4] Kirmayer (1988) has argued that the diagnosis of psychiatric illness is predicated on values — intentionality, volition, responsibility and self-control — specifically associated with moral philosophy and the concept of 'mind' in Western metaphysics. In this way (and in relation to the biomedical focus on a 'subjectless' body), Kirmayer argues that psychiatry contributes directly to the ongoing cultural construction of the person as a dualistic category combining agency and accident, reason and emotion, accountability and blamelessness.

on the other hand, emphasized the context-dependence of knowing who or what they were, the heterogeneity of their roles, and the multiplicity of ways in which they might act. In addition to this diversity, however, all participants evinced a sense of person which was centred on their extraordinary experiences.

Diagnosis — which for participants was the most obvious outcome of their involvement with psychiatry — was the pivot of contested interpretations of the person. Diagnosis, as the capacity to discern the condition of a person by determining the nature of disease[5], was the field's most powerful and most penetrating process of construal. As Aiden commented wryly: "Schizophrenia is the label of all labels — with it they can do anything to me". To diagnose a person with schizophrenia had greater consequences than to diagnose many other disease categories; to be designated a 'schizophrenic' was more pervasive than to be attributed with a range of other identities.[6] Estroff (1989; 1993: 256-63) calls this 'an *I am* illness' — one which conflates diagnostic category, social identity and self. This conflation was epitomized in a locally-produced autobiography, the title of which, *Turning Into Schizophrenia* (Webb 1995), emphasized the capacity of schizophrenia to engulf a person. To configure the whole of a person in terms of psychopathology was an extremely powerful instrument of definition. Since there was no 'cure' it was also an irrevocable designation. This power was supported by a vast and — with mobile treatment teams — pervasive institutional apparatus which evoked authority and legitimacy for the work of psychiatry.

The following two examples illustrate the power of psychiatric constructs to penetrate the person, reorienting both identity and the capacity for agency. Yet in their particularities the

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[5] In taxonomic terms, to 'diagnose' is to discern an entity's distinctive character.

[6] As Barrett (1996: 288-9) has demonstrated, this was the essence of constructing a 'case' of schizophrenia, as exemplified in the 'full [clinical] work-up': 'Schizophrenia permeated each dimension of the case. It was located in the person's inner mental state. It arose from the biological and genetic core. It was manifest in behaviour and could be consciously used for ulterior gain. More broadly it ramified through the person's family and social network... Through this bio-psycho-social approach, schizophrenia was equated with the 'whole person'. The total identity of the person was subsumed by the illness. The 'whole person' became a 'schizophrenic'.' (ibid: 140)

examples also highlight the potential for this penetration to remain incomplete, or to result in a disarticulation of these categories. This is the case in the first example (that of Anne), whose taking on of a 'schizophrenic' identity helped her understand some things about her situation, but did not result in her feeling able to act in or on her world; this left her bereft of a sense of agency which had previously been so important in her life. Like the negative self-attributions which Corin and Lauzon (1994: 22) found amongst the most often hospitalized patients in their Montreal study, Anne's identity was subsumed by a psychiatric labelling focused on deficiency. The second example (that of Gordon) highlights the strategic adoption of psychiatric constructs in order to utilize their power against other institutional forces. But the control which Gordon initially sought to exercise in this way was lost. The example emphasizes the capacity of psychiatry to render agency itself as pathological and thereby appropriate it to a psychiatric frame. Gordon remained defiant of psychiatry's attributions, despite his acknowledgement of their totalizing effects.

Anne: relinquishing agency and embracing schizophrenia

Most participants acknowledged the field's power to restructure both agency and identity, and thereby determine their present circumstances. Anne, an articulate woman aged in her mid-fifties, presented herself to us in precisely these terms. Prior to diagnosis of schizophrenia Anne's capacity for taking action in her world had been remarkable: she was tertiary educated, had held positions in a large law firm and had worked with several judges. Following many years of research into what she saw as an anomaly in the Australian electoral system she had made submissions to government enquiries, had conducted her own case before the High Court of Australia, had published articles on the subject in the mainstream press, and twice run for Parliament as an independent candidate. When we meet Anne she was living an isolated and impoverished existence in a rented flat. By her own estimation, Anne's previous capacities for action in the fields of law and politics had been stripped away by a period of hospitalization following a psychotic 'episode', and by a subsequent diagnosis of schizophrenia. Having lost her job, with her credibility "shot to pieces" and support for her investigations removed, Anne presented herself as completely lacking in the capacity to control her world, or to have her beliefs and concerns taken into account. Her identity had been subsumed by diagnosis. She commented on her induction into the category of 'schizophrenic' and the ready-made meanings she had found there, some of which appalled her and others which she embraced:

> "… part of my depression is still the shock of knowing that I've become a schizophrenic. It is a terrible shock. You know, you have a certain image of yourself … and then it's shattered … The worst word is "incurable" — that I have to live with [schizophrenia] to the end of my days … I don't know enough about it really. I've got a misconception that schizophrenics are killers, I think. Which is why I stressed that I was never contemplating doing anyone any harm. I brought in this newspaper the other day and they had a fellow who was discharged from hospital who was a schizophrenic and he went out and stabbed a few people. So it does happen …
>
> I have a certain feeling of being unclean, I think. [That] would be schizophrenia to me. Of being contaminated. That sort of thing. Well, it's the old bogey of mental disease I suppose."

Anne's image of herself was a particularly negative one since it was based on relinquishing the agency which had been expressed through her 'investigations'. Her adoption of a 'schizophrenic' identity had not been accompanied by the 'positive' attributes of agency promulgated by the new field of mental illness. She did not see herself as a 'client' or a 'consumer'. Her assumption of a psychiatrically ascribed identity was thus disarticulated from the agency on which it was predicated, casting her adrift in her own life.

Anne's previous lifestyle had afforded her money, property and a professional affiliation. Diagnosis had profoundly affected her circumstances, especially in terms of income and accommodation: "Finding somewhere to live, having to starve in order to keep a roof over your head — oh what a nightmare", she said. During the period when we were meeting with Anne her only social contact was with a church group which catered for the needs of people much older than herself. But even in the church she felt isolated and disconnected:

> "*Has the church been an important part of all of this, throughout?*
> Well, it's a very good way of meeting people, you know, decent people. It's the only way I have left now. I mean, you couldn't go on a pub crawl. You meet the wrong sorts, so -

> *I guess what I was asking is, has there been a religious sustenance … throughout this period of -*
> Yes, yes, it was, you know, at the still point I could sort of hang on, yes. Yesterday [it] was important to me to go to church. I ran into a funeral which upset me. I suppose what upset me was to hear the panegyrics and hearing a sketch of a man's life. His five daughters were there, and they'd all got their careers as well as their husbands. And the little ones, the babies and so on, and again, I'm just a spectator at the parade of life, you know. I'm just a spectator. I'm not involved. Never have been. No-one ever invited me to be involved, you know? So I'm just a spectator and that's depressing … So there was everyone else in the mesh of their final relationships, the whole congregation, and there was I, totally alone and space all around me. There, but not there, you know."

Schizophrenia provided Anne with a framework to explain her loneliness and disconnection, but it did not provide her with what she considered an acceptable capacity for agency. To be 'schizophrenic' was to be discounted as a person — to be a 'spectator at the parade of life' as she so eloquently put it — to be 'unclean' and 'contaminated'.

Gordon: an example of aberrant agency

Another participant, who I will call Gordon, provided an example of self-enacted agency which, against his will, reinforced his encompassment by the field of psychiatric institutions. After a series of dramatic and illegal acts Gordon had attempted to engage the powerful constructs of a psychiatric diagnosis in order to avoid prosecution and thereby counter the legal system. To his chagrin, however, this strategy had left him enmeshed in the mental health system. Having deployed the latter to escape a possible jail term, he now found his identity and avenues of agency severely curtailed by a field which could determine these in a far more penetrating way than he had ever anticipated.

In the late 1980s Gordon had been employed by a local power-generating plant, but had been given a 'warning' for poor performance and an 'unsatisfactory attitude' toward safety. When he thought that he was about to be sacked he attempted to sabotaged the power generator in order to "shut the place down", although he only succeeded in damaging some fuses. Nevertheless he was pleased with the attempt: "I certainly put a spanner in their works". He also began mailing items to various personnel, such as a packet of marshmallows sent to the chief engineer in order to remind him of a fire which had occurred several years earlier. Following this provocation the police charged Gordon with malicious damage. His family began "pestering" him to go to the local psychiatric hospital. He eventually agreed as he saw this as a way of avoiding the police charges. At the hospital he "invented" symptoms of schizophrenia:

> "I didn't feel right, but I didn't think I had schizophrenia. [Gordon believed he was "depressed" as a consequence of exposure to electro-magnetic radiation at the power plant.] They asked me if I was hearing voices and I said 'yes'. 'What were they saying?' — 'Oh, they're going to blow up the power station'. I wasn't hearing voices [but] they started to give me anti-psychotic medication and I didn't like it, it didn't do me any good, it was horrible stuff. I told them I'd made it all up just to be admitted and they wouldn't listen. They continued with the diagnosis of schizophrenia and the drugs."

In hospital he was given Modecate, which he claimed paralyzed one arm, caused his legs to "jiggle" uncontrollably, and led to severe insomnia. He thought he had been "deliberately damaged" in this way and his anger then turned against the hospital staff.

Out of hospital Gordon began taking medications which he believed would counter the effects of Modecate:

> "I was going from doctor to doctor and getting angrier and angrier. I found some medication. L-dopa is the opposite to Modecate [he believed that this would increase the levels of dopamine in his brain]. I thought the problem I had was caused through Modecate and I kept on getting the doctors to give me a trial dose of this L-dopa and ended up doing a thousand dollars damage to medical equipment at [a general] hospital because they laughed at me when I told them I hadn't slept for 6 months. I was furious."

His interest then turned to obtaining compensation from the power company for unfair dismissal. He started writing letters, "trying to get the workers to misbehave and do more things to the power station". A restraining order was issued against him, making it illegal for him to approach the company's equipment. He acted again to damage two electricity sub-stations, this time succeeding, but was arrested by police at the scene. After a court appearance he was placed on a custody order and returned to hospital. Again he "invented" psychiatric symptoms which he insisted to us he did not have:

> "I said I heard messages on the radio that they were going to blow up the power station.
> *Who were 'they'?*

> The workers, just 'they'. That's what I told the [psychiatrists].
> *So you were having a bit of a joke with them?*
> No, the doctor led me along. Because I had the bail agreement and all that and I had the [police] charges I figured she [the psychiatrist] was going to do what I wanted — make up an illness and get me off because I was justified in doing it. So she asked me if I was hearing voices and I said 'yes' ... I really didn't believe about mental illness much then and I figured that if someone was justified maybe the psychiatrist would go getting people off ...
> I got the medical reports four or five months later and it said it in there: 'auditory hallucinations'. I told them that I heard messages on the radio and then I tried to tell them that I'd made it all up, but they wouldn't listen."

Gordon was unrepentant concerning his actions. A newspaper report on the second incident (including a photograph of him in handcuffs) was displayed on his kitchen wall and he was pleased to give us copies. The article reported that 20,000 houses had been 'blacked-out' and that 2700 litres of oil drained from a transformer had leaked on to nearby roads at peak hour, creating a major traffic hazard. He particularly like the headline: 'I MADE MY POINT'. It confirmed for him that his actions and concerns had indeed been noticed, and that he had been taken account of as a person.

Gordon's account of these events pivoted on issues of personal power and autonomy, and how, in his view, each of these had been compromised by institutions (both the law and psychiatry). He began by painting a picture of himself as 'manipulating' the mental health system in order to avoid prosecution, but also to obtain accommodation by way of 'compensation' for the 'damage' which he had sustained. He knew that he had to present to the hospital with 'something wrong':

> "They generally don't admit you unless something is wrong. So I did that [i.e. sabotage the sub-stations], one, to get back at [the power company] and two, to get admitted into the mental health system because I didn't have anywhere to live and I thought my brain damage was caused by the Modecate and it was their fault and I was angry because they had deliberately done it to me."

But once he became involved with the hospital he felt himself being "led along". Eventually he was, in his terms, "trapped" by the system and its power to define him. His self-directed displays of agency were re-defined in terms of psychopathology. This was one of the major themes of Gordon's narrative: he had entered the psychiatric system for his own purposes, only to find that he could no longer leave or stop taking the medication. The agency which he had initially exercised in order to get into hospital had been transformed, in the same way that he had been ascribed a new identity as someone with schizophrenia.

CONTROLLING PERSONHOOD

Most participants, however, asserted that as persons they were more than just the object of psychiatry. They insisted that their experiences be interpreted, not in terms of psychopathology, but in terms of the tropic devices which they found most pertinent in grasping those experiences, together with the biographical contingencies which had shaped their own lives. Most participants rejected the 'totalizing' capacity of psychiatry to designate their identities and capacity for action. Psychiatry's myopia in this respect was highlighted by Aiden when he said:

> "Scientists are only interested in reducing phenomena to chemicals and atoms, and denying the person and their experiences. Psychiatrists won't allow us to believe that these experiences are real. They say they are delusions. According to psychiatry, I'm just a brain with a chemical imbalance. [But] I'm not just a bunch of chemicals, I'm a PERSON! [He went on to ask rhetorically:] What about love: is that a chemical reaction?"

In asserting that he was a 'person', Aiden invoked the various capacities in which he had interacted with us: as guide, informant and friend. We had seen him in a range of settings and circumstances, and knew him to perform a number of roles: son, brother, lover, writer and counsellor among them. Like anyone, he moved in and out of a variety of such roles (cf. Estroff 1989: 192). But these were not his principal concern. Aiden was not just a generic 'anybody', the centre of a quite ordinary 'role set' (see Merton 1957). He was a specific 'someone' who had experienced what psychiatrists called schizophrenia. It was this which was the focus of his identity and an impetus to his daily activities. This was why we had sought him out and this was what he was most eager for us to understand.

Aiden was like many other participants in being preoccupied with the meaning and implications of extraordinary experience for their lives and identities. Their agency was principally turned upon themselves: either as a strict self-management of their environment, relationships, emotions and bodies, or as an active interpretation and documentation of an experiential enclave.[7] From their perspective, the professional work of psychiatry was directed toward them as toward an object, making them its object (cf. van Praag 1992). Hence Aiden's articulation of what he surmised was psychiatry's view of him: "I'm just a brain with a chemical imbalance". From participants' perspectives, this work took on the character of what Garfinkel (1956) called 'status degradation ceremonies' in which the identity of an actor is 'transformed into something looked on as lower in the local scheme of social types', such identity being 'total' and referring not just to a person's performance, 'but to what the group holds to be the ultimate "grounds" or "reasons" for his performance' (ibid: 420), in this case, mental illness.[8]

In respect of their own experiences, however, participants' claimed ownership of the work of interpretation and identity formation (cf. Nugent 1997: 36-7). Given the often intense self-reflection directed toward them (see Chapter 5), these experiences appeared as both the primary subject and object of participants' lives; participants were, as a consequence, both subject and object to themselves.[9] Controlling this conjunction represented the type of control which many participants sought over the definition of their person. Shaun, for example, protested that he was rendered "invalid" by psychiatry when it "discredited" his

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[7] See Rogers (1998: 81-4), who employs Natanson's concept of 'enclave' to describe the experiential locus of the 'remission society' of cancer patients. Developed from Schutz's concept of 'finite provinces of meaning', Natanson proposed 'enclave' to describe a distinctive 'placement' in the world caused by an experience of 'otherness' which negates common sense. Rogers suggests that life-threatening illness dictates such a placement. An enclave circumscribes '... an intensity of experience concerning several provinces of meaning, a remembered, anticipated, imagined, or phantasied state of affairs *in which only the aspect of experience relevant to the enclave is attended to* while the rest ... is not only set at a distance but is apperceived as anonymous' (Natanson, cited in Rogers 1998: 81-2; emphasis added).

[8] See Laing (1967: 86, 101, 106), who also used Garfinkel's characterization to critique psychiatry.

[9] Fernandez (1986: 246ff), Jackson (1998: 7-8; 77) and others (see Crapanzano 1992: 70-90) have examined this dialectic of subject and object as 'practical and normal' in social life. Here I note, following Holzner (1978: 299-300), that the self-reflexivity associated with schizophrenia often had the effect of heightening the degree of subject-object interpenetration, as well as the social processes by which these categories were established and differentiated. This was exemplified in participants' self-consciousness of themselves as the objects of 'assaultive' experiences, and of diagnosis, or as centres of exceptionally sensitive subjectivities. Domínguez (1989) examines another example — the negotiation of Israeli 'ethnic' and national identity — in which this relationship is similarly heightened by reflexivity from within and without.

experiences as mere pathology.[10] He insisted that he knew as much about schizophrenia as the 'doctors' did because it was, in the most intimate way possible, who he was. He also insisted that this articulation (and the meanings which accrued to 'schizophrenia' as a consequence) "didn't count" in clinical constructions.[11] In the course of a PSE interview, Aiden similarly emphasized that the depth and pervasiveness of his experiences rendered any diagnosis inadequate: "I have such a deep understanding of them [i.e. his experiences] that it's hard to put a label on it". Shaun asserted that clinical constructions employed a reified and abstract knowledge which served only to place psychiatrists "on a pedestal":

> "By controlling knowledge they maintain a position of power over patients. This is written on all the walls [of the hospital]. You are placed in the [category of] invalid. But institutions don't possess your being."

Across this breach Shaun constructed his identity as an "outlaw" and a "dissident":

> "An outlaw identity — we've all got a bit of that and it's valued by society, but schizophrenics have it in abundance ... It doesn't take much to get a rebellion out of a schizophrenic. They're masterful at dissidence. So yeah, I'm a dissident, I love being a dissident. Although sometimes I give in, you know. I don't mind being socially controlled because everyone is anyway, you know."

Other participants similarly made the point that psychiatrists did not share their everyday experiences (in either ordinary or extraordinary modes); they were not present to each other except through a veil of authority which defined psychiatric knowledge as a professional and privileged domain.[12]

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[10] Cf. Corin and Lauzon (1994: 14) and Laing (1967: 101). Shaun used the adjectival form of 'invalid', although it would more properly be rendered as 'invalidated' since it always conveyed a sense of active placement: "I've been put in the [category of] invalid", he would say. This self-attribution expressly played on a slippage between 'invalid' (literally lacking in force, efficacy or power) and 'invalid' (a local synonym for an infirm or 'disabled' person). Several other participants on Disability Pensions made the same word play.

[11] Cf. Wilce Jr. (1995: 929, 946) on the devaluing of patients' accounts in the hermeneutics of medical diagnosis. Ware (1992) examines the 'delegitimation' which trivializes or dismisses subjective perceptions of illness in chronic fatigue syndrome. For Kleinman (1995) this is one side of a dual process in which medicine's disaffirmation of illness experiences as genuine and serious can intensify the delegitimation of experience which is wrought by illness itself — a prior 'existential' state in which personal and social efficacy is radically diminished, inhibiting experience's further growth or continued 'becoming'. Kleinman thus explores the *mutual* entailment of medical practices and of human 'suffering' in the delegitimation of experience, as exemplified in chronic pain.

[12] Cf. Desjarlais (1996b: 885) who noted that shelter residents 'tended to move in different circles, primarily because they were in a position distinct from, and defined in opposition to, that of the staff'.

QUALIFIED COMPLICITY: "SOMETIMES I GIVE IN"

As suggested by Shaun's comments on his occasionally "giving in" and being "socially controlled", alternate constructions of identity by psychiatrists and participants themselves were neither exclusive nor impermeable. Most participants displayed a capacity to merge them, or to replace one with the other, depending on the strategies appropriate to a given setting. Moreover, participants could move between these constructs, effecting contradictory stances between institutional incorporation and experiential distance. Thus, to identify as 'clients', 'consumers' or 'schizophrenics' afforded them ways to act and realize their aims in certain ways and circumstances: to work as a consumer advocate on state committees, or to obtain a public rental house, for example. But even these designations were not taken up uniformly. The majority of participants accepted them conditionally, either when they had no choice (as when visiting an out-patient clinic, for example), or when it suited their strategic purposes (such as accessing the resources of the mental health administration).

Some participants made graduated distinctions within their attributed 'schizophrenic' identity and insisted on a modified characterization of their 'condition'.

- Rachel, for example, distinguished herself from a category of persons she called "chronics": people she had seen in the street who were dishevelled, talking to themselves, lonely and "out of touch". Of herself she said:

  > "I'm only sub-chronic. I'm not all the way gone ... To me, a chronic is someone who is fully gone, just lost it, and there's no helping them or getting them back. It's someone who's gone too far into their delusions, there's no pulling back ... the illness has taken them too far. I'm only half way there."

- Kelvin similarly stated that he did not agree with his diagnosis of 'chronic schizophrenia' and that he had always thought of himself as "acute". He insisted that schizophrenia is not "all there is about me", since he only ever had episodic "attacks", and that there were other forces at play at other times.[13] Many participants employed this psychiatrically-derived distinction between

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[13] On the erasure of time from clinical constructions of the 'chronic schizophrenic' see Barrett (1996: 172; 297). In eschewing chronicity, Kelvin, like many other participants, insisted that biographical temporality be taken into account as a crucial medium of his identity (cf. Estroff 1989: 190; 1993). Harris (1989: 604) noted that it is only the temporal dimension of biography — a continuity of identity through time such that someone can be held responsible for their past actions — which affords the person moral ascription. Holland and Skinner (1997) similarly emphasize that agency and identity are necessarily the products of 'co-development' over (biographical) time.

> 'chronic' and 'acute' to distance themselves from the capacity of schizophrenia to pervade their person, as well as to distance themselves from others labelled 'chronic'.[14] In addition, Kelvin invoked alternate aspects of his identity when he said:
>
> "Chronic sounds like ... [he screws up his face and winds his hands around his ears, describing this enactment as a 'loony tune']. I may be a drug addict and an alcoholic, but I'm not chronic. Chronic has a certain edge. It means hearing voices all the time, [like] the ones they used to lock up many years ago."

Far from subverting the hegemony of positioning, however, such 'rhetorical moves' could be seen to replicate the hierarchies on which all such positions were based (that is, psychiatric prescription). They employed the language of psychiatry to shift a negative imputation elsewhere — in Kelvin's case, distancing himself from a characterization which he nevertheless employed to characterize others. In another ethnographic context (that of Newar untouchables in Nepal), Parish (1996) has commented on such processes of collusion and neutralization: '... those untouchables nominated by others as the lowest of the low often reject the honor, deny they are the lowest, and propose that someone else is still lower' (ibid: 204). Such strategies have the more generalized effect of replicating encompassing hierarchies:

> Stigmatizing others lends a semblance of value to self, gives one's life meaning by contrast ... To replicate oppression is to distance it — perhaps even to gain a kind of emotionally significant pseudo-power over it. The subordination of others reassures self, and implies a solidarity with those with power over the self. (Parish 1996: 205)

But such moves always remain incomplete (ibid: 204). Thus, lacking the clinical expertise and authority to designate schizophrenia in others, Kelvin could not replicate all of the institutional processes and positions of power by which the hierarchy of attributions was maintained.[15] He did not command a position with the power and resources to designate schizophrenia in others (or least, to have that designation count). Moreover, there is

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[14] Cf. Hannan (1990: 240): 'Neil's standing among his peers worsened when they believed that staff considered him to be "chronic". Once considered a talented, intelligent, young and interesting schizophrenic who wrote poetry and drew skilfully — and who had had only one admission to hospital — he began to be considered hopeless by his peers.'

[15] Cf. Wilce Jr. (1995: 944): 'Because of the inherent asymmetry in the practitioner-patient relationship, such authority to construct persons can never belong to the patient. In that sense labeling is the exclusive privilege of the practitioner.' Elsewhere in the same paper he noted: 'In the speech economy of doctor-patient relations, metacommunicative privileges such as the right to assign labels or evaluate processes are typically held by the doctor' (ibid: 929).

always ambiguity about who is lowest in the system — hence, in Kelvin's case, the imagined and historically distant in-patients of locked wards.

Other participants rejected psychiatric predications outright as either wrong or irrelevant. It was from this standpoint that they devoted the greater portion of their time to (and invested their identities in) activities which were not circumscribed by institutions in any obvious way: to writing and documenting, to painting, to philosophizing, to a range of contemplative, meditative and ascetic practices, or to fanciful planning (such as a 'raid' on the electronic banking system). Such activities avoided sanctions so long as they were confined to the privacy of participants' homes. This was the right and 'freedom' afforded all citizens (and explicitly extended to people with psychiatric illnesses under both national and state mental health policies), so long as such activities did not breech the law or threaten the 'public' good. Indeed, it was only in the privacy of their homes that participants could safely contemplate and seek to effect an agency which rejected or confounded those forms of agency which were socially sanctioned within the field.

Claims by the psychiatric profession to both totalize and comprehend (see Barrett 1996: 105-6) were thus forcibly contested. This contestation highlighted 'the distance[s], the gaps, the asymmetries between the various specific forces that confront one another' and gave the field its own distinctive dynamic, rendering it also a 'field of struggles' (Bourdieu & Wacquant 1992: 101).

STRATEGIES OF INVOLVEMENT, COLLUSION AND UNDERSTANDING

The previous chapter examined some of the principal institutional structures which constituted the local field of mental health. These structures — legal, governmental and bureaucratic — circumscribed roles for both researchers and participants in the present study. Here I examine the forms of agency and the types of identities which were constituted for participants and researchers alike by the research process itself.

That participants would disclose information to us in an attempt to have us 'understand' them was a palpable demonstration of their desire for intersubjectivity and a confirmation of the relationships which we had entered into for this purpose (see Chapter 2), but it was also a strategy which must be read against a background of not being able to control, *on their own terms*, the processes of understanding and meaning-making which took place in various other contexts. Many participants had attempted to exercise some measure of control over the interpretation of their experiences by refusing to divulge information to other family members and psychiatrists. Juggling these processes of disclosure — and moving strategically between them — was a major component of participants' everyday lives and a principal expression of their agency.

EVINCING AGENCY THROUGH INVOLVEMENT IN THE RESEARCH PROJECT

As researchers based in a university department of psychiatry we were already positioned at the pre-eminent historical site for the production of knowledge about schizophrenia (Barrett 1996: 178, 204). Just as 'researcher' was a recognizable role imposed by the institutional conjuncture of university and hospital, all participants had previously been cast (by hospital admission procedures and professional psychiatric practice) as 'informants' and 'research subjects'. Like 'patient' or 'client', these were positions generated by the field itself, participants' experiences (as examples of psychopatholgy) being a specific form of capital which conferred a 'quantum of social force' in the struggle to define and treat schizophrenia (cf. Bourdieu & Wacquant 1992: 229-30). All participants were accustomed to having details of their lives and illnesses recorded whenever they approached hospitals or government agencies[16], and several had been involved in other research projects conducted by clinicians.

The state's recent 'realignment' of mental health had also rendered the university an explicit 'stakeholder' in the delivery of psychiatric services. Since the university department from which the researchers worked was located in a general hospital with a psychiatric ward (where several participants had been patients at various times in the past and to which two were admitted during the course of the project), we could also be construed as representatives of the institutional forces which had the power to define and confine people with schizophrenia. That we should travel to homes in the suburbs was not so unusual in an era of deinstitutionalization, with its community nurses and mobile treatment teams. One participant clearly understood our role in these terms: he would persistently address Megan and I as 'nurse', despite our explanations to the contrary. For others, it was equally important that we were distinguished from such personnel. Arriving at Shaun's flat one day he ushered us in furtively and proceeded to tell us about how he had, earlier that morning, refused entry to the community nurse who had come to give him a 'depot shot' (an intramuscular injection of anti-psychotic medication). He was now awaiting the punitive repercussions of this (as he saw it) act of defiance against the state. Our entry, and the nurse's exclusion, were significant markers of our relationship. He couched that relationship in terms of collusion: he let us know that we had a privileged entrée to his home and to the 'core' of his belief system (which he did not disclose during a PSE conducted for this same project, for example), whereas he resisted what he saw as the intrusion of 'professional' representatives of the health care system. For reasons of his own, Shaun was prepared to work with us precisely because, in his eyes, we were not clinicians. Other players in this field, such as clinicians themselves, likewise never identified Megan and I as psychiatric professionals.

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[16] On the integration of ethnography, history and biography in the production of medical case records see Epstein (1995: 57-75).

The participation by participants in the study, like the participation of the researchers, was rarely disinterested. It became clear that most people's purpose for engaging with us was to convince us (and therefore others) of the 'reality' of their experiences, and in turn, to have their own interpretations validated and authorised by academic interest — that is, to have their knowledge and appreciation of these phenomena rendered a legitimate part of the field (see also Chapter 6). Many participants saw the research project itself as a vehicle for exploring their capacity to interpret the ('real') situation at hand, and to have themselves interpreted in the light of that capacity. They sought, as Corin and Lauzon's (1994: 33) 'non-rehospitalized patients' did, to 'position themselves as a credible source of self evaluation'. This is a capacity which Taylor (1985a: 271) has identified as a fundamental attribute of agency and, consequently, of being a person.

It was the imperative to have themselves interpreted as engaging in meaningful action in respect of their experiences that prompted some participants to offer elaborate 'explanations' of their actions and beliefs. It was why they were eager to present tangible 'proof' (in the form of video tapes, television viewing, or excursions to the shopping mall) in order to convince us. It was why being in their own homes — as the everyday setting for their lives — was so important to an appreciation of their experiences. The proffering of examples and demonstrations in their relevant settings was a key expression of participants' agency, and entailed reciprocal actions on our part: to acknowledge, witness and debate the experiences which they associated with schizophrenia, to engage with them seriously, and to 'understand' them to the best of our ability. We were assigned various roles in this process — as sounding board, confidant, witness, counsellor, co-interpreter and translator — which we were not necessarily aware of at the time.[17] We made it known that we were committed to an analysis of schizophrenia which went beyond the confines of medical research to focus on those things which participants themselves valued

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[17] See Favret-Saada (1990: 189) on the contingent nature of fieldwork and the arbitrariness of personal positioning without plan or control.

the most, namely meanings and subjective interpretations. People consistently said that they were willing to talk to us because we were sympathetic and non-judgmental. These were not idle compliments or forms of ingratiation, but entailed an implicit contract to make available the knowledge so gleaned in ways which respected the circumstances and conditions of its production. Many participants saw (and some argued explicitly) that to have their views recorded in a sympathetic way meant that schizophrenia might also be represented in new ways, and that these representations could have novel effects in the wider society. It was obvious that we had access to resources — equipment, audiences, professional language, cultural and symbolic capital — that they did not. Participants knew that we would present what we had learnt from them in forums such as seminars and public talks (some participants were even present for these), in publications, and in this dissertation. In this lay the hope that such knowledge could potentially change the stakes in a field of power in which participants knew themselves to be relatively powerless.

Engagement in the research process was thus a strategy of its own, one which embodied identity and the capacity for agency. It was also a strategy which was structured by the forces at play in the field itself, where definitions and treatment regimens had been in flux for at least the past century and where people had a stake in having them changed. Institutional realignment, deinstitutionalization and consumer advocacy meant that during the period of fieldwork there was potentially more to be gained by challenging established discourses of 'mental illness' and its associated identities than ever before.

CIRCUMVENTING 'MISRECOGNITION' AND THE DIMINUTION OF AGENCY

Participation in the research project highlighted the diminished sense of agency which some participants said had occurred in interactions with those institutions and professions whose rhetoric and ideology otherwise espoused its promotion. Many participants contrasted their involvement with us with the pervasively dismissive stance which they said characterized their interactions with psychiatrists, other clinical staff, or social workers. Most reported a history of having had their experiences treated as 'sick' or delusional and their beliefs disparaged as false or (at best) misguided. Shaun, in a typically metaphoric style, pointed out some of the wider ramifications of such depreciation when commenting on the effects of drug treatment:

> "It's like a woodchopper working at the base of you — cutting half way — sort of lopping off half of your self. You know, I don't want that. You want the continuation of your existential self. It's far preferable to having aspects of your personality or your history being lopped off. It's like a big notation mark — a sort of semi colon, but you didn't ask that someone put it there, you know? Someone's notating your handwriting, or if you're writing a novel, someone's editing it for you. A state censor, you know? I mean, if you're writing a novel you wouldn't want a state censor suddenly start putting in punctuation ... or ripping out pages.
> *So you're talking about notions of ownership and control?*
> Yeah, of the self, you know? Of your own being."

Aiden similarly protested the refusal to acknowledge that his experiences had value.[18] Aiden saw this process, in itself, as detrimental: to be treated only as "sick" made him "sick". On one occasion he reported a hostile meeting which had taken place the previous day, during which his private psychiatrist had dismissed him as being "just another schizophrenic". Aiden denied this emphatically; the psychiatrist responded with the assertion that Aiden "lacked insight".[19] Aiden said that he had previously believed he had schizophrenia only because he followed the advice of his "doctors", but now he refused the "total alienation of the disease concept" and had come to accept what psychiatrists called schizophrenia as part of himself, his beliefs and his reality.[20] That is, he had conflated schizophrenia with his person while at the same time eschewing the meanings

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[18] That is, to treat his experience as a form of capital: a source of power and influence which was efficacious and of stake in the field (see Bourdieu & Wacquant 1992: 98). This too was a misrecognition on Aiden's part: his experiences supported a diagnosis of schizophrenia (and validated his psychiatrist's skill in diagnosing it), thereby confirming the capital which psychiatry possessed by way of being able to designate certain experiences as pathological.

[19] It was Aiden's insistence on his own interpretations of experience which confirmed his 'lack of insight' and this in turn ratified and perpetuated the diagnosis of his schizophrenia; he, however, rejected this tautology. On the centrality of notions of 'insight' to the definition of psychosis, in particular, see the papers collected in Amador and David, eds (1998).

[20] Walton (1996: 63), writing of the participants in her New Zealand study, noted: 'They avoid dwelling with their illness or in the past, yet ... continue on with life in the light of the understanding they have from those experiences, which are part of who they are in the world. It is not only the participants themselves who must let go; in their experience they also find that family and health professionals must learn to accept them as no longer unwell, and to let go of the 'patient' or 'sick' ways in which they were previously known.'

and attributions of identity which were entailed in the psychiatric designation. He was upset that he had gone to the psychiatrist feeling "quite well" and had came away feeling "unwell" because his own interpretation of "what was going on" had been questioned and disparaged. This, according to Aiden, was the problem with psychiatry as a clinical practice: it created an illness state out of people's difficult or unusual experiences.

Such accounts resonate with what Bourdieu (1977: 191) has described as 'symbolic violence': censored, euphemized, misrecognized forms which effect domination through 'enchanted relationships' which are socially validated and confer legitimate authority (his example being relationships between kin; here the analogy suggests the relationship between 'patient' and 'doctor'). In engaging with us, some participants sought explicitly to circumvent what they saw as the institutional 'misrecognition' and misrepresentation of their experiences. To us they asserted their capacity to be agents of their own experience — that is, to purposely seek out extraordinary experiences if they wanted to[21], to interpret them within frameworks of their own choosing and to structure their beliefs and daily lives around them. One of the most obvious ways to take this sort of control was to deny the categorization and interpretations which had been placed on their experiences in institutional settings. Participants' assessments of what had been excluded from psychiatric view — causes, biographical referents, belief systems — were largely confirmed by a reading of case notes, which typically failed to record the content (let alone the personal meaning) of 'hearing voices' or 'delusional beliefs'.[22]

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[21] As, for example, Aiden did periodically when he stopped taking medication in order to (as he said) "re-connect" with his experience of the 'Ethereal Plain'.

[22] Case records are constructed in accordance with international classifications (DSM and ICD) which confer validity on the category 'schizophrenia' (see Boyle 1990: 76-7). Mishara (1994) has detailed the epistemological bases which determine that such schemas systematically eschew the issue of subjectivity, both as an analytic concept and as an experience which is manifest in the person exhibiting mental disorder. See also van Praag (1992), Keitel (1989: 31), Epstein (1995: 54-5) and Corin and Lauzon (1994: 4).

STRATEGIC COLLUSION

Participants' commitment to and investment in the research project reflected the strategic aspect of any field which Bourdieu has characterized in terms of a 'game' (Bourdieu & Wacquant 1992: 98).[23] There were 'stakes' involved, and I have already indicated how high these were for people who believed that they could be incarcerated for their beliefs and experiences. There was also 'investment', whereby players were taken in by the game. Thus, several participants had (literally) invested heavily in both time and money trying to 'prove' the reality which they saw expressed in and through their experiences. Anne had spent her life savings in various attempts to have her beliefs about irregularities in the Australian electoral system verified. At the time of our first meeting with Tony he was spending sixteen hours a day on his research into the effects of electrical phenomena on his body, together with a computerized investigation of numerical sequences encoded in various texts; he had previously engaged in an extensive recording of his experiences on video tape, copies of which he had sent to various psychiatrists and to national media outlets. Thus, a number of participants were actively involved in various projects of their own devising which had the general aim of having their experiences taken notice of, and thereby taken into account.

According to Bourdieu, even the opposition between players is predicated on 'the extent that they concur in their belief (*doxa*) in the game and its stakes' and believe that it is worth playing (Bourdieu & Wacquant 1992: 98). For clinicians and participants alike, schizophrenia was serious indeed, either as a 'chronic' disease state or as the embodiment of a perplexing and inaccessible subjectivity. Some participants apprehended it as an extreme existential potentiality, an expression of the "ultimate truth" of human Being, or a heightened awareness of what it meant to be "in reality". Both participants and clinicians

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[23] This is not to imply the strategizing individualism of symbolic interactionism. Bourdieu emphasizes that a field is 'not the product of a deliberate act of creation' (Bourdieu & Wacquant 1992: 98), that it contains forces of power and misrecognition ('symbolic violence') which players are not necessarily aware of: 'A field is a game devoid of inventor and much more fluid and complex than any game that one might ever design' (ibid: 104).

concurred on schizophrenia's capacity to disrupt perception, emotional stability and everyday life. The appreciation of schizophrenia as a category worth fighting over was itself an expression of participants' agency in this field.

Some element of collusion is also required as the very basis of competition within a field. Taking up the options and vehicles of agency provided by dominant institutions was of value to some participants in altering their circumstances and, ultimately, in changing how they were viewed and treated.[24] Thus, Jimmy expressed his pleasure at having obtained a rental house in the centre of the city, one which afforded him easy access to public transport and all of the facilities that he needed; he said: "I would've had to work twenty years to get a house like this, but I've got it through the government". He acknowledged that his acceptance of "the system" entailed some personal restraints which he was willing to observe:

> "Being is hospital is very boring. People look for subversive things to do, like drinking in the pub. I try to stay away from alcohol and drugs. I want to give the doctors their best shot."

Oscar articulated the seemingly contradictory stances of opposition and collusion which he had 'played on' in order to obtain his present home (which simultaneously afforded him distance from psychiatric surveillance):

> "I could see my life disappearing down the spout. I'd been jumped on, I'd been locked up, I'd been force-fed medication ... Unless I came into contact with people who were prepared to report my behaviour as strange to the police ... I tended to avoid [the state psychiatric hospital] completely. When I heard about this rehabilitation in the community I thought that [it] might suit me. It's something that's an option I prefer. It works for some people and not for others, but I've been patient and I've been prepared to play a certain part of the system's game — getting letters of recommendation, getting a place [his present house]. It's a question of residence. It's a very important factor ... given some of the crap-holes I've lived in."

As Huizinga has noted (1970: 32), playing a game is always a 'contest *for* something' as well as 'a representation *of* something'. Sometimes it entailed 'giving in' and colluding

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[24] Hence I also distinguish this analysis from earlier 'labelling theories' which focused on the imposition of a false and stigmatizing identity upon the 'patient' — see Scheff (1966) and Waxler (1980). Participants in the present study attested to the ways in which conceding to the power of psychiatric ascription was a valuable resource in certain circumstances.

with those forces which otherwise appeared to dominate and oppress. Strategizing thus highlighted the dialectic by which 'consensual submission is accomplished in and through conflict', and any straightforward distinction between conflict and consensus is abolished (Bourdieu 1990b: 41).

To raise the issue of 'strategy' in this way is not to romanticise the individual with schizophrenia, or to champion his or her resistance (as popular versions of anti-psychiatry have done), for as this perspective derived from Bourdieu suggests, such strategizing is intrinsic to a field. To strategize, resist, or collude were expressions and capacities of personhood generated by the field itself.

INDETERMINATE EXPERIENCE AS A 'SPECIES OF CAPITAL'

The analogy with a 'game' also admits of 'trump cards': 'master cards whose force varies depending on the game', and whose relative value may represent 'different species of capital (economic, social, cultural, symbolic)' (Bourdieu & Wacquant 1992: 98). Participants' extraordinary experiences could operate in this way. They were phenomena (such as 'voices' or 'delusions') which had the power to transform a person's sense of self and the world, and which instigated the attention and work of psychiatry. Yet it was precisely in this way that the same experiences could be subject to very different forces, just as they were constituted by divergent meanings. As 'symptoms' they confirmed the knowledge and power of the psychiatric diagnostician to discern mental illness, but they also resisted easy classification and remained largely inaccessible to anyone who has not had schizophrenia (see Chapter 7). As idiosyncratic experience, they encapsulated a form of indeterminate knowledge which participants alone possessed, which they could flourish, or to which they could retreat in defiance of the institutional forces at work in this field. Here I examine indeterminacy as an option which participants could use to escape the dominant predications which institutions made upon persons in this field.

In their study of the French university hospital, Jamous and Peloille (1970) stress the central role of 'indetermination' in constituting the identity and power of a profession. In their usage the term covers forms of knowledge and material practices which escape codification in the form of rules, formal instructions or rational codes. Such indetermination allows the agents of an activity to make use of its 'qualities' to monopolise a field and to avoid intervention and reappraisal from outside (ibid: 117). In medical care this was achieved by clinicians' emphasis on individual and social potentialities, experience, talent and intuition, all of which they themselves defined and controlled, and which were evaluated on the basis of qualities they alone possessed (ibid: 139; see also Weiss 1997: 293-4). Barrett (1996: 46-7) has demonstrated the role of indeterminate knowledge (in the form of clinical judgement, acumen, intuition, 'psychological mindedness', and a 'sixth sense') in maintaining psychiatry's dominance of a multi-disciplinary treatment team. More generally, Bourdieu (1990b: 133) has argued that the 'openness' of any field is constituted by degrees of indeterminacy, 'vagueness' and 'semantic elasticity' which are the result of its 'interchangeable' components and their changing meaning over time. Such indeterminacy is the symbolic space which renders any field a site of struggle:

> This objective element of uncertainty ... provides a basis for the plurality of visions of the world which is itself linked to the plurality of points of view [available within a field]. At the same time, it provides a base for symbolic struggles over the power to produce and to impose the legitimate vision of the world. (Bourdieu 1990b: 133)

Such indeterminacy was equally a resource on which participants could draw in order to comply with or resist dominant forces in the field, or both at different times or in alternate settings. They did this by emphasizing alternate formulations and interpretations of what 'schizophrenia' meant. In stressing the indeterminacy of their experiences many participants defied psychiatric claims to classify, evaluate, sanction and control them.

I noted, earlier in this chapter, that the experiences associated with schizophrenia were acknowledged by psychiatry and participants alike, but that they could be construed in very different ways. This was facilitated by their indeterminacy. There was no reason to impute a 'mythic' or imaginary quality to these experiences, as having been created as an epiphenomenon of institutions themselves, as has been suggested by some readings of Szasz (1962), for example. These phenomena were indisputably real insofar as they constituted 'relations of force' (Bourdieu & Wacquant 1992: 103) which jointly engaged doctors and patients in a struggle to define them, and provided the vehicle by which occupants of positions ('patients', 'psychiatrists') sought, individually or collectively, to 'safeguard or improve their position and to impose the principle of hierarchization most favourable to their own products' (ibid: 101). It was the interpretation of these experiences which was fought over, not the fact of their occurrence: most participants saw them as devalued by being rendered mere examples of psychopathology and attempted to elevate them and broaden their meaning through tropic appropriations of (in particular) religion, philosophy and humanism. In claiming authority for their interpretations, participants sought to favour their own knowledge (and themselves as persons capable of such interpretation) within the hierarchies which generated and were generated by the field.

Not only were these experiences real to participants, they had real effects on both other people and institutions. They provided the material on which clinicians exercised the power of diagnosis and accrued to themselves the authority, prestige and distinction of being skilled diagnosticians. They conferred positions within the field insofar as they provided principles of, and a justification for, differentiation (sane/not sane) or distribution (in hospital/in the community), and were contested as such:

> The categories of perception, the schemata of classification, that is, essentially, the words, the names which construct social reality as much as they express it, are the stake *par excellence* of political struggle, which is a struggle to impose the legitimate principle of vision and division …
> (Bourdieu 1990b: 134)

It was the socially constituted 'reality' of these phenomena that had transformed the field by re-defining what were the significant categories, perceptions and 'methods of objectification' (Bourdieu 1985: 730) which pertained to the treatment schizophrenia in 'the community'.

THE AUTHORITY OF EXTRAORDINARY EXPERIENCE

It was their extraordinary experiences which allowed participants to declare themselves experts and authorities on what it was "really like" to live with schizophrenia — something which, they said, only they could know. Such experiences were, I suggest, a 'species of capital' which 'allows its possessors to wield a power, an influence, and thus to *exist*, in the field under consideration, instead of being a negligible quantity' (Bourdieu & Wacquant 1992: 98; original emphasis). They represented both a weapon and a stake in the field. They were the 'tokens' of a game by which participants sought to change 'the exchange rate between various species of capital, through strategies aimed at discrediting the form of capital upon which the force of their opponents rests … and to valorize the species of capital they preferentially possess' (ibid: 99). What participants alone possessed was an intimate, experiential knowledge of phenomena which were extremely difficult to understand and convey: this was their uniqueness, conferring uniqueness and indeterminacy on those who could claim such experiences as their own. Given the right setting (such as this research project, a protest meeting, or a community arts exhibition), this indeterminacy could be wielded in order to discredit, or at least disarm, psychiatry's claim to an exclusive, authoritative pronouncement on the status of both those experiences and the persons who had them. Such indeterminacy provided at least the possibility of alternate bases for the validation and valorization of participants' experiences.

This image of a 'stake' in the play of forces within a field also suggests a reason why participants' sense of themselves as certain kinds of persons — marginalized, anomalous, but also unique and powerful — was so heavily invested in their experiences. Participants knew that their experiences solicited wider interest and concern. They knew that this was why we had come to see them and sought their participation in the research project. Our very approach acknowledged that they had something of value: a form of symbolic capital which had the power to draw others to them and to effect an engagement which reinforced their sense of personhood.

POWER, CHOICE AND INDIVIDUALITY: THE STRUCTURED CONTRADICTIONS OF IDENTITY

From the perspective of their homes, especially those living by themselves, participants' ability to consume freely of almost anything (including psychiatric services) was severely curtailed by a lack of material resources and the absence of any real instrumental power. Their publicly acknowledged right to be consumers could be realized only within very strict limits. During the period of fieldwork, a Disability Support Pension paid them (approximately) AUS$360 a fortnight. For those residing in public housing, $70-80 a fortnight would go in rent, leaving them with something like $140 a week with which to buy food, clothe themselves, pay utility bills (heating, telephone and electricity), and pursue any recreational interests they might have (such as the purchase of art materials). The fact that some people spent more than $50 a week on tobacco or cigarettes meant that they had less than $100 a week to cover all of their living expenses. In some circumstances, participants' financial means barely stretched beyond providing accommodation and feeding themselves until the next fortnightly cheque arrived.

The plethora of images which transformed Zöe's living room into a shrine were either found (torn from magazines or photocopied in the public library), appropriated (images of Krishna obtained from incense packets), or her own creation (drawn, painted and embroidered). Clothes, furniture, domestic appliances, televisions and stereos and were all usually obtained second-hand (when they were not gifts from family or resourceful friends). When equipment broke down it often could not be repaired: Shaun's stereo was borrowed from his sister, but it had "blown a fuse" and he could not afford to have it fixed; nor could he return it to her in that condition. Shaun also highlighted the stringencies of his everyday existence:

> "I have less than $200 a fortnight left after I pay the rent. Say winter is coming. I could go to town and buy a jumper, a pair of jeans and have a haircut and there would be nothing left to live on for the next week and a half. I've done it a couple of times and come home absolutely panicked, wondering what I am going to do. But I survive, I don't know how."

Oscar was beset by similar limitations, which he attempted to aestheticize:

> "I'm restricted now because I don't have money, but, for my day to day living I try to make things an art form. Like the moonstone cufflinks I found for a song the other day. I hunt around the op-shops — books, music, literature, jewellery — I try to do it all on the cheap … I can't afford new clothes. I buy my underwear new, my socks new and my shoes new, but everything else is second-hand."

Oscar's week could be mapped out according to the places which fulfilled his needs in the cheapest manner possible: the local bakery which supplied him with day-old bread free of charge; the charity which provided what was often the only substantial meal of his day; and the second-hand stores whose stock he would constantly survey, waiting for a book or a vinyl record which took his fancy. Sometimes he would purchase an item for the expressed purpose of exchanging it among a small network of friends for a conversation, a cup of coffee, or a meal. He talked, for example, about obtaining some pieces of china which were not to his liking — "I'm a blue willow man myself", he said — but he took them to a friend and got a glass of scotch whiskey in return. He gave another friend a book (which he had purchased for 50¢ in an opportunity shop) and got a schnitzel dinner in return: Oscar offered this as an example of how he sometimes made a 'profit' on such exchanges. Or he would draw on his educational background to provide help to others, with the expectation that, at some future time, they in turn might be in a position to help him:

> "Within my personal life I operate in the New Guinea Big Man system … I didn't set out to make that my system, but I think [that] I started to live a certain way and then I realized that it fits a certain system… As I understand the New Guinea Big Man system, it's not the man with the most number of pigs, it's the influence which he gets from having the pigs go through him. So, if I am given something which might not be valuable, I'll give it to somebody else who might regard it as something quite valuable. Or, if somebody wants documentation interpreted — they know I am an Arts graduate, and I can help them … On pay days I'll go to St Vincent de Paul … for my pie with gravy, mashed potato and carrots. People might come up to me and say, 'What's this mean?' They lack the education to understand documentation that's given to them, if they have only been to Grade 7. I know a few people like that. Life hasn't been very kind to them. So, I'm in a position to help them, and sometimes, then, they are in a position to help me. So there's a flow through. It's reciprocal in some ways… While I haven't got any money and while I am marginalized [this] system suits me just fine."

For Oscar, these various strategies were not simply economic transactions: they were, as he said, a source of interaction which alleviated his loneliness, turning economic necessity into a social value in its own right:

> "Not only is it a form of social exchange, it helps me because … it's a form of social interaction. I not only get to go for a walk, but I also get a conversation, and this is the way I make a profit. This is my Big Man system. I get a walk, I get a social interaction. I can't afford to go to a dance or anything like that, so I get a social interaction that's free. I probably get a cup of tea, and that's how ruthless I can be. Inevitably, something will flow through me or come back through me that is something I want."

The element of choice which is implicit in the ideology of consumerism was often replaced by contingency. Daily life for many participants was dictated by the chance contingencies of luck, a gift, or a small windfall. Finding a "real bargain" at the opportunity shop, or artists' materials at a clearance sale, or receiving a smaller than expected bill for utilities were all occasions for joy. People's choices were largely constrained by their economic circumstances. So too was the power they had to shape those circumstances, change their lifestyle, or influence the way in which others perceived them.

In this respect, participants were no different from the many other people who lived on low incomes or received financial support from the state. What they did have access to, however, was a diagnosis of schizophrenia which could be used to effect changes, however minimal, in their material circumstances. For example, it gave them some priority in the allocation of public housing. When one of the state's psychiatric hospitals was closed down in the early 1990s, Nick and his elderly mother wished to move closer to the out-patient facilities which were located on another hospital campus. Without a car, gaining access to these facilities would have entailed several bus trips on each visit. As residents of public housing they could have expected to wait up to a year for a transfer, but with Nick's diagnosis (and his corresponding claim on institutional and state resources) their move to a new house was completed within weeks. A diagnosis of schizophrenia also gave participants access, should they choose to exercise it, to social workers who were expert in the area of 'community living'. It afforded them the right to specialist help in their own homes or in the conduct of such everyday tasks as shopping. Zöe had obtained access to special 'mental health' funding which allowed her to frame her artworks and hang her solo exhibition. These were just some of the ways in which the power of a psychiatric diagnosis had facilitated specific types of action — a power to which participants had access should they choose to exercise the appropriate strategies and identifications.

As with their ability to consume material goods however, participants' capacities to choose or control access to psychiatric services were also severely curtailed. The conflation of these two fields — the market and medicine — around the idea of consumption was highlighted by Aiden when he noted in his journal: 'The mental health system is much like any other industry, they sell their product (at extremely high prices), counsel you how to use it and make you addicted to their mind-altering drugs'. A certain lack of choice was configured by the health and welfare systems of which participants were a part. Some, such as Shaun, articulated a critique of this systemic effect, but most focused only on the powerlessness which they said flowed directly from their inability to control the interpretation and treatment of their 'illness'.

In the face of institutional forces with the power to shape their lives, a private home, an indeterminate experiential domain, and a capacity to elaborate personal meanings were privileged sources for the construction of identity and the exercise of self-directed agency. Aiden, for example, was outraged when his community nurse contacted the 'key worker' who cleaned his house, requesting that the latter no longer talk to him about spirituality (which the nurse believed was perpetuating a delusional belief system and increasing the symptoms of his mental illness). Aiden's outrage focused on his assertion that the nurse "had no right to dictate what our private conversations were about". In his journal of the time, Aiden reflected on his power to affect the situation, his rights, and the essential contradictions which followed from them:

> That night I decided that when I saw [the community nurse] the following day I would confront her and finally resolve the whole thing. So this morning when she came to take me to [the Department of] Community Services I talked to her and found out she is just another member of a corrupt mental-health system. We had a long conversation about the rights of those who are convinced they are not mentally ill and their right to think and believe what ever they want. When I told her that I didn't believe I was schizophrenic she became angry and even aggressive toward me, just like my Doctor did several weeks before. It seems to me that these people really don't like to lose their power over us by taking away their most effective means of controlling our lives. They label you with Schizophrenia ... and then control your entire reality by convincing you that all your personal beliefs that oppose theirs are delusional... It is my experience that if we deny that we are mad the doctor tells us that we are and if we agree with him ... we are not. [We are told that] whatever we believe to be reality is in fact the opposite of reality and consequently our minds and beliefs in our own reality are under their control. They seem to want to put people they can't understand into a box which they label as madness, lock them in there and then leave them to it. Even after being in there for a long time and becoming completely normal they still keep them in there and never allow them to escape their little trap ... It seems to me that these people are actually puppets of a system which seeks to control every aspect of human life, including our hearts and minds!

Aiden went on in his journal to reflect on how even this expression of his anger could be encompassed by psychiatric categories:

> This might seem to be quite paranoid and it is true that people who are classified as being Schizophrenic are told that this is a delusion of persecution. However it also seems quite obvious to anyone who has been through the experience that we are the most persecuted minority in all society. Not only do they enforce their own beliefs upon us that we are mad and then persecute us for it, but they turn around and deny they are doing it.

The only site at which Aiden felt he had control over his own reality was in 'private' conversations (a classification which excluded treating personnel) conducted in his own home. It was only in such a setting that his 'heart and mind' were afforded free expression and he could claim a sense of his own agency.

What Aiden also articulated here — and what was voiced by many other participants as well — was the conflict and competition which Bourdieu identifies as a field of power: here expressed as conflict over the capacity to name and treat an illness, and what that naming and treating means for everyday existence.[25] The location and circumstances of participants' everyday lives highlighted the competition between medical authority in the clinic and experiential authority in the home. It was in their own homes, and on the basis of their often hard-won identities, that participants conducted a battle over what species of knowledge (scientific, religious, existential) or what cultural capital (diagnosis, care, belief) was most effective in organizing the field.

Participants were acutely aware of, and able to strategize over, their positioning as clients or consumers of mental health services. But these positions within a field dominated by psychiatric institutions did not constitute the totality of their identities. From participants' perspectives, their selves existed as authentic entities apart from their presentation to (and by) psychiatry. Similarly, they represented their minds as their own place of dwelling and contemplation, rather than as objects which could be judged from someone else's perspective.[26] The meanings they attached to their lives were not wholly encompassed by

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[25] Cf. Bourdieu (1985: 729; original emphasis): '... one of the elementary forms of political power ... consist[s] in the quasi-magical power to *name* and to make-exist by virtue of naming'.

[26] In both these dimensions — their 'authentic' selves and their sovereign minds — participants contradicted Goffman's (1959) account of the social presentation of self as a management of impressions which depends on the agreement of others: 'The self ... 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' (ibid: 252-3). Being credited or discredited was the focus of participants' strategizing, but they rejected psychiatry's domination of the criteria for judgement. To focus only on the 'dramatic effect' of their presentation to (and by) psychiatry would privilege only an institutional view, rendering participants' asserted inner experiences inauthentic and 'delusional'.

the positions which were attributed to them by those institutions which dominated the field: 'angels', 'devils', 'prophets' and 'seers' (or even the more mundane 'artist' and 'philosopher') were not identities which could be legitimated by psychiatry, yet they were central to how some people understood and conducted themselves day-to-day — that is, to how they acted as agents of their own lives and experts in their own subjectivities.

In part, these identities relied upon a recourse to other fields which were already implicated in the field of schizophrenia, religion and art being prominent examples.[27] This did not mean that participants were readily accommodated in these alternate settings: their philosophizing frequently lacked a scholarly context, they did not exhibit their art work, or they failed to comply with the strictures and hierarchies which defined authoritative knowledge in a particular field (questioning Christian doctrine or demanding a broad syncretism of beliefs, for example). Even when they did find an alternate arena in which to operate, they did not necessarily escape psychiatric dominance:

- Despite his highly idiosyncratic interpretations of the Bible, Gerald was a member of a mainstream church congregation and attended a regular 'Bible study' group. He had not divulged his interpretation of the Book of Revelations to this group, although he had discussed some of his concerns with the minister. In another context and quite by chance I met this minister. We got to discussing the relationship between religion and schizophrenia and it soon became clear, without either of us disclosing his identity, that we were both talking with Gerald in mind. The minister admitted his incapacity to deal with such 'cases'. He spoke of his pastoral role in supporting people like Gerald, but also of 'shepherding' them toward what he saw as more 'appropriate' sources of professional care, treatment and advice. In the minister's view, Gerald was clearly 'misguided', through no fault of his own. It was this 'reality' of mental illness — as an expression of unreality — which elicited the minister's resigned compassion.

  Thus, the issue of Gerald's beliefs was referred back to psychiatry as the only legitimate way of encapsulating his identity and knowledge claims. This highlighted for me the hegemony which psychiatry maintained across the various institutions which were encompassed by the field of schizophrenia.

Other participants did not seek such institutional accommodations — some having tried and failed in the past; others never having had the opportunity. Instead, they asserted a transcendence of the field itself, in the sense that Fernandez (1986: 239ff) derives from

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[27] Here emphasizing again that despite the dominance of psychiatry, the field of schizophrenia was not totalizing, but open and emergent — see Chapter 3.

Emerson.[28] Thus, it did not matter to Gerald how the church (or its representative) responded to his claims, just as it did not matter whether Megan and I accepted the 'revelation' of his identity as a prophet and an "Angel of the Apocalypse" (see Chapter 6). Given his 'emotional conviction' (ibid: 243) to the 'truth' of his own experiences, concurrence and confirmation were beside the point. The interpretation he offered of his experiences transcended the distinctions (as between pathology and religion, for example) which were dominant in the field. He appeared like those 'enraptured' individuals — one an African hunter, the other a Spanish mountain herdsman — described by Fernandez (ibid: 245-6), whose 'transcendent' lifestyles for the most part removed them from social life and whose experiences, when recounted to others, allowed their arguments to 'transcend categories, awakening certain kinds of emergent conviction in auditors by … the use of elevated associations' (ibid: 245). Fernandez compared his examples to 'the possessed or the ecstatic in worldly cultures': these were men who had 'placed themselves (or have been thrust) beyond and above those interactions of the subject-object world held to be practical and normal' (ibid: 246). Like them, Gerald was alienated to the extent that he eschewed social intercourse and was perceived by some as 'sociopathic'; he kept to himself but occasionally returned to society (in this case, the research team) in order to communicate his visions. Like Fernandez's hunter and herder, Gerald had taken exceptional advantage of certain cultural possibilities, especially the privacy afforded him by his own house. Like them he was behaviourally and psychologically distinctive, although the experiential extremities which he explored also had their everyday and institutional referents. Thus, Gerald's account of his experiences pivoted on certain recognizable elements of the everyday world, especially childhood memories, religious images, the events of twentieth century history, and his reading of Greek mythology. This everyday world (with its institutions, hierarchies and hegemonic forms of knowledge) was

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[28] A Kantian tradition found also in Cassirer and Susan Langer, this emphasizes (in a striking resonance with Gerald's own experiences) the transcendence of received and customary categories through an alertness to the 'voices of other realms' which are present in mundane things (Fernandez 1986: 245). Burke (1966: 187), also writing of Emerson, designates bridge building as the essential transcendent act: '… the building of a terministic bridge wherein one realm is transcended by being viewed in terms of a realm beyond it'.

therefore a referent and point of departure, but it was also disordered and re-ordered in constant reference to his experiences and their interpretation.

The very lack of institutional support for such projects of identity formation emphasized and accentuated participants' isolation and invisibility. In this way, deinstitutionalization facilitated the incomplete interpellation of a schizophrenic subject.[29] This was an effect which both supported and confounded the deinstitutionalization project of governments and psychiatry. Identities were both construed by psychiatry *and* sustained independently of it. Participants made manifest a dialectics of identity: as persons they were both constructed by and unencompassed by the field which sought to define them. Their extraordinary experiences were both a positive and a negative resource which they could combine in unique ways.

As the image of Shaun refusing entry to his community nurse suggested, there was a power which accrued to living in his own home but it was not absolute. As Shaun himself recognized, authorities would be notified and he could expect redoubled efforts to have him accept the 'services' which he was required to consume (literally in this case, his medication). He commented: "Behind the clinic [more accurately, the mobile treating team] lies that huge hospital and if you don't comply, someone is going to get you". Power was every-present by virtue of the positions (including his own) which sustained the field. Shutting his door to the agents of this power achieved very little; it was already embodied, as Shaun acknowledged, in himself, in his attributed identity as a 'schizophrenic', and in his consumption of deinstitutionalized psychiatric services.

Bourdieu is ultimately pessimistic of an agent's capacity to 'opt out' of a field's 'game'. Such an agent risks 'falling into oblivion' (1981: 307): 'The only absolute freedom the game leaves is freedom to withdraw from the game, by a heroic renunciation which —

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[29] See Althusser (1971: 160ff) and the critique by Butler (1997: 106ff). See also the Conclusion, below.

unless one manages to set up another game — secures tranquillity only at the cost of social death' (ibid: 316n). This was the threat, but also the thrill which Shaun entertained after refusing entry to the community nurse: locked inside his apartment, monitoring the corridor by way of a 'peep-hole' in the front door, and refusing to answer the telephone, Shaun was the epitome of social withdrawal, except that he was also excited that Megan and I could share in his resistance, however temporary it might prove. In his more maudlin moments, however, 'social death' could have been a phrase that Shaun would use to describe his own life.

Yet Shaun also sought to take control of his identity, proclaiming himself "an elite schizophrenic" who would one day arrive at his psychiatrist's office in a Ferrari sports car, just for the shock effect of disrupting the latter's expectations. His home provided only a temporary stay on the explicit exercise of power which emanated from psychiatric institutions, but it was an interlude which he nevertheless cherished. He revelled in this display of his own agency, no matter how limited. Shaun knew he could defend his privacy for only so long and he was angry and frustrated by these inherent tensions in his world; he also derived enormous amusement from playing them for all they were worth.[30]

As Parish (1996: xvii) has argued in respect of Newars' reflections on the seemingly overwhelming determinism of caste hierarchies in Nepal, agents' critiques of their own cultural life often lead to disappointment, even tragedy, but this does not diminish the sociological importance of such critique.[31] Nor does the impotence of much critique

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[30] Shaun was a consummate performer of what Jackson (after Bruner) calls 'mastery play': a 'largely imaginary or magical mode of play [which] enables us to toy with, reconstrue, reauthor, and reverse a situation in which we find ourselves confounded and unfree. It is a way of acting that, while leaving unchanged the objective situation (as seen from outside), transforms our *experience* of the situation.' (Jackson 1998: 30; original emphasis)

[31] Recent ethnography has seen a burgeoning of concern with such cultural critique — indigenous processes of resisting, reflecting on, objectifying and distancing culture either from within or below (see Parish 1996; Bhabha 1994; Scott 1990) — especially in the context of such dominant systems as Brahmanic ideology and the Hindu caste system. Thus, Dirks (1992) analyzes competing claims to the indices of dominance in south Indian rituals, depicting them as contests of power which are realized through the manipulation and refusal of ritual roles and positions. Holland and Skinner (1995, 1997) have shown how Nepali women's ceremonial songs during *Tij* create 'a space for the production of

diminish its felt significance for self-identity. Indeed, 'identity may be forged in failure and irony' (ibid).

BETWEEN STRUCTURE AND EXPERIENCE

While public discourses had re-wrought participants into individuals with the power to choose, in their private homes they were thrown back on themselves and their own experiences. Participants' lives were pervaded by this tension between what was institutionally given and what they made of and for themselves. Their everyday worlds were characterized by this tension (and sometimes contradiction) between structure and experience.

The distinctiveness of schizophrenia (see Chapters 1 and 5) afforded many participants an identity, a uniqueness, and a individuality which confirmed their existence: many asserted that to be the subject of such powerful and overwhelming experiences could hardly have other consequences.[32] These were not negligible people; they had a presence and an effect even when, like Gerald, they were simply ensconced in an arm chair. Numerous biographical narratives emphasized the failure of parents, of schools, and of 'society' in general to appreciate their uniqueness and address their particular needs (cf. Chadwick 1997: 36). Many participants espoused a philosophy of being their own person, and of seeking the freedom to pursue their own self-creation outside of institutional frameworks

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alternate, conflicting and conflicted subjectivities' (1995: 280-1) which challenge 'important voices' (especially those of fathers, husbands and in-laws) in women's understandings of themselves, becoming also a basis for collective political action. In the context of a dominant gender hierarchy in Bangladeshi medical encounters, Wilce Jr. (1995) has argued that some female patients are not merely passive before powerful health practitioners and other family members, but challenge and resist them, setting limits to their dominance. In a Boston shelter for the homeless and mentally ill, Desjarlais (1996b, 1997) has similarly emphasized the capacity of residents to both adopt and subvert the modalities of language, time and action given by the institution and its staff.

[32] Cf. Chadwick (1997: 184n): '... to have high or low self-esteem ... one clearly has to *have a Self*— and be able to reflect on the quality of that Self and take defensive manoeuvres if necessary... These may be in some respects dysfunctional but in positive symptom patients they certainly are *there*.'

such as hospital or work.[33] They asserted that their tastes for certain types of music, art, or elements of popular culture (such as television) and their special capabilities (for writing, painting, or making up stories, for example) emerged directly from their unique knowledge and experiences. In particular, many showed an intense, self-reflexive fascination with how their own minds worked, which had prompted some of the more elaborate documentation projects we encountered.

Largely lacking economic capital (money or property), cultural capital (such as higher education), or symbolic capital (prestige, reputation, renown), most participants' primary resource was the 'embodied' capital (Bourdieu 1985: 725) of themselves, their distinctive biographies and their 'condition' (ibid) as people with schizophrenia. Lacking other avenues of self-definition (such as paid work or family roles), many participants worked instead with the only materials which were available to them: their own perceptions and beliefs, their idiosyncratic pasts, and their interstitial position between institutions. The self and its experiences were thereby configured by the field itself as being pre-eminent domains of activity and interpretation. These were the 'pertinent' categories which underscored participants' claims to distinction:

> … because social agents are capable of perceiving as significant distinctions the "spontaneous" distinctions that their categories of perception lead them to regard as pertinent, it follows that they are also capable of intentionally underscoring these spontaneous differences in life-style by what Weber calls 'the stylization of life' … The pursuit of distinction … produces separations intended to be perceived or, more precisely, known and recognized, as legitimate differences … (Bourdieu 1985: 730)

These 'legitimate differences' were not only the participants' right (as asserted by government inquiries and the instruments of international law), but were the principal source of identity in their lives. The individuality attributed to them by public discourses was often the only tool they possessed to exercise (as agents) their attributed rights and

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[33] In this they claimed the position of what Althusser (1971: 167) has called the 'Subject *par excellence*, he who is through himself and for himself [*sic*]', or the 'I am that I am' of God within religious ideology. The correlation of this positioning with the grandiosity of some participants' identities, together with the religious frameworks which many used to interpret their lives, is worthy of further exploration.

freedoms, and the only 'property' capable of conferring strength and force within a 'field of power' (cf. Bourdieu 1985: 724). It was in this sense that individuality — as a particular configuration of personhood — was both generated and constrained by the field itself.

Participants thus both conformed to public discourse in some of its aspects, and contradicted it in others. Many participants had retreated to their own homes, as was their right, only to be engulfed by a profound isolation.[34] Living *in* the community did not mean being part *of* a community, or even necessarily forming a community of ex-psychiatric patients. Lawrence, for example, found the idea of "schizophrenics associating with schizophrenics" a "very unpleasant option": "it would just be another recognition that something has gone wrong". Or, as another participant once said: "sickness is not a good enough reason for a relationship [with others]". Hannan (1990: 202ff) similarly noted that the 'clients' she studied did not organize on the basis of their stigma and did not evolve social groupings of their own. They rejected society's assumption that they were each other's natural peers, as in the example of her participant 'Les' who believed that he belonged to a category of "rejects", each of whom rejected the other (ibid: 203). They did not come together to improve their position as Goffman says 'normally stigmatized' people do: if others 'discounted' them, they believed this to be justified. They had neither loyalty to, nor sympathy for, fellow sufferers (ibid: 207). Rather, they believed that their peers jeopardized the limited resources available to them — they were 'bad risks' — and were openly destructive and undermining of such access (ibid: 205-6). Hannan concluded that although 'clients' did not share a common purpose, they believed that they shared a common fate (that is, rejection by 'normal' society). Most participants in the present study would agree.

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[34] This, too, was the experience of the 'displaced' Vietnamese migrants with whom Thomas worked and who found that Australian houses did not provide the contact with people which Vietnamese houses did: 'Even if a [Sydney] street has many Vietnamese people living in it, the closed and private nature of the dwellings often means that there are fewer everyday experiences of social contact and connection with other Vietnamese-speaking people... Here, being in the house may be viewed as equivalent to imprisonment, alienating within and alien outside.' (M. Thomas 1997: 110)

Isolation provided some participants in the present study with space and opportunity for an elaboration of ideas, stances and identities which they knew contradicted the images of "social health" (as Shaun called it) which afforded most citizens the right to be left alone. In their own homes participants readily displayed the 'individuality' which was prominent in public discourses of mental health, but in developing their unique identities they could also reach a point of idiosyncrasy where their actions and beliefs again came under psychiatric scrutiny. When the process of social construction (moulding themselves as private individuals) was deemed socially unacceptable (acting like a 'psycho' or a 'schizophrenic'), retribution and legal constraint could again be invoked, regardless of the protections afforded a private home.

THE OVERDETERMINED INTERSECTION OF PSYCHIATRY AND HOME

It was the interpenetration of psychiatry and home — at the intersection of at least two fields — which principally shaped participants' everyday lives, identities and capacity for agency. While some participants were involved in other social fields[35], it was this particular confluence which shaped all of their lives.

This intersection was the site of delivery for reconstructed and innovative psychiatric services. It was the focal point of 'community' as envisaged in the rhetoric of mental health policy, and thereby actualized and embodied a range of attributed rights and responsibilities. It was the site of normalizing (and therefore therapeutic) social practices: an appropriate setting for the exercise of 'living skills', especially those of household- and self-management.

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[35] Taking Figure 3.4 as a guide it is notable that several participants were (or had been) members of various church congregations, that some were actively involved in non-government organizations such as Clubhouse and the Schizophrenia Fellowship, and that Wynn was a casual employee of the (state) Department of Education.

In being simultaneously configured by the category of 'home', this intersection was also imbued with all of the meanings which were entailed in that concept. As a component of civil society, home embodied a set of freedoms, especially those pertaining to the privacy of individuals and the inviolate nature of private property.[36] In terms of social practice it was the centre of everyday activities and experiences. It was implicated in cultural norms of consumption, sexuality and social relationships (especially family kinship and marriage). And it embodied the subjectivities which are presumed to accompany such relations and practices (see Chapter 1).

Extraordinary experiences bisected this confluence, representing phenomena which were (at one and the same time) claimable as pathology by psychiatry, or as sources of activity and identity which escaped such labelling if they could remain sheltered or concealed by the privacy of a home. Thus this intersection was also a site of epistemological contestation: a struggle to assert what sort of knowledge (everyday and biographical, or clinical and taxonomic) was most authoritative in representing the phenomena associated with schizophrenia.

In the disparate levels which were represented there, the multiplicity of institutional political and experiential domains which impacted on it, the heterogeneity of the forces which it contained, and the manifold knowledges and practices which it encompassed, this intersection was especially overdetermined.[37] Elements of this intersection are represented schematically in Figure 4.2.

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[36] The concept 'civil society' refers to a sphere of freedom and voluntary association — comprising a plurality of relationships, identities and values — which is distinguished from the coercive political power of the state and governments (see Keane 1998). It is derived from a Hegelian tradition which sought to distinguish a 'private' (egoistic, but also economic, ethical, cultural and educational) social realm from a 'political' realm of governance and bureaucracy. In the Marxist tradition, following Gramsci, civil society is a site for the maintenance of consent to bourgeois hegemony and for the production and reproduction of inequality, and is therefore a focus of critique (see Wood 1990). The concept is ethnographically apt, however, for the capitalist, liberal-democracy in which participants lived. Its intimation in the *National Mental Health Policy* (see Chapter 3) attests to its ideological relevance in shaping participants' lives.

[37] See Ricoeur (1986: 125ff). In the Marxist-Leninist tradition represented by Althusser (1965) this overdetermination is invoked as a way of accounting for the complexity of reciprocal action between

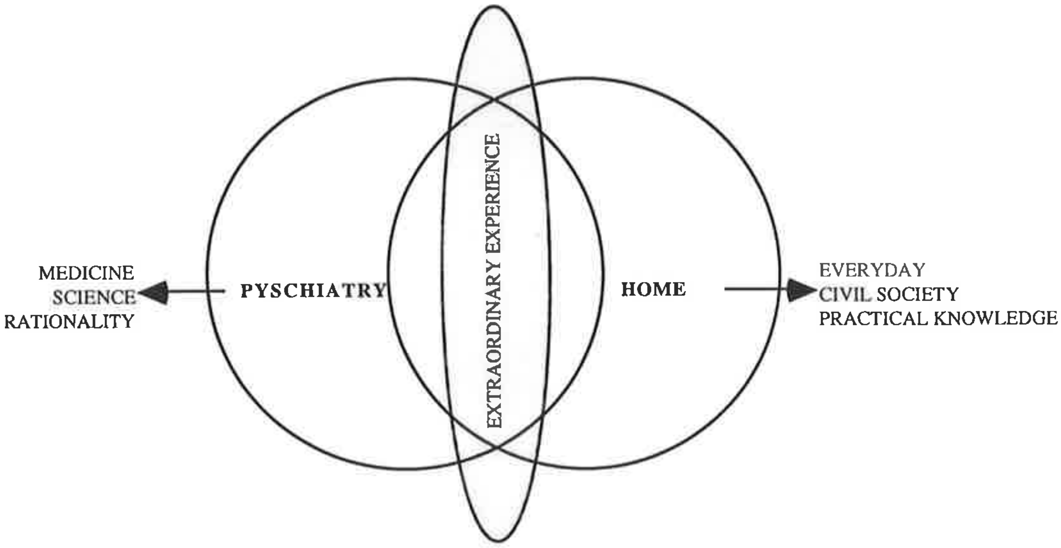

Figure 4.2

Living at home with a diagnosis of schizophrenia — being 'in the community' in official parlance — was structured by a specific contradiction. As I have demonstrated in Chapter 3, 'home' as a place of dwelling (that is, as a locus of meaning, concern and involvement) was most often to be found in individual houses. No participant had built their own house — these existed as physical forms in an already 'cultivated space' (Baumann 1996: 37ff) which was appropriated by habitation. Nor had participants who lived in public rental accommodation chosen their homes in any absolute sense, these having been assigned to them by the state. Yet it was here that many participants felt most 'at home' — the term denoting safety, security, self-determination and, most particularly, freedom from

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infrastructure and superstructure, together with the latter's relative autonomy. It was manifest in the Russian Revolution, which for Lenin was the result of all the various levels and instances — circumstances, history, traditions and 'character' — of the social formation and not simply determined by an (underdeveloped) economic base. Althusser also drew on Freud, especially *The Interpretation of Dreams* (1953) and its discussion of 'condensation' and 'displacement'. In Freud the concept accounts for the way in which dreams are not derived from any single source, but can be traced back to a number of elements that need not be closely related since they belong to disparate psychic regions. Dream affects are similarly fed by a confluence of different sources and are overdetermined in their reference to dream-thoughts (ibid: 480). Over-determination thus refers to a multiplicity (or heterogeneity) of reciprocal and potentially conflicting determinant factors.

surveillance by the mental health system. This tension between what was objectively given (a pre-existent physical structure in the form of a house or apartment) and what was facilitated therein (freedom, seclusion, innovation) reflected the 'ambiguous and elusive' concept of 'home' itself as noted by Jackson:

> Home is a double-barrelled word. It conveys a notion of all that is already given — the sedimented lives of those who have gone before — but it also conveys a notion of what is chosen — the open horizons of a person's own life. (Jackson 1995: 122)

This was also reflected in the tension between 'home' as actively constituted by the realigned field of schizophrenia (and therefore configured by 'already given' institutional forces which existed beyond personal intention), and 'home' as a specific place of self-identification and self-creation.

This contradiction (between what was given and what could be created) extended outwards to encompass all aspects of participants' everyday worlds. As members of civil society they were accorded the capacity to both privilege and conceal aspects of themselves, depending on the context. Their identities could be given form and meaning through engagement in a range of social relations and activities which varied in time and place. Identity formation could thus be seen as a matter of choice, involving processes of self-ascription and purposive identification. There remained, however, inescapable 'structures of race and culture, class and caste, gender and sexuality, environment and history' (Clifford 1997: 12) which cross-cut the liberal-democratic ideologies of self-selection and self-creation. A diagnosis of schizophrenia looked like another one of those determinant structures in its totalizing claims to designate the 'whole person' and to be the authoritative discernment of an empirical (natural or objective) disease state.[38] Yet the simultaneous positioning of people within civil society — a location facilitated by the process of deinstitutionalization itself — provided them with identifications, roles and knowledge

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[38] In this, psychiatry (as a medical speciality and a clinical 'science') manifested a feature of the scientific field. Bourdieu (1991b) characterizes the latter as a 'unique' site of struggle for the production of products ('true knowledge') that transcend the historical conditions of their production — what he calls the peculiar history of scientific reason.

claims which served as forms of escape from such determination. This tension between what was given and what could be chosen — a tension which could be said to characterize all of social life (see Jackson 1998) — had a specific, historically constituted dynamic for people diagnosed with schizophrenia, just as it incited particular strategies of avoidance and invisibility.

Thus, participants were both positioned by psychiatry (as 'clients', 'consumers' and 'schizophrenics') and, in their own homes, had a facility to refuse the significant categories, identities, and sources of agency which were given by the institutional configuration of mental health. The distinctiveness and indeterminacy of their extraordinary experiences rendered these a specific 'species of capital' which allowed participants to withdraw from a field dominated by psychiatric determination. This withdrawal was a unique consequence of their overdetermined positioning at 'home', in 'the community'.

This overdetermination accommodated many ambiguities, contradictions and ruptures in participants' experiences. In this it recalls the 'negativity' which Good (1994: 179) associates with the 'gaps among domains of experience' — those 'breaks in meaning' which illness has 'made painfully obvious' (ibid). Good derives this notion from Iser's (1978) reader response theory, especially the 'structure of indeterminacy' which is inherent in texts. Good applies this theory to stories about illness which, like those he collected in Turkey, are filled with 'blanks and negations' which confound explanation and resolution. The image serves equally well for many participants' experiences, which were also indeterminate in some respects (see Chapter 7), and which represented a disjuncture with the normative schemas of both subjectivity and social classification (see Chapter 5). Theirs' too was an experience of 'the reverse side of the represented world' (Good 1994: 178). Living in the interstices between institutions, participants embodied the 'negativity' which affronts presumed norms. Their lives and experiences challenged a sense of what is conceivable (both for themselves and for me), forcing each of us to 'reimagine the world' (ibid) from their perspective.

Escape, avoidance, and the possibility of alternate constructions of identity were positive potentials of this overdetermination. Thus, it specifies the grounds or conditions — both structural and experiential — for the 'positive withdrawal' which Corin (1990: 174) has identified as 'the general way of relating to the world that is associated with an ability to remain outside of the psychiatric institution'. This combined the '... "distancing" and "relating" elements that can be associated with varying domains of life ... that allow the person to be simultaneously "in" and "out," at an optimal distance from the social field' (ibid). In the overdetermination of 'home' as an element in the field of schizophrenia lay the possibility of 'inhabiting' a space of retreat, to imbue that space with self-selected connotations (that is, to turn it into a place of dwelling), and to frame those connotations at a symbolic level in a way which supported a range of meanings for participants' lives.

More than just accommodating dualistic (positive and negative) attributes, however, this overdetermined intersection highlighted the qualities of fluidity and potentiality in participants' social circumstances.[39] Participants lived their lives between two manifest poles: the institutional structures which determined what schizophrenia was, and their own experiences which were fitted to those structures with varying degrees of precision and relevance. Neither pole was exclusive. Each necessarily entailed the other, but the distance between them was a space of manoeuvre, evasion and diversion. It was the very overdetermination of their positioning which facilitated participants' strategizing, avoidance and withdrawal. It was this overdetermination which accommodated seemingly contradictory displays of agency and identity: both the capacity to act in accord with institutional attributions, and to resist or subvert them. Thus, Gerald could declare himself

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[39] In structural Marxism the concept of 'overdetermination' was intended to oppose that of (Hegelian) 'contradiction' — see Ricoeur (1986: 126).

"sick" in the course of a PSE interview, but reveal himself as a religious "prophet" through his engagement with Megan and I.

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This perspective on the field, its institutions and spaces, highlights the central ambiguity which shaped the identity of people diagnosed with schizophrenia. A constellation of institutional forces had attributed them rights, designated the arenas in which they were to act, and provided the means by which that action was to be achieved. This agency — as a structural feature of the field itself — was 'properly' expressed through rehabilitation in the community, by self-management of their daily lives, by the choices that they were facilitated to make, and by the consumerism in which they were presumed to engage. In their own homes and away from psychiatric scrutiny, however, participants in this study were relatively free to construct identities out of their own extraordinary experiences. Within limits — represented by participants as public places, "the street", or simply "outside" — they were also able to act in and through those constructions to be agents of their own lives. These alternate bases for knowing and acting in the world provided a specific disjuncture from dominant institutions, especially psychiatry, and a circumscribed but fluid domain of manoeuvrability.

The dual constructions of agency and identity (one institutional, the other personal) each had their locus in the 'individual', which was thereby a category which combined specific structural and experiential components, and was also overdetermined to this extent. For this reason, agency and identity could act in concert, or in contradiction, or both, depending on the circumstances. Agency and identity could combine in a person strategizing to seek advantage within the field's institutional context: for example, to effect receipt of a disability pension, to obtain subsidized housing, to advocate for changes to the servicing of mental health, or to mobilize support for such changes. Equally, institutionally-given and personally-construed forms of agency could be disarticulated, with a person using the resources of the field (such as a private home) to withdraw to an inaccessible experiential realm where they were relatively free to elaborate on subjective states and idiosyncratic lifestyles which would incur the disapproval (and corrective action) of those institutions which had made such withdrawal possible.

Chapter 5

CRISIS AND REFLEXIVITY
THE 'SCHIZOPHRENIC BREAK' AND ITS CONSEQUENCES

In this chapter I return to participants' extraordinary experiences as delineated in Chapter 1, but locate them in relation to the broader processes of anomaly and contradiction which characterized the field (see Chapters 3 and 4). Thus, I demonstrate that uncanniness and anomaly were not just qualities of idiosyncratic experience, but were replicated and amplified by participants' social location. The uncanny conjunction of strange and ordinary experiences was structured and reproduced by the field. The disjuncture occasioned by extraordinary experience was ramified by diagnosis and treatment. The pathologizing of certain experiences amplified their extraordinariness, as did participants' interrogation of them. Both of these processes rendered participants highly reflexive, making it almost impossible for them to take their experiences or themselves for granted. This represented a specific type of break with an everyday, taken-for-granted world. Images of this disjuncture accrued resonances which were both internal to the person and reflected throughout his or her social world. In this wider context, then, experience itself was singled out, made reflexive, and extraordinary.

Reflexivity and transformation are the dual foci of this discussion. Both were entailed in participants' responses to unprecedented experiences. Both were substantive issues in participants' own lives, just as they raise particular issues for the analysis of those lives.

Participants attested to how they often did not have prior models which would allow them to grasp and understand the experiences associated with schizophrenia. Not only did such experiences effect a radical separation from other people, they also initiated a breach in participants' understandings of themselves and their lives. Over time, most appeared to have assimilated these experiences, claiming them as part of their person (see Chapter 4), and interpreting them within various frameworks which accorded them meaning (see Chapter 1). However, the sense of initial disjuncture seemed never to have completely disappeared. It was encapsulated in the motif of a 'break' — most commonly a 'breakdown' or a 'schizophrenic break' — which recurred in various parts of the field and could be articulated by participants themselves. For participants, this sense of disjuncture generated an intense scrutiny of what was and what was not schizophrenia, and of what they as persons were before and after diagnosis (cf. Estroff 1989: 191). One of the consequences of participants' experiences was therefore a pronounced reflexivity about themselves and their experiences.

Participants also attested to how these experiences had transformed them. Not only were perception, self, and body transformed during psychosis, but these experiences in themselves transformed how perception, the body, and the self were subsequently known and appreciated. This was the transfiguring and (after Hegel) 'dialectical' effect of such experiences (see Chapter 1). Participants attested to how they had been initiated into new ways of experiencing themselves and the world. They had, as Shaun said, come to know "other ways to be". I gloss this effect as 'transformation', without imputing to it any particular end point, such as Webb's (1995) 'turning into schizophrenia' (see Chapter 4). What to make of transformative experience, and how to accommodate a knowledge of it, were ongoing, practical imperatives for most participants. In demanding such attention, transformation also elicited and enhanced reflexivity.

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Anthropological approaches to knowledge and cognition tend to emphasize the cultural filters which inflect ways of thinking and perceiving — especially as these are encapsulated by a language which implicates a common reference world through its sharing. In emphasizing classificatory and symbolic systems as these are supposedly given to all members of a social group, such analyses prefigure the group's commonalty. Such approaches to 'worldview' and 'ethos' usually imply either deep structures of symbolic code, or some level of consensual agreement as to a culture's core categories and implicit assumptions (see Jones 1972). The role of new, unprecedented knowledge and experience is problematic for such approaches (see Shokeid 1992), as is conceptualizing change, managing diachronic relations within relatively unchanging frameworks, comprehending novel circumstances, and envisioning how new social and cultural experiences become possible.

Thus, Douglas (1975) suggests that within any culture there is some information which is self-evident and does not require to be justified. In remaining implicit it forms 'a stable background on which more coherent meanings are formed' and is 'too true to warrant discussion', providing 'the necessary unexamined assumptions upon which ordinary discourse takes place' (Douglas 1975: 3-4). She also suggests that it is through these background assumptions, 'these implicit channels of meaning', that 'human society is achieved [and] clarity and speed of clue-reading ensured'. In respect of Lele cosmology, Douglas claims (ibid: 28) that the 'broad framework of assumptions about animals and humans' are so fundamental 'that one could almost describe them as unformulated categories through which [the Lele] unconsciously organize their experiences'. Based on these observations, Douglas asserts (ibid: 51) that the 'schemes or structure of assumptions' act as a framework for organizing and assimilating new experiences. Such an assimilation serves to validate and strengthen the scheme of assumptions by which it is structured. Conversely, when an experience is truly unfamiliar, its accommodation may lead to a modification of the scheme of assumptions.

Ortner has addressed similar questions in discussing the articulation of practice to a cultural 'system':

> … there seems to be general agreement that action is constrained most deeply and systematically by the ways in which culture controls the definitions of the world for actors, limits their conceptual tools, and restricts their emotional repertoires. (Ortner 1984: 153)

She goes on, however, to question 'whether in fact *all* practice, everything everybody does, embodies and hence reproduces the assumptions of the system' (ibid: 155):

> There is a profound philosophical issue here: how if the actors are fully cultural beings, could they ever do anything that does not in some way carry forward core cultural assumptions. On the more mundane level, the question comes down to whether divergent or non-normative practices are simply variations upon basic cultural themes, or whether they actually imply alternative modes of social and cultural being. (Ortner 1984: 155)

In popular representations, schizophrenia seemed to exemplify the 'non-normative' and divergent. It was not articulated with social values and regulatory principles, except as 'illness' or 'madness'. The experiences associated with schizophrenia were also perceived in this way by those who were diagnosed with it; they similarly emphasized such experiences as a rich source of 'alternative' modes of being. Schizophrenia may thus provide a case study in the limits of culture to determine practice, or of the capacity of practices and experiences to escape such determination.[1] In this same extremity lay the possibility for representing schizophrenia as a purely natural (or unnatural) phenomenon which escapes core cultural assumptions altogether.

Both Douglas and Ortner point to the relationship between a set of assumptions corporately held and a world which is, to some extent, corporately perceived. In implying a distinction between core and non-core assumptions, Ortner also raises the issue of how alternative or non-normative practices are related to change in core assumptions. Ortner frames this question without resolving it:

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[1] This was also Sahlins' (1981) theoretical interest in the unprecedented appearance and death of Captain Cook amongst the Hawaiians, where the effect of putting culture into practice was to give some actors and actions a significance that had not been traditionally envisaged:

> Nothing guarantees that the situations encountered in practice will stereotypically follow from the cultural categories by which the circumstances are interpreted and acted upon. Practice, rather, has its own dynamics — a 'structure of the conjuncture' — which meaningfully defines the persons and the objects that are parties to it. And these contextual values … have the capacity then of working back on the conventional values. Entailing unprecedented relations between the acting subjects, mutually and by relation to objects, practice entails unprecedented objectifications of categories. (Sahlins 1981: 35)

> … the central problem for practice theory is … precisely the question of how actors who are so much products of their own social and cultural context can ever come to transform the conditions of their own existence, except by accident. (Ortner 1989: 14)

People diagnosed with schizophrenia were faced with similar questions, especially concerning their relationship to a wider culture. They pondered how much sense they could make of their situation on the basis of their own prior knowledge and experience, and of how much control they could exercise over that sense-making. This was manifested in their struggles for agency, especially by way of claiming the right to name and interpret their experiences (see Chapter 4). Schizophrenia points to a limit or border condition which highlights the role of individuals in influencing (by strategy, reflexivity or critique) their social context, as well as the capacity of individual agency to transform culturally-given conditions of existence.

Bourdieu also addresses what is regulative and predictable in social life:

> I can say that all my thinking started from this point: how can behaviour be regulated without being the product of obedience to rules? (Bourdieu 1990b: 65)

He answers this — and also approaches the question of society's core, consensual assumptions — by way of the concept of *habitus*. With this concept Bourdieu focuses not on group cosmologies (as Douglas did), or on the commonalty which is manifested as group identity (as canvassed by Ortner), but on the mundane regularities of everyday practice. With it he sets out to specify the practical achievement of what is 'taken for granted' in practice itself. *Habitus* is the principle by which choice and strategy are generated in social life. It develops as a habitual pattern of responding to various situations out of a history of pragmatic choices which have proved (without explicit calculation) to offer optimum social advantage. It produces agents' 'moves', which are adjusted to objective social conditions without the need for a conscious strategic intention (Bourdieu 1990b: 62-3). This *habitus*, once formed, is then manifest as a disposition, propensity or inclination to act in a particular way (Bourdieu 1977: 214n), such dispositions shaping and giving form to the way in which members of a group respond to situations (ibid: 76-8). Within individuals, such propensities are developed through socialization, with a 'disproportionate weight' being attributed to early experiences in families and in households, which in turn provide the 'basis of the perception and apperception of all subsequent experience' (Bourdieu 1990a: 54). The *habitus* provides for the 'correlation' of objective social possibilities and agents' 'subjective aspirations' — which correlation Bourdieu calls *doxa* — by its regularizing of experience, anticipation and practical outcome:

> The *habitus* which, at every moment, structures new experience in accordance with the structures produced by past experiences, which are modified by the new experiences within the limits defined by their power of selection, brings about a unique integration, dominated by the earliest experiences, of the experiences statistically common to members of the same class. (Bourdieu 1990a: 60)

The unprecedented experiences associated with schizophrenia — those which 'assaulted' recipients 'out of the blue' and thereby demanded innovative interpretive schemas (see Chapter 1) — defied this integration into what was common and taken for granted. These experiences stood in sharp contrast to all of those other experiences that participants themselves took for granted and others around them took for granted (see van den Berg 1982), and it was this very disparity which engendered reflexivity. This, in part, was what made such experiences extraordinary.

I argue in this chapter that, being quintessentially disruptive, the experiences associated with schizophrenia prompted a re-imagining of both past and future, and constituted a specific experiential break in the taken-for-granted relationship between *habitus* and social structure. Participants evinced an abiding reflexivity toward — and hence distance from — that common sense which the *habitus* produces. They confronted this common sense in their diagnoses (which were opposed to the 'madness' of their own delusions about themselves), in the authoritative 'reason' of psychiatrists, family members and others of their acquaintance, and in the practical 'living skills' they were taught as a component of community rehabilitation. Thus people diagnosed with schizophrenia were forced to confront and reflect upon what others took for granted: a common sense which is normally placed beyond consciousness, introspective scrutiny, control or will (Bourdieu 1984: 466).

Bourdieu canvasses a number of 'critical moments', 'maladjusted expectations' and (after Goffman) 'discrediting events' which disturb the taken for grantedness of the *habitus* (see Bourdieu 1988). With these examples he also attempts to account for the role of crisis, rupture and 'heresy' in the reproduction of what is socially implicit and taken for granted. A number of these scenarios are considered below, and their applicability to schizophrenia is assessed. Schizophrenia emerges from this discussion as a case study in the limits to which some subjectivities are articulated with social structures. In reflecting on how the taken for grantedness of their everyday worlds had been transformed by schizophrenia, participants offered a critical perspective on those processes of reproduction by which the *habitus* 'normally' facilitates the production of common sense.

In this chapter I also compare the analysis of schizophrenia using Bourdieu's concept of *habitus* with an analysis using Turner's concept of liminality. Although based in very different theoretical traditions, each of these approaches allow me to clarify and sharpen what I propose is characteristic and distinctive about schizophrenia as a social phenomena entailing crisis, reflexivity and transformation. Thus, the convergence of these approaches and the resonances between them further elucidate what is pivotal to the experience of schizophrenia.

THE 'BREAK' WITH EXPERIENCE

Images of schizophrenia as a break with past experience were shared by psychiatrists and participants alike. Psychiatry rendered this disjuncture as a dramatic break with reality. Participants agreed that the experiences which they associated with schizophrenia were profoundly disruptive. In particular, they suggested that the meaning of such experiences was not self-evidently given by past experience. In Bourdieu's terms, they were not structured by a *habitus* which normally functions by way of assimilating new to old, integrating an ongoing present with the 'earliest' experiences of socialization, and rendering individual experience 'statistically common' with that of all people in similar social circumstances (see Bourdieu 1990a: 60). I examine here some of the meanings which participants brought to this disjuncture, especially its location within a broader framework of transformation.

Schizophrenia has long been held to epitomize a rend in the fabric of consensual reality and a living in a different world. Corin and Lauzon (1994: 6ff) summarize various psychiatric and phenomenological characterizations of this alteration of experience, which include:

- a loss of vital contact with reality (Minkowski);
- a disruption of the 'consistency and continuity' of experience, producing a 'sundering' from the world (Binswanger);
- a lack of balance between 'assimilation' and 'accommodation', such that a person either excessively assimilates an object into his personal sphere or accommodates himself entirely to an object and is absorbed by it (Tatossian); and
- a 'breakdown' into either extravagance, distortion or mannerism, all characterized by a frozen, rigid stance (Binswanger and Tatossian).

All of these, Corin and Lauzon suggest, 'reveal a basic disturbance of the "transcendental thrust" described by Husserl as "the constant presumption that experience will continue to unfold according to the same constitutive style" ' (ibid: 8; their translation). Other phenomenological psychiatrists, such as Blankenburg, describe a loss of that 'self-evident' quality which normally sustains the feeling of inhabiting a familiar world: this includes losing access to a 'general universe' in which things are understandable; to the 'rules of the game' which regulate ordinary life; to temporal structures that sustain the projection of a self into the future; to a 'self-evident' self ; and to the intersubjective constitution of a common sense world (Corin & Lauzon ibid 7-8).

As I have shown in Chapter 1, participants in the present study could and did make similar assessments of living with their "broken" brains in an altered world, in "another universe" or in "another dimension". They could, like Roland, locate themselves out of their heads and out of society. Zöe conveyed this positioning with images of violation and irreparable damage — the effect, she said, of various phenomena such as 'voices' and the mysterious theft of her "power", as well as physical assaults and hospital treatment:

> "And that's why I think I'm schizophrenic too. Because once you are violated it's like a cracked glass, a cracked window pane. It's irreparable. You can fuse it together but the damage has been done... Violation alienates you from what you were, so in other words it puts you in a strange place and the strangeness is the schizophrenia, the other reality, the separate reality, another world, another dimension, another layer — just slightly separate. And the more you get raped and the more denied you are the bigger the other reality becomes and the less able you are to become part of [society]... Anyway, that's where the schizophrenia starts."

But these very declarations — which were made in dialogic and therefore social engagements with us researchers — hinted at a wider horizon for the notion of 'breakdown'. These were not merely introspective accounts. They evinced, particularly through the negotiation of biography, a consciousness of what had been broken with, especially relationships, families, childhood expectations, old value systems, past modes of thinking, and previous identities. The 'break' in experience was not a single point of catastrophe and erasure, but a multi-faceted transformation which had both a 'before' and 'after', with points of contrast, continuity and on-going consequences. These were also breakages which were contemporaneously reinforced in innumerable settings. Experience was only extraordinary by contrast with what had previously been ordinary, and with the ordinariness which continually imposed itself on participants from all quarters: from other people, on the streets, in a parent's house, in their own homes, in our sitting together to talk, or in our visits to a cafe.

Such ruptures were not contained within an individual subject, person or brain, but reflected a set of relationships with a wider world. Standing at an ATM on a busy shopping street, worried about the video surveillance which was probably taking place, Shaun commented in hushed tones: “All this talk of aliens and space ships — you know, don’t you, that it’s all really about our relationship to society”.

The ‘break’ represented by extraordinary experience was also a breach with cultural models available to interpret such experience. Lawrence, as usual, was extremely articulate about the lack of accommodation for his “disproportionate sensory experiences”, his heightened perceptions (especially of light and colour), and his “esoteric symptoms” (such as a feeling of ‘infinity’). He emphasized the “gap” which existed between them and any particular cultural form, be it language, music or art. He said:

> “I’ve been mucking about with paint for about five or six years. Before that I was into music. How can I put it? I think you need to be quite dedicated, because there’s a gap between what I perceive and what I can communicate. It’s not that easy to describe those aspects of perception …
>
> I think the simple thing is, language is learned and it’s a cultural experience. Now what I would say is that the … facility of language that you have comes from your culture and that culture probably does not really recognize those experiences. I was at the Art School and I said to the lecturer, “What about when the colours change?”, and the lecturer, he was reluctant to talk about things like that. And that’s the whole thing about schizophrenia … There are people that are interested, but I don’t think it’s part of the culture or the language as such.”

This is not to say that such fissures were painless, or merely intellectual affairs. Many participants insisted on precisely the opposite. Lawrence himself was occasionally tormented by agonizing pain and distressing physical sensations (diagnosed as somatic hallucinations) for which, he said, the paintings of Hieronymus Bosch were the only analogy. Shaun noted similarly that,

> “After a breakdown you don’t see things the same way. You’re reborn in acid, in vinegar. It’s a horrible re-birth.”

He also said: “breakdowns are like a plane crash, and all you can do is walk away from the wreckage”. And walk away he did, to continue a life which had to accommodate such dramatic contingencies. Perhaps it was for this reason that Shaun thought it was best to relinquish the past. The only option he saw was to transform himself, his expectations and his identity; the endless re-decoration of his apartment with sculptures, collages, and other constructions was an expression of his desire to externalize and represent (if only to himself) these processes of transformation.

The category 'schizophrenia' itself could sometimes gather up all of the disruptions of a life, drawing them together to make sense of them at last. Evelyn's story evinced a pervasive concern with breakages in her world, especially of family and close personal relationships, together with her expectations for those relationships. These culminated in schizophrenia as the ultimate 'breakdown' which, she said, had freed her of the past and initiated a new life.

Evelyn: breaking down, taking control and making a new life

Evelyn was a grandmother aged fifty-five when we began work with her. She had been diagnosed with schizophrenia for only three years. The most striking feature of her life story was the extent of abuse she had endured from childhood through to her second marriage. Violence in one form or another permeated this account of her father's violent death, of being stabbed and having her head split open by a crowbar at the hands of her brothers, of being assaulted by a relative while pregnant. Without a trace of self-pity she said: "I was used to violence, my whole background is violence". It was hardly surprising, then, when this violence was metaphorically extended to the illness itself, which "hit" her with a force, shocking her entire "system". A psychic pain continued to "hit" her in the chest or throat before travelling up to her head. This motif of being hit was even extended back to the earliest moments of her life: she said that at birth she was not breathing and had to be "hit hard" in order to "get me going".

She represented her mental illness as the "cumulative effect" of these biographical stresses: "I know that my background did this to me and I'm not surprised it happened". Evelyn said that schizophrenia had been brought on by a 'self awareness' course which caused her to seek out and divulge aspects of her past life which had hitherto remained hidden: the image was one of being overwhelmed by contacting a mass of terrible memories which, as she said, had been "pushed to the back of my mind". Some of these memories (such as the childhood beatings which she said she never felt at the time) were re-lived or re-experienced as psychosis.[2]

Her account of the initial experience — a "powerhouse" which enveloped her "whole being" — was remarkable for its emphasis on bodily sensations and effects:

> "It was when I started my self-awareness course at [a tertiary college] ... It was more or less a 'go with the flow', 'sort yourself out' sort of thing. I decided that I was going to go with it and go right through my background. Later, I think that I regretted it. I think it took me right off the deep end. I was already living under stress here. My husband was violent and we were living in separate rooms so I was more or less isolated. I used to study in the room alone, so that allowed me to go more in depth into myself because I was alone. It was very difficult. I remember saying to myself out loud that this was hard. Somewhere along the line in the early stages it just happened. What happened to me was physical. I felt what happened in my brain. It frightened the life out of me. It was like a switch. It was like a division had happened in here [pointing to the top of her head]. It was a very strong feeling ...
>
> The top of my brains were totally numbed, I couldn't feel any pain. In fact, I didn't feel any emotion during my initial onslaught of this powerhouse that had enveloped my whole being. What happened to my whole body was like a powerhouse. It hit my head first and then travelled right through. I knew the hormones in my body had been affected, as well as the transmitters in my brain. I knew. I knew everything had been affected, I knew my whole nervous system was really strung out. The strange thing that happened then was terror — I became terrified."

Evelyn recalled the exact time, where she was, and what she was doing (lying in bed ready to go to sleep) when these events took place. She was also very precise about when the "next phase" started, in which she believed she was being spied upon from planes passing overhead, "using laser things to look into my brain". Later she heard 'voices' coming out of the radio, directing her actions.

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[2] Other female participants made similar claims. Wynn said that sexual abuse she did not remember from childhood had "come out in psychosis", but that she did not know if it was a "true memory". Francis similarly asserted that she had only became aware of her brother's sexual abuse in the context of psychosis; it was later verified by witnesses.

Evelyn did not refer to these initial experiences as schizophrenia. Rather, they represented "my breakdown", or "the episode" — designations which suggested a discrete, circumscribed event already located in the past. This temporal containment was one of the mechanisms of control which she sought to exercise over her diagnosis. This control was epitomized in her having diagnosed herself, using textbooks borrowed from the library. Only when the initial "onslaught" abated did she take herself to a psychiatrist.

Over several meetings Evelyn always stressed the positive benefits which she saw accruing from her experiences. Principal among these benefits were divorcing her abusive husband ("I was sane enough to take advantage of the situation"), and going on to further study. She said:

> "… going into psychosis I just got this strength, this madness, and off I went and did things I had never done before in my life… I'm not the same person. I'll take anybody on now."

She employed a number of cultural and religious models for this image of 'growth through adversity', as well as popular axioms along the lines of "what doesn't break you makes you stronger".

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Evelyn emphasized a view of schizophrenia as the embodiment and instrument of transformation. It had allowed her to 'break' with her past and transform her life. In various ways she felt free from previous encumbrances. Peter represented his vagrancy in similar terms. This was also the freedom which Jeff celebrated by painting, and Adam utilized to compose stories and invent children's games. Lawrence insisted that there were insufficient cultural models (especially in language) which would allow him to communicate his experiences, a situation which had fuelled his isolation but had also led to his exploration of non-figurative painting and the exhibition of this work. All of these participants — and many more besides — attested to the impact of unprecedented experiences in transforming their lives and in compelling them to explore new possibilities.

Because of the breaches which were entailed in these experiences, most participants were highly conscious of their consequences, and were endlessly confronted with the ongoing effects of this transformation.

TORN AND BROKEN *HABITUS*

For Bourdieu, new experiences are assimilated to the *habitus* when (and to the extent that) they become 'reasonable' and taken for granted; in this way, *habitus* is also transformed, encompassing change through endless cycles of reproduction. As positions within fields change, so do the dispositions which constitute their *habitus*; likewise: '... the same habitus can lead to very different practices and stances depending on the state of the field' (Bourdieu 1990b: 116). Residing in persons, *habitus* also includes their knowledge and understanding of the world, such knowledge being not simply a reflection of some external, 'real' world, but having genuine constitutive power (Bourdieu 1984: 467).[3] However, there are constraints on individual agency to effect these constructions, and limits on what they can accommodate, especially in respect of the power which resides with other socializing agents (such as a preceding generation, the product of a previous reproductive cycle — see Bourdieu 1977: 167), and in the objective conditions of a material and social environment (ibid: 77). This returns us, then, to the question of unprecedented, divergent or non-normative practices — and to those experiences which confound implicit cultural assumptions — raised by Douglas and Ortner. Schizophrenia seems to exemplify such a limit. In this section I compare schizophrenia with those 'critical moments' (Bourdieu 1988: 159ff) which confront the reproduction of *habitus*. In this way I seek to highlight schizophrenia's similarity to, and divergence from, other forms of social rupture.

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[3] In this lies the doubleness of social reality: 'in things and in minds, in fields and in habitus, outside and inside of agents' (Bourdieu & Wacquant 1992: 127).

Bourdieu suggests that the articulation of the individual and the social — *habitus* and field — can result in a variety of outcomes ranging from a 'perfect mutual fit' to a 'radical disjunction' (Bourdieu & Wacquant 1992: 130). Most routinely, some form of disturbance is liable to occur when one generation is replaced by another and the social structure must, as a consequence, be reproduced in the face of changing conditions and personnel.[4] Thus there are generational conflicts centred on a *habitus* which has been produced by 'different modes of generation', that is,

> ... by conditions of existence which, in imposing different definitions of the impossible, the possible, and the probable, cause one group to experience as natural or reasonable practices or aspirations which another group finds unthinkable or scandalous, and vice versa. (Bourdieu 1977: 78)

This is the 'hysteresis effect' — when changes in a system lag behind changes in the phenomenon causing it — which is built into (and usually contained by) the *habitus* itself. It is also the context, however, in which senses and dispositions risk attracting 'negative sanctions' because they confront a social environment which is 'too different' or 'too distant' from that to which they were objectively fitted (Bourdieu 1990a: 62). This is the context in which practices and dispositions become 'out of phase' and 'ill-adapted', in the manner of Don Quixote (ibid).[5]

Throughout his works, Bourdieu has canvassed a number of scenarios in which practices and dispositions can outlive the economic and social conditions in which they were produced, becoming 'the source of misadaptation as well as adaptation, revolt as well as resignation' (1990a: 62). Thus, old Kabyle peasants speak of 'the heretical methods of cultivation practised by the young'; or university teachers could 'only express their stupefaction, their incredulity in the face of the *incredible*, the world upside-down' which

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[4] Cf. Turner (1982: 44) on the 'exigencies of structuration itself', and the 'process of containing new growth in orderly patterns or schemata', in which there is 'an interval ... of *margin* or *limen*, when the past is momentarily negated, suspended, or abrogated, and the future has not yet begun, an instant of pure potentiality when everything, as it were, trembles in the balance'.

[5] The figure of Don Quixote also being a major (counter) vehicle for Schutz's (1962b: 236ff) analysis of the primacy of the common sense world — Don Quixote having 'withdrawn the accent of reality from the world of working and ... bestowed such an accent upon the world of his imageries', his 'finite province of private phantasms' (ibid: 236-7).

was Paris in May 1968 (Bourdieu 1988: 183; original emphasis). Such disruptions threaten the most intimate of beliefs and deny agents 'all that they hold most dear' (ibid). Bourdieu locates the Paris crisis within a series of temporal disruptions, conflations, and synchronizations within and across fields, the combined effect of which was to 'disconcert' those anticipations and expectations on which the 'ahistorical continuity of the perceptions and actions of common sense' were based (ibid: 182). Such a crisis,

> … introduces a break in duration, because it suspends the ordinary order of succession and the ordinary experience of time as presence in an already present future; in overthrowing … the structure of objective opportunities … to which behaviour reputed reasonable is spontaneously adjusted, and which creates social order as a world one can count on, that is, a predictable and calculable world, the crisis tends to undo that sense of placing, both as 'knowing one's place' and as knowing how to place sound investments, which is inseparable from the sense of realities and possibilities which we call sensible. It is the *critical moment* when, breaking with the ordinary experience of time as simple re-enactment of a past or a future inscribed in the past, all things become possible (at least apparently), when future prospects appear really contingent, future events really indeterminate, the moment truly instantaneous, suspended, its consequences unpredicted and unpredictable. (Bourdieu 1988: 182; original emphasis)

Other examples of disjuncture include a 'divided' or 'torn' *habitus* occurring at the intersection of fields, especially when there is a discrepancy between them (Bourdieu & Wacquant 1992: 127). These are discrepancies in which 'conduct remains unintelligible' until it is brought within the bounds of the *habitus'* 'specific inertia, its hysteresis' (ibid: 130). The case of the Algerian revolution provides another example of mis-fit in which 'peasants endowed with a precapitalist habitus were suddenly uprooted and forcibly thrown into a capitalist cosmos' (ibid). Bourdieu suggests that this is typical of broader revolutionary circumstances in which agents' 'mental structures' become 'obsolete', inopportune and 'at cross purposes' (ibid).

Bourdieu has also canvassed potential differences between 'class *habitus*' and 'individual *habitus*', but suggests the latter always returns to a 'statistical' approximation of the former (1984: 109), by which it is ultimately defined. The 'individual *habitus*' are,

> … united in a relationship of homology, that is, of diversity within homogeneity … Each individual system of dispositions is a structural

> variant of the others, expressing the singularity of its position within the class and its trajectory. 'Personal' style … is never more than a deviation in relation to the style of a period or class, so that it relates back to the common style not only by its conformity … but also by the difference that makes the 'manner'. (Bourdieu 1990a: 60)

An individual *habitus* is subject to accidents, changes of fortune, or 'spontaneous intervention', but Bourdieu insists (1984: 110) that a given social agent can only respond to these in terms of the social capital already preserved in his or her social position, thus rendering idiosyncrasy into an image of deviation from what is common (cf. Ortner 1984: 155). Ultimately for Bourdieu (1990a: 60), the 'individual *habitus*' is 'a subjective but non-individual system of internalized structures, common schemes of perception, conception and action' which pre-condition the coordination of practices and the sharing of a worldview. Its breakages lead nowhere, and are, except in large-scale revolutions, of no social account.

IMAGES OF CRISIS: SCHIZOPHRENIA AS A BROKEN *HABITUS*

These descriptions of crises, maladjusted expectations, and discrediting events all point to the unsustainability of breakages in the *habitus*. The adjectives and images which Bourdieu uses to convey these breakages all attest to their extremity: they are 'crazy', 'incredible' and 'heretical' (1988: 183); or they are 'unthinkable' and 'scandalous' (1977: 78); they result in 'a world turned upside-down' (1988: 183); or they signal 'the end of the world' (ibid) and social 'oblivion' (1981: 307). Implicitly, such conditions must be resolved and a (new) common sense inaugurated: revolutions end; radicalism is assimilated; revolutionary regimes become institutionalized; the French university system adjusts and continues; there is a convergence of individual *habitus* and class *habitus*. Change happens and the world is righted, at least for a time.

These same images could equally be applied to schizophrenia, some participants using them to describe themselves and their situations. Indeed, some (like 'crazy') betray a common source.[6] Unlike the generational and temporal ruptures which signify a broken *habitus*, however, the breakages which participants associated with schizophrenia were not subject to the same projected resolution over time. This was epitomized in what participants saw as the irrevocable status of schizophrenia as a diagnosis. In participants' understandings, the 'break' in experience which coalesced in diagnosis was a break in history — their own biographical history as well as the various social histories which rendered experience predictable and taken for granted. In particular, schizophrenia confounded that 'history turned into nature' which is *habitus* (Bourdieu 1977: 78).

Such experiences compelled a confrontation with different definitions of the possible, the impossible and the probable, for participants as much as for others. This was not restricted to individual perception and phenomenology, but was a pragmatic effect which encompassed a person's social world, as self and others were forced to recast identities and expectations, as well as deal with everyday issues of income, accommodation and support. This confrontation between the probable and the improbable, expected and unexpected, was not a consequence of collective, generational, institutional or historical change, but was seen to occur within a household, a family, and (especially) within a single person. This was its individuating and alienating effect. There were few social markers for this rupture, except hospitalization which (for participants and their families alike) signalled incompetency, failure, pathology and 'madness'. Diagnosis and treatment thus became a further source of rupture. This duplication — indeed, ongoing ramification of breakage — was itself a source of distance and reflexivity on all that a person could take for granted about themselves and others.

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[6] Thus Free (1996), in a broader critique of Bourdieu's use of the terms 'objectivism' and 'subjectivism', notes how 'madness' and 'irrationality' have been positioned in his thought without explication and analysis. Free notes how the Foucault of *Madness and Civilization* has shown that the 'other' of madness is implicated in the rational discourse of civilization, a position sustained in the categories of 'objectivity' and 'subjectivity': 'Rather than being equal partners in a pair, the terms 'objective' and 'subjective' have historically been used in strategies of inclusion and exclusion from the 'rational' and 'scientific' discourses at the centre of our civilization and the social positions dependent on them' (Free 1996: 396). Free argues that the dialectic which Bourdieu seeks to establish between objective and subjective positions does not erase their distinction, the implicit role of madness in their formulation, or the privileging of 'science' and the 'scientific' which this sustains. See also Dreyfus and Rabinow (1993) and Young (1990: 71-3).

Reflexivity is implied in the hysteresis effect when practices are perceived as 'too different' or 'too distant' to constitute a taken-for-granted present. People diagnosed with schizophrenia exemplified this distancing, and attracted 'negative sanctions' as a consequence. Participants knew that their experiences exemplified what was socially 'unthinkable' — madness, chaos, unintelligibility — just as these experiences were deemed by psychiatry to disorder participants' thinking, rendering them unable to account for themselves. Like those 'older people' who have been rendered 'out of sync' by social change, schizophrenics were deemed to 'think in a void' (cf. Bourdieu & Wacquant 1992: 130). It was this rendering, however, that the people I worked with contested most vehemently.

Participants' hyperawareness of their own and other people's bodies (see Chapter 1) defied that 'economy' of the *habitus* which divests everyday practices of the need for interrogation and interpretation. In focusing on other people's bodies and dispositions, and in reflecting on their own, participants seemed to perpetuate a reflexivity which Bourdieu characterizes as arising most clearly in states of social crisis. This suggests an image of people with schizophrenia as embodying crisis — an image which is congruent with dominant representations generated by the clinical practice of psychiatry. It was the incessant and enduring nature of this crisis which highlighted the distinctiveness of people diagnosed with schizophrenia.

The penetration of diagnosis effectively erased a temporal dimension from this image of crisis. Psychiatry could potentially effect an endlessly receding discovery of schizophrenia in the patient's behaviour prior to onset (the 'prodrome'), in their upbringing, their childhood, their genes, and even in preceding generations (see Barrett 1996: 138-9). This rendered schizophrenia ever-present both retrospectively (as nascent 'schizoid' traits, suspiciousness or a tendency toward social withdrawal, for example) and prospectively (as an abiding potential for 'relapse'). A number of participants were haunted by this spectre of an ever-present schizophrenia, whether latent or active. They registered this collapse of temporal discriminations as a sign that progress and recovery were 'officially' impossible within the terms of psychiatric diagnosis. Similarly, participants themselves could suspend a sense of 'ordinary' temporal duration and discrimination when, as for Evelyn, the 'break' with their past gathered up and unified all the breakages in their lives, combining them in a meta-narrative of ongoing transformation and transcendence. Both mechanisms point to the possibility of an atemporal suspension in schizophrenia: a 'moment of crisis' which extends indefinitely. In this erasure of temporal distinctions — in breaking with a re-enactment of the past and with no foreseeable future with which to inscribe the present — expectations of change were liable to become unfettered. Not that there was no change, but it was uncircumscribed, making, as Bourdieu says, all things seem possible. In this lay hope and freedom, as well as scope for agency and play (see Chapter 4). Participants attested to the freedom and fantasy which they associated precisely with a breaking with the 'ordinary experience of time' (Bourdieu 1988: 182). In escaping socially prescribed scheduling (such as a working week, weekends and public holidays) many participants were released into, and seemed to dwell permanently in, that indeterminacy of unpredicted and unpredictable time which Bourdieu associates with crisis (ibid; see above). This was the freedom of Peter's vagrancy, which made all of his life contingent, and of Shaun's quest to "live only in the moment".

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There is a remarkable correlation between what Bourdieu says can go wrong with the *habitus* — discrepancy, maladaptation, disjunction, unintelligibility and 'social death' — with what is deemed to go wrong in schizophrenia. In some ways, especially in popular representations, schizophrenia looked like a version of Bourdieu's broken *habitus*:

maladapted, unintelligible, at cross purposes, and of no social account.[7] Participants themselves could articulate these images, since they were also part of the culture which generated them. But such images were not the only ones which participants used to comprehend and communicate the break occasioned by their experiences. They equally emphasized the release from convention and social expectations, freedom, transcendence, and initiation into various 'higher' states of spirituality and creativity. I suggest, therefore, that the analogy with a broken *habitus* is only partially representative of how participants understood and lived with the disjunctures entailed in their experiences.

OTHER MODELS OF DISJUNCTURE: LIMINAL AND LIMINOID

In their emphasis on transformation, their interstitial location between institutions, and in the temporal anomalies of their situation, participants might seem to embody another form of social disjuncture which Turner has called liminality. A comparison with this and its related concepts allows me to highlight both the broader commonalities and the distinctiveness of schizophrenia, as well as further qualify the image of 'crisis' emerging from Bourdieu's work on *habitus*.

Schizophrenia shared many of the 'scenic' attributes which Turner sought to encapsulate in the concept of liminality:

> Liminality may be the scene of disease, despair, death, suicide, the breakdown without compensatory replacement of normative, well-defined social ties and bonds. It may be *anomie*, alienation, *angst* ... [and] it may be represented by the "extreme situations" beloved of existentialist writers:

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[7] Cf. Jackson (1989: 124-33) who analyzes the ludic component of Kuranko initiation ceremonies as an 'entertainment' in which the *habitus* is both broken and played with (although not as an object of verbal or conceptual knowledge). Jackson argues that these rites entail a public disruption of the 'set' relationship between ideas, experience and body practice. Contra-Bourdieu, however, he argues that this disruption has both personal and social significance in that it: '... lays people open to possibilities of behaviour which they embody but ordinarily are not inclined to express. Furthermore, I believe that it is on the strength of these extraordinary possibilities that people control and recreate their world, their *habitus.*' (Ibid: 129)

> torture, murder, war, the verge of suicide, hospital tragedies, the point of execution, etc. (Turner 1982: 46-7)

As I have shown in Chapter 1, participants in this study could generate similar images of themselves and their situation; they lived in a variety of 'extreme situations' where, as Shaun said, they were "up against the wall" and anticipating the worst. Moreover, they seemingly shared many of the attributes of initiates in rituals of transition described so extensively by Turner. Ritual liminaries are often separated from the rest of society, accompanied by symbols of effacement, ambiguity and paradox. They mediate oppositions between life and death, male and female, food and excrement, since they are dying from, or are already dead to, their former status and life; or they are structurally 'invisible', having a liminal 'non-status' (Turner 1982: 26). Many of these images recall the 'mortification' of psychiatric confinement described by Goffman (1961), and well as the frequent association between schizophrenia and a 'living death' (see Chapter 1). Like 'chronic' patients liable to be designated 'rubbish' or 'grots' (Barrett 1996: 175), liminaries may be considered polluting because they transgress classificatory boundaries (Turner 1977: 37; Douglas 1966).[8] Liminality is also subversive and ludic, and can involve the isolation of cultural elements and symbols which are then recombined in numerous, often grotesque and 'unnatural' ways (Turner 1982: 27), such that mundane, quotidian experiences are 'split off' from their expectable contexts (Turner 1977: 38). In liminality, people 'play' with familiar elements and 'defamiliarize' them (Turner 1982: 27). A similar quality was evident in many of the artworks which participants created, in the decoration of their houses, in the stories they wrote or recorded, and in the explanations for schizophrenia that they canvassed. Similarly, their experiences often seemed 'split' by the juxtaposition of the ordinary and the extraordinary, the expectable and the unexpected, and some even described themselves or their minds as 'split' in just this kind of way.

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[8] Turner contends (1967: 97) that liminal *personae* are universally regarded as polluting to those who have not been 'inoculated' against them through having been themselves initiated into the same state. This, too, could be seen as a measure of the distinctiveness and alienation of people diagnosed with schizophrenia, who must contend with clinicians, family members, and a host of others in 'the community' who have never had such experiences.

While these similarities are compelling at the level of images, there is an obvious constraint on adopting 'liminality' as a characterization of schizophrenia. The transition states which Turner described using this concept are all part of broader ritual processes resulting in the reintegration (and often the social enhancement) of the liminary. Schizophrenia was not part of such a ritual sequence and did not accomplish the work of ritual in Turner's sense. In particular, schizophrenia implicated a perpetual 'chronicity' which did not afford those people diagnosed with it a sense of reintegration or social incorporation — this was the persistent 'crisis' which they also evinced in terms of the *habitus*. In Turner's terms, theirs was a perpetual 'betweenness' which could not be resolved, only 'managed'.[9]

Without the ritual setting, schizophrenia appeared more like the 'liminoid' phenomena which Turner has described for complex, industrialized societies. Turner has developed several long lists distinguishing between the concepts of liminal and liminoid (see Turner 1977: 44-5; 1982: 53-5), the most pertinent categories being:

• Liminal phenomena are collective, cyclical or corrective (mediating internal adjustments, external adaptations, or unexpected disasters);	• Liminoid phenomena are collective (e.g. carnivals, sports events), but produced and consumed by named individuals; they are continuously generated, but not cyclical;
• are integrated into a total social process, even though they represent the negativity and subjunctivity of that process;	• are outside central economic and political processes, occurring along margins and interfaces;
• engage common intellectual and emotional meanings;	• are, plural, fragmentary and experimental;
• represent the inversion or reversal of secular, mundane reality and social structure.	• are not just reversive but subversive, producing a radical critique of central structures and proposing utopian alternatives.

Thus, the symbols found in *rites de passage* are only subjected to permutations and transformations within relatively stable, cyclical and repetitive systems (Turner 1982: 29).

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[9] It was this characteristic which generated analogies with other illnesses, especially diabetes, which similarly could not be cured, only managed.

Liminality is 'earnest play' — that which accomplishes social and cosmological work — and has to be kept within bounds (ibid: 32).[10] The liminal phases of tribal society 'invert but do not usually subvert the *status quo*, the structural form, of society' (ibid: 41). The liminoid, however, is a domain of individuation and choice: 'Optation pervades the liminoid phenomena, obligation the liminal' (ibid: 43). The liminoid encompasses a capacity for variation and experiment, and it is an independent and critical source which can be turned against the normative social structure itself, here recalling Bourdieu's inter-linked concepts of strategy and struggle.[11]

Turner asserts that liminoid phenomena arise in the context of role specialization, innovative ideas and technological change. They originate in 'free time', in a realm of 'leisure' which is sharply distinguished from that of 'work':

> ... "work" is ... the realm of the rational adaptation of means to ends, of "objectivity," while "play" is ... divorced from this essentially "objective" realm, and in so far as it is its inverse, it is "subjective," free from external constraints, where any and every combination of variable can be "played" with. (Turner 1982: 34)

This could almost be a description of most participants' ideal (and in some cases, actual) everyday world: since they did not work and had few requirements for a 'means to ends' rationality, they sought to inhabit a realm free from external constraint, in which they could explore their own subjectivities and 'play' with elements of their culture in a variety of combinative ways. There are echoes here of the images of temporal freedom, unpredictable synchronizations, improbable conjunctions, and the 'more or less anarchic combination of fragments of diverse discourses taken out of context' which Bourdieu (1988: 173ff) uses to characterize crisis and revolt. Having been divested (by diagnosis)

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[10] Here recalling Douglas' concept of implicit assumptions which form a 'stable background' on which meaning is formed, the restricted cultural repertoires referred to by Ortner, as well as the limits on creativity and inventiveness which *habitus* imposes by way of the social structures it internalizes.

[11] This also recalls the struggles over Hawaiian tabu hierarchies (and the eventual collapse of the chiefly tabu system) which are a primary vehicle for Sahlins' (1981: 46ff) analysis of the functional effects of transgressive practice. Turner notes (1969: 126) that most definitions of social structure share the notion of a superorganic arrangement of parts, positions or statuses that continues, with more or less gradual modification, through time. Conflict is therefore inevitable, since the differentiation of parts is liable to become opposition between parts, and scarce status becomes the object of struggle between the persons and groups who lay claim to it.

of the obligation to be part of the workforce, most participants embraced the two types of freedom which Turner associates with leisure: the *freedom from* institutional obligations prescribed by technological and bureaucratic organization; the *freedom from* 'forced, chronologically regulated rhythms of factory and office' (here recalling Jeff's appreciation of schizophrenia as freeing him from appointments); the *freedom to* generate 'new symbolic worlds of entertainment, sports, games [and] diversions of all kinds' (here recalling Adam's board games and children's stories); and the *freedom to* 'transcend social structural limitations … to *play* … with ideas, with fantasies, with words … with paint … and with social relationships' (Turner 1982: 36-7; original emphasis). This latter image was an ideal after which most participants strove, and which some asserted they had achieved.

According to Turner, liminoid situations are 'the settings in which new models, symbols, paradigms, etc., arise — as the seedbeds of cultural creativity' (Turner 1982: 28). This recalls Shaun's declaration of schizophrenia as "the powerhouse of culture", as well as the popular association of schizophrenia with artistic creativity on which Shaun himself played. It also recalls Karlsson's (1968: 91-2) coining of the term 'superphrenic' to describe a category of persons who are more than ordinarily gifted, highly logical, have a vivid imagination, are good at games, are highly productive, and tend to assume leadership in cultural or social affairs. Karlsson places his 'superphrenic' on a spectrum with the 'normophrenic' (the 'average or normal man'), the 'tensiphrenic' (individuals who develop nervous tension), and the 'schizophrenic' proper. In this view, schizophrenia is one point on a continuum that encompasses all of humanity and all experience, but is accorded a potentially privileged status:

> Schizophrenia is perhaps a state of overstimulation, which in most instances leads to a toxic condition, but in a few individuals results in the type of creativity on which mankind is dependent for scientific and cultural progress. (Karlsson 1968: 94)

Such images of innovation (if not Karlsson's neologism) are widely available — amongst those diagnosed, in popular culture, and in the by-ways of psychiatric theory — for thinking about schizophrenia. In this way, schizophrenia might be said to take its place among the other liminoid phenomena which Turner has identified: theatre, poetry, writing, film, sport, rock music and pop art — those 'genres of industrial leisure' which 'play with the factors of culture, sometimes assembling them in random, grotesque, improbable, surprising, shocking, usually experimental combinations' (Turner 1982: 40). These genres were the focus of most participants' daily activities, as well as vehicles for their most ardent interests, desires and aspirations, and they 'played' with them in the same way that Turner has described.

In their resistance to and evasion of dominant institutions (see Chapter 4), people diagnosed with schizophrenia could have been said to enact a version of Turner's 'anti-structure': the dissolution of 'normative social structure with its role-sets, statuses, jural rights and duties' (Turner 1982: 28). This anti-structure is not a simple reversal,

> … but the liberation of human capacities of cognition, affect, volition, creativity, etc., from the normative constraints incumbent upon occupying a sequence of social statuses, enacting a multiplicity of social roles, and being acutely conscious of membership in some corporate group such as family, lineage, clan, tribe, nation, etc., or of affiliation with some pervasive social category such as a class, caste, sex or age-division. (Turner 1982: 44)

Anti-structure is fuelled by 'communitas', an 'unmediated relationship between historical, idiosyncratic, concrete individuals' (ibid: 45) by which they see, understand, and act towards one another free of normative roles and social expectations. In its spontaneous form, communitas is a 'direct' and 'immediate' confrontation of human identities (ibid: 47). It is,

> … an alternative and more "liberated" way of being socially human, a way both of being detached from social structure — and hence potentially of periodically *evaluating* its performance — and also of a "distanced" or "marginal" person's being more attached to *other* disengaged persons — and hence, sometimes of evaluating a social structure's historical performance in common with them. (Turner 1982: 51; original emphasis)

Communitas allows the 'structurally damned' to pronounce judgement on the social structure, and provide it with alternative models (ibid). Small, informal groups (coteries, clubs, gangs, fellowships) nourish communitas by withdrawing from the mainstream of economic and domestic life. Turner suggests (1977: 47) that people who are similar in one important characteristic — sex, age, physical or mental condition — typically withdraw from the total system from which they feel alienated and seek the 'glow' of communitas and anti-structure.

The concept of communitas could be used to describe what a few participants found of value in the Schizophrenia Fellowship. This was a place where Adam, for example, felt "it's very much birds of a feather, people who hear voices hanging around with people who hear voices", where "we swap stories and try and work out what the 'voices' are up to", and where the "best scenes" were "when guys are going really high, jumping around talking about spirits". The concept of anti-structure could also be used to designate the detachment and critique which participants cultivated in respect of their social position. As I have argued in Chapter 4 and Hannan (1990) has demonstrated for her Sydney 'clients', however, this situation did not lead participants in this study to form bonds with other 'marginal' people, or even with others diagnosed with schizophrenia. The majority did not attend the Schizophrenia Fellowship and did not associate with others diagnosed with schizophrenia. They rarely sought a direct revelation of who and what they were; most of their strategies were aimed at avoiding detection, cloaking their experiences, and hiding their institutionally ascribed identities. Indeed, an unmediated 'flow' into other people, objects or events — outside of such socially-approved contexts as a sporting event, artistic appreciation or mainstream religion — might look a lot like a 'loss of ego boundaries'. If detected, this could lead to reinforcing the diagnosis of schizophrenia. Some participants reflected ironically on the fact that it was dangerous for them to exhibit excitement, let alone self-abandonment or ecstasy. They did not expect (and nor did they want) to be embraced in the 'We-relationship' of communitas. The confrontations with which they were most familiar were characterized by the expectation of hostility and an absence of understanding.

IMAGES OF TRANSFORMATION: SCHIZOPHRENIA AS A 'STATE' OF LIMINALITY

With his concept of liminoid, Turner does not address the question formulated by Ortner (1984: 155) and cited above, *viz.*: are these liminoid phenomena merely variations on basic cultural schemes, or are they alternate modes of social and cultural being? Nor does he provide a framework for considering their location within broader structures, or the social conditions which generate and sustain their existence. They exist negatively, as subversive, alternate and marginal domains.[12]

While most participants were excluded from (or excluded themselves from) the communitas of liminoid situations, they did appear to subsist in a permanent state of liminality. Such a construction is somewhat contradictory since liminality is, in Turner's terms, more of a process than a state. In small-scale, relatively stable and cyclical societies where change is tied to biological and meteorological rhythms, *rites de passage* constitute transitions between states. Turner defines this concept of 'state' as any type of stable or recurrent condition that is culturally recognized. It is possible to talk about 'a state of transition', but he prefers to regard transition as a process, a becoming, and a transformation (ibid: 94).[13] Liminality entails, not so much structural contradiction but that which is essentially unstructured (which is at once de-structured and pre-structured). In 'traditional' societies this finds expression in bringing neophytes into contact with a deity or with superhuman power — with what is often regarded as the unbounded, the infinite and the limitless (ibid: 98). Participants in the present study evinced something similar in their recourse to religious tropes to explain their 'mystical' and 'esoteric'

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[12] Strikingly, some of those liminoid areas which Turner identifies — art, writing and sport, for example — appear to correlate with the 'fields' of cultural production with which Bourdieu has been much concerned.

[13] Elsewhere in his work Turner does contemplate situations in which (with increasing social specialization) the transitional quality of 'betwixt and between' can become an institutionalized state (see Turner 1969: 107). He contends that this institutionalization of liminality is most clearly seen in the monastic and mendicant traditions of world religions, as in Benedictine and Franciscan communities. Thus, Francis appears to have compelled his friars to inhabit the fringes and interstices of their contemporary social structure, and to have keep them in a permanent liminal state where there were optimal conditions for the realization of communitas (ibid: 145).

experiences (see Chapter 1). In ritual contexts, such contact with *sacra* is often a pedagogic exercise, teaching neophytes about 'reality' as it is culturally constituted. In this it is also essentially reflexive. In liminal transition neophytes are alternately forced and encouraged to think about their society, their cosmos, and the powers that generate and sustain them. Turner states (ibid: 105) that it is in this sense that liminality can also be described as a 'stage of reflection'. This also resonates with what I have demonstrated concerning participants' reflexivity toward themselves, their social position, their experiences, and the nature of experience itself. For people diagnosed with schizophrenia in Australian society, however, assertions of contact with *sacra* and a sustained reflection on cosmological issues often lacked a sustaining context in people's everyday lives, or in the wider culture generally.[14] Such foci could, in themselves, support and validate a diagnosis of mental illness.

In later works, Turner also canvassed liminality as a condition of personhood. Thus, he proposed a state of 'outsiderhood', a condition of being either permanently and by ascription set outside the structural arrangements of a given social system, or being situationally or temporarily set apart, or voluntarily setting oneself apart from the behaviour of status-occupying, role-playing members of that system (Turner 1974: 232-3).[15] The capacity of schizophrenia to be rendered synonymous with the person (as 'schizophrenic') echoes this process of constructing a quintessential liminal person — specifically, the person who embodies liminality and outsiderness as a cultural condition.

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[14] Cf. Corin and Lauzon (1994: 45-7) on the lack of an 'integrative frame' for 'restoring' schizophrenic experience among their Montreal patients. Corin's earlier analyses of possession rituals in central Africa had revealed a 'back-and-forth movement between integration and retreat' which was sustained by an etiological idiom which articulated personal, interpersonal, social and supernatural frames of reference (ibid: 46). In North America, however, a drift toward marginality and a lack of meaning meant that identities and 'life-strategies' remained idiosyncratic, fragmented and uncontained by a larger social and cultural frame that could reinforce and integrate them (ibid: 47).

[15] Examples include diviners, mediums, priests, hippies, hoboes and gypsies (Turner 1974: 233), these being categories of person with which a number of participants identified. 'Marginals', by contrast, are simultaneously members of two or more groups whose social definitions and cultural norms are distinct from, and often even opposed to, one another (ibid). Many participants evinced qualities associated with both of these categories, again highlighting their transgression.

Since liminal *personae* are antistructural, interstructural, and structurally invisible (Turner 1967: 97), they represent structure in a negative way. Since they represent 'not this, not that', as well as 'both this and that' (ibid), they encompass all possibilities. This also echoes the apparent limitless freedom and indeterminacy ('all things become possible') afforded agents when there is a 'break' in their doxic relationship to the social world. Such a break potentially unmasks (and thereby throws up for reflection) the hierarchies which sustain the correspondence between objective, external structures and personal, internalized structures (see Bourdieu 1988: 182).

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As models of disjuncture 'within limits', the concepts of broken *habitus* and liminality offer tools for thinking about schizophrenia, although largely by way of contrast. Both implicate periods of discontinuity, indeterminacy and disarray (see Bourdieu 1988: 183), in which the world as taken for granted is discredited and rendered vulnerable to reflection, critique and play. Schizophrenia appeared both as an abiding expression of such 'crisis', and as the embodiment of its liminality.

The extended 'critical moment' and a perpetual state of liminality are theoretical possibilities implied in the work of Bourdieu and Turner respectively, although they are not ones which either theorist has explored in detail, and, indeed, create logical inconsistencies within their overall frameworks. The thrust of each of their writings suggest that such possibilities are anomalous, and that, even if they should arise, are equally likely to resolve or disappear. Schizophrenia embodies this anomaly, thereby highlighting the normative operations of *habitus* and liminality by way of contrast.

For Turner (1967: 110), the phenomena and processes of mid-transition paradoxically expose the basic building blocks of culture at the point of passing out of, and before re-entering, the structural realm. For Bourdieu, *habitus* accommodates (at both the individual and social level) those processes of transformation which similarly mediate the production and reproduction of social forms. In both conforming to and confounding the *habitus*, schizophrenia is an extraordinary case which highlights the limits and transgression of that accommodation. It focuses attention on the dialectic with which Bourdieu is principally concerned, that is, the 'dialectical relations between the objective structures … and the structured dispositions within which those structures are actualized and which tend to reproduce them' (Bourdieu 1977: 3). As a case study, schizophrenia may elucidate this dialectic by focusing on its transgression which, as Foucault has noted (1977: 34), clarifies a limit or a border by way of its crossing and re-crossing (see also Conclusion). As the epitome of reflexive transformation, schizophrenia provides a unique perspective on both *habitus* and liminality, their dynamics, and their limits as analytic concepts. It brings such transformation into view, into consciousness, and embodies it in a perpetual condition.

Habitus and liminality are both concepts addressing change and contradiction within a broader temporal framework of resolution. Broken *habitus* and unresolved transition introduce possibilities for temporal suspension and irresolution. As a potentially atemporal 'chronic' condition, schizophrenia epitomizes this suspension and confronts the social capacity to accommodate aberrant temporal trajectories. The psychiatric attribution of chronicity implies the collapse of temporal distinctions. Participants resisted this collapse (or, as in the case of Evelyn, put it to an alternate use). Both Kelvin and Rachel insisted (see Chapter 4) that they were something other than 'chronic'. Their insistence on biography as a source of understanding relied on a recourse to time, specifically a reflection on their lives through time. Participants thus countered chronicity (a time collapsed to the focal point of diagnosis) with a reflexive chronology grounded in biography and transformation (cf. Estroff 1993). From psychiatric and social theory perspectives, reflexivity and unresolved transformation signalled crisis. From participants' perspectives, such reflection and transformation were the motifs of biographical continuity. They mediated and lived the contradiction between these perspectives.

REFLEXIVITY IN CONTEXT

While schizophrenia throws reflexivity into sharp relief — at least amongst those people with whom I worked — reflexivity is equally a component of many other experiences and social processes. Here I note briefly the role which has been attributed to reflexivity in such life-transitions as adolescence and death. I also note its role in organizing accounts of social change and modernity. With these observations I wish to emphasize the point that reflexivity is not restricted to a pathologized object such as schizophrenia, but is an intrinsic component of both social practice and social theorizing.

Although illness is an obvious site of heightened reflexivity[16], it is not the only one. Reflexivity is equally an aspect of life-cycle transitions, life crises, trauma, grief and death. These are all occasions, 'in the normal course of events', when the usual way of making sense of things fails and we must address them and make sense of them anew. Thus Wolff notes (1984: 194-5) those 'extreme situations' in which there is 'deep confusion, the unshakeable grip by something new, the feeling that everything is a riddle, that there is no sense in the world', when 'our traditional, habitual, customary methods fail'. All such processes have the potential to cause breaks in experience, to problematize that which has been taken for granted, to unmask the apparent naturalism of the quotidian, and to render the everyday world an object of reflection.

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[16] See Kapferer (1991: 324): 'Illness is the irregularity which disrupts the regularity of daily life. It is the disorder of being in the very circumstances of life's existence ... Illness is not part of life's schedule, and ... it attacks the basis of a cultural and social order which human beings impose.' See also Good (1994: 131): 'Sickness and pain submit experience to the body's vital rhythms, infusing everyday experience with its distorting presence, focusing our awareness on the body as object, alien to the experiencing self, the object of cultural practices. The normal personal and social rhythms of experience are often subverted, shaped to the body's demands.'

Simon (1996), for example, has noted how such reflexivity marks the conjunction of (biological) puberty and (cultural) adolescence — both points of life-cycle transition for the individual and his or her social group — in contemporary North America:

> What is casually permitted in childhood is often accorded great significance in adolescence… [A] self-forming heightening of self-consciousness attaches to the sexual in both dimensions of significance: the larger and more diffuse issues of gender and, within gender, the character of the erotic. Such self-scrutiny must include a nervous monitoring of one's own intrapsychic responses and the perceived, often imagined, attributions of a growing number of significant others for whom the individual's gender competence and sexuality are of concern. (Simon 1996: 89-90)

Sexuality, Simon suggests, exemplifies a state of complexity and pluralism in which 'the ordering of the self is not merely the reflection of social life, but is occasioned by problematic, choice-laden encounters within social life' (ibid: 70). This is a conflicted and ambiguous 'cultural scenario' in which the self is expanded by way of 'internal dialogue' and heightened reflexivity (ibid: 41).[17] It is also a scenario in which the individual confronts, often for the first time, a range of attributed pathologies. More generally, it is the multiple transitions occurring during adolescence, as well as the discontinuities of adulthood ('mid-life crises'), which form 'normal pathologies' in the west (ibid: 79-80). As another transition entailing the body and constructions of self, death similarly initiates heightened anxiety and reflexivity, especially in those cultures where it is masked or denied. Thus, Mellor and Shilling argue that,

> With the decline of the religious frameworks which constructed and sustained existential and ontological certainties residing outside the individual, and the massive rise of the body in consumer culture as a bearer of symbolic value … there has been a tendency for people to place more importance on the body as constitutive of self… [T]he presence of death appears especially disturbing in this context of reflexively constructed self-narratives which have at their centre a concern with the body. (Mellor & Shilling 1993: 413)

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[17] Cf. Laing (1965: 106): 'The heightening or intensifying of the awareness of one's own being, both as an object of one's own awareness and of the awareness of others, is practically universal in adolescents, and is associated with the well-known accompaniments of shyness, blushing, and general embarrassment'.

In many ways schizophrenia highlighted these wider processes of crisis and transition, often by way of counter example. This had the effect of making 'normal' and taken-for-granted processes a ubiquitous object of reflection (and, occasionally, of self-recrimination as well). Thus, many of the parents we interviewed represented their adult offspring as being trapped in a perpetual state of troubled adolescence (and themselves as trapped in a perpetual parenting role). They lamented the fact that their children had failed to take on 'adult' roles by way of participation in the workforce or having children of their own. Many participants could offer similar images of themselves: of forestalled physical and social development; of being "stuck" in a juvenile world of fantasy and dreams; of having failed to 'grow up'; of never being likely to achieve what they saw as 'normal' kinds of sociality and intimacy with others.[18] Thus they could represent themselves, as psychiatry did, as afflicted by time not passing properly, or as persons who had not transformed (grown up, relinquished childhood, become independent) in the culturally appropriate time. Equally, however, some participants valorized this stepping out time, thereby countering its negative and moral connotations. Given their sometimes horrendous and traumatized backgrounds, some participants rationalized their 'lucky escape' from relationships and social expectations; others appeared to flaunt their non-conformity as a conscious social critique. Some rejoiced in their exclusion from economic responsibility, mortgages and conspicuous consumption. For both parents and participants there was always the spectre of death through suicide.[19]

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[18] Similar images of schizophrenia mirroring childhood are widely available in the psychiatric literature. Kraepelin (1992 [1920]: 522-3), for example, asserted that *all* of the 'schizophrenic manifestations' — 'primitive instincts', submission, impulsiveness, repetition and playfulness — could be found in children. Cameron (1966: 51) likened 'schizophrenic thinking' to 'functional immaturity' and the 'asocial thinking of young children', although he rejected the idea that a schizophrenic 'breakdown' was simply a regression to childhood: 'It is hardly more correct to assert that as the schizophrenic loses his adult organization he becomes a child in his thinking, than it is to say of normal children that as they grow up they recover from schizophrenia' (ibid: 59-60). The 'disorganization' of schizophrenia is, according to Cameron, something entirely 'new and unique' in a person's life history (ibid: 60). More generally, schizophrenia has often been represented as a devolution of socialization in which an adult is believed to lose the pragmatic skills of social interaction and thought organization (see Ribeiro 1994: 236n).

[19] None of these attributes had to be realized empirically in order to have force within the field. As the Vigil and its accompanying church service made clear (see Chapter 3), such images of unfulfilment, breakage, loss and death were on display and widely available, whether or not they were realized within any known person's life.

Other commentators have sought to contextualize this reflexivity historically, arguing its relationship to complexity, social differentiation, change and modernization in particular. In one of the earliest sociological accounts of Western industrial society, Durkheim noted the evolution of this tendency toward reflexivity — of taken-for-granted things becoming 'objects of representation' — in a movement which in turn transformed society:

> [A]s societies become more vast and particularly, more condensed, a psychic life of a new sort appears. Individual diversities, at first lost and confused amidst the mass of social likenesses, become disengaged, become conspicuous and multiply. A multitude of things which used to remain outside consciences because they did not affect the collective being become objects of representation. Whereas individuals used to act only by involving one another ... each of them becomes a source of spontaneous activity. *Particular personalities become constituted and take conscience of themselves.* Moreover, this growth of psychic life in the individual does not obliterate the psychic life of society, but only transforms it. It becomes freer, more extensive, and as it has, after all, no other bases than individual consciences, these extend, become more complex, and thus more flexible. (Durkheim 1964: 347-8; emphasis added)

Such observations proliferated with the subsequent growth of industry, bureaucracy and technological specialization. Both Trilling (1972) and Elias (1978) have argued that modernity occasions a significant expansion of the domain and powers of 'psychic reality' — the consequence of heterogeneity in social experience and a plurality of mirrored semblances for the self. In the Weberian tradition, Calvinism is seen to have induced an 'incessant examination' of the individual's outward life and 'inward soul' for evidence of 'salvific grace' (Turner 1982: 38) — a heightened individuality and reflexivity which Weber linked, via the 'Protestant ethic', to the rise of capitalism itself. More recently still, such accounts reach an apotheosis in analyses of post-industrialism and post-modernity. Post-modern sociologies and psychologies emphasize the incorporation and normalization of change within both society and individual lives, such that even proximate social cohorts 'share fewer and fewer natural paradigms' and therefore 'the ability to share a "taken for granted" sense of what otherwise appear to be shared worlds' (Simon 1996: 5). As a consequence of the multiplication and segregation of roles, such change is said to accelerate the process of individuation and heighten reflexivity:

> The social roles we occupy are increasingly experienced … not as natural and fixed representations of the self, not as we experience the constraints of our skins, but as optional appliances, as costumes that celebrate, and at times disguise, *assertions* about who and what we have been, as well as what we are and what we desire to be. This enlarged domain of reflexive management of the self is the major source of the development of a more managerial and more abstract self. (Simon 1996:7; original emphasis)

Giddens (1991) similarly accounts for the self in modern society as a 'reflexive project' which must continually adjust itself to changes in circumstances and to the individual's unfolding life course.

Some participants accounted for their schizophrenia in similar images of historical change. Aiden, for example, saw it as a consequence of being human in an age of globalized electronic media. Shaun saw himself as being "caught' in an unprecedented "communications web". Roland saw his schizophrenia as a form of grief occasioned by the post World War II migration of his family and the severing of his ethnic "roots" — a dislocation which he equated with the destruction of indigenous cultures around the world. Others saw schizophrenia arising out of a confrontation with (and an inability to choose between) the proliferating paradigms and 'styles of life' they apprehended in contemporary society, or as a response to what they viewed as the fragmentation of shared worlds.

It is this common grounding in reflexivity — elaborated throughout the history of social theory — which allows schizophrenia and modern society to serve as analogies for each other, whether by way of disintegration (Leighton 1959) or alienation (Laing 1967).[20] Those diagnosed with schizophrenia could generate this comparison as easily as various theorists and commentators have done. It is the same analogy (and its theoretical entailment) which makes schizophrenia potentially crucial to debates in social theory itself.

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[20] See Lucas and Barrett (1995) on some of the resources and frameworks used to construct a formal analogy between mental illness and modern society.

CODA: GENERATING AND MULTIPLYING REFLEXIVITY

In being anomalous and unprecedented, the experiences associated with schizophrenia rendered unstable the taken for grantedness of common sense. Participants asserted that, as a consequence of such experiences, what was common could never be taken for granted. Lawrence, for example, was perplexed by what he called an "exaggerated" awareness of gravity, by which he felt himself immobilized at times; this had led to a sustained contemplation of those forces which held the world together. He was particularly interested in the constitution of material reality and speculated on what was to stop someone falling through the infinite spaces between molecular matter. How could he take a step outside having experienced the cosmic devolution — "dust to dust", as he said — of the ground into its constitutive elements? Of course, Lawrence did leave his house to follow the certainties of his "pilgrimage" routes (see Chapter 3), but he did so with the doubled awareness of what could not, and what must be, taken for granted. Similar speculations had caused Lawrence to have difficulties recognizing everyday objects in his world:

> "I sometimes find it difficult recognising objects. I get this sense that the world is infinite and I'm unable to make sense of it because every part of it is infinite, and that can be a very uplifting experience, that sense of infinity, but it can [make me] think, 'How can I possible do things if everything is infinite?' You know, 'What part of reality do I take out for this time?'
> Sometimes objects appear as just matter, without form. It can be quite interesting, things like that. But sometimes it's a bit frightening ... I am fascinated by it. I'm really interested in light and things like that. I find that amazing. It's just very beautiful. Even at night-time — I think the night is very beautiful, very pristine, like a little bit of Bach or whatever. It's very ... complex, very delicate, very involved. Sometimes I'll look at the light and I'll see that. Sometimes I don't see anything.
> You know Jackson Pollock? That's what I guess his paintings were about — infinity."

Another participant, Jonathon, articulated similar consequences from contemplating the meaning of infinity — in this case manifested as the limitless generation of numbers represented by π:

> "I felt like things had to be bounded or else I wouldn't be able to see where I was in relation to the world and my mind couldn't function right unless I knew what infinity was... I was lost thinking about these things with no answers."

Explaining her 'cubist' drawings, Zöe commented:

> "I see things from too many perspectives. I've got an ability to think things out from all sorts of angles. Being pushed into denial and hurt and pain makes me think in different angles."

Many participants pointed to how they recognized experiences as common to everyone — such as the perception of gravity, light or physical form — but were unable to take these for granted. Instead, they were compelled to constantly check and assess those things which made common sense to others. In this they often gave uncommon sense to common things, or had uncommon experiences of ordinary things. This represented a specific experiential break with a shared, taken for granted and intersubjective world.

Christopher articulated the need to 'face up to' and embrace the 'mystery' of those experiences which assaulted him:

> "... you've got to work towards experiences to become familiar with the unknown. You familiarize yourself with the unknown. You can't do it any other way. You're met with this mystery or this unsolved thing and the only way to understand it is to face up to it and experience it yourself. Otherwise it will remain a mystery to you."

This intentional stance, with its consequential objectifications, was a major source of reflexivity for many of the people with whom I worked. This was, perhaps, their most distinguishing feature.

I have suggested bases for this reflexivity in participants' experiences, in their social circumstances, and as a dimension of the field in which they acted. Each of these aspects were mutually reinforcing, so that the distinctiveness of participants' experiences was heightened by the psychiatric diagnosis which such experiences attracted, and this diagnosis in turn perpetuated their distinctiveness from others, throwing them back on their experiences as a privileged source of knowledge and veracity about themselves and their world. This multiplying and mutual reinforcement of reflexivity was supported by other features of the schizophrenia field, especially a private home which could accommodate and amplify these effects. Reflexivity was thus both a distinctive characteristic of persons, as well as a specific feature of schizophrenia as a socially constituted phenomenon.

Participants lived with a fundamental disjuncture: their experiences of schizophrenia were not articulated with the *habitus* given by their backgrounds, their socialization, or their everyday worlds (which is what made their experiences extraordinary, even to themselves) and were not, therefore, easily aligned with the values and regulatory principles of a wider society (which is what rendered them 'mad'). This did not mean, however, that such experiences existed without reference to social categories, to history, or to institutions. Indeed, most participants had been forced into a confrontation with institutions and the state (and with the power which was materialized therein) in ways that are demanded of few other people. Moreover, the very extraordinariness of their experiences contained within it the contrast with what was ordinary and taken for granted — a contrast which was perpetually reiterated and highlighted in their daily lives. It was this multiplying of subjectivity and reflexivity which grounded the psychological 'hyperawareness' identified by Sass (1992a) in practical and cultural necessity.

Schizophrenia has long tested the social limits and tolerance of 'diversity within homogeneity' which is characteristic of social life.[21] Schizophrenia highlights the fact that some deviations in personal style (cf. Bourdieu 1990a: 60) are more threatening than others, and attract greater surveillance, restraint, and management as a consequence. Some deviations are 'too different' indeed (ibid: 62), and are associated with pathologies which, by definition, are removed from social causality and personal agency, even when they implicate the whole person. Such pathologies are, by institutional caveat, embedded deep within an individual body or mind. There they are segregated from the 'style' of a period, class or culture, and from the efforts of a strategizing social agent to influence them. In the case of schizophrenia, such segregation and individuation is actively achieved

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[21] See Barham (1993: 199ff), who has elaborated on the conceptual, historical, social, and political effects of locating schizophrenia 'at the edge of the common'.

by way of clinical practices which have a specific power to designate persons by way of diagnosis, and to dispose them throughout the hospital or the community on this basis. Everyday life for participants in this study required that they mediate the disparity between an 'objective', authoritative rendering of pathology which implicated them without affording them responsibility for it, and the effects of this designation which ramified throughout their social worlds and thereby demanded that it be subject to some measure of personal control. It was the disparities created between this power (which was remote, diffuse, and constituted across a field of institutions) and its effects (both practical and intimate) which accentuated and perpetuated the reflexivity which accompanied the experiences of schizophrenia.

PART III

DIALOGUES

TALKING, ‘VOICES’, TEXTS

Chapter 6

"WHO'S GOING TO BELIEVE ME?" THE IMPERATIVE OF TALKING ABOUT SCHIZOPHRENIA

> I did not know the cure for the disease of images, but I believed in the healing power of words and stories.
> *Until the End of the World* (W. Wenders, 1991)

In this chapter I am concerned with the problem of gaining access to those phenomena which participants asserted were central to their lives and identities. I treat talking primarily as a medium of intersubjectivity. Talking, insofar as this was a dialogue 'across' and 'between' my own and participants' often incomparable experiences, was a major vehicle for gaining access to the meanings that schizophrenia had in people's lives. Talking constituted a particular form of participation which focused on bringing something — unusual experiences, an 'illness', a life history, a lifeworld — into view. Given schizophrenia's lack of physical stigmata, it could often be approached only through what participants said about it. This talking was a strategy facilitated by the project itself, and not necessarily one which was available to all people diagnosed with schizophrenia. It was also the vehicle by which extraordinary experience was objectified, reflected upon and negotiated.

I argue that participants' ability to speak of and through their experiences, situated as this speaking was in a particular type of place (that is, their own homes), substantiated their agency and shaped their identity. Talking revealed participants' distinctiveness within specific social circumstances. The chapter thus addresses the broader politics of talk whereby participants asserted their identity and sought to make sense of their lives. Wilce Jr. (1995: 927) has demonstrated how the conflict which is inherent in medical encounters in Matlab (Bangladesh) is centred not only on a patient's explanatory models of illness, but also on the right and capacity of patients to speak of those explanations in medical encounters in which they must struggle 'to find their voices or make them heard' (ibid: 928). This research project was itself an alternative forum in which participants' critical voices might be heard.

Given participants' susceptibility to having their identities ossified as 'schizophrenic' in their engagement with psychiatric hospital processes, and for their talk to be apprehended as symptomatic of that totalizing state, there were clear imperatives attached to this talking. For most participants, the fundamental imperative to be recognized as moral agents with the capacity to account for themselves could only be realized through engaging others and convincing them that the experiences associated with schizophrenia were real and recognizably human. Talking was the principal vehicle of that engagement. It served as a means of demonstrating agency, asserting identity and contesting prescribed attributes of person. Moreover, the ability to talk at a time and place of their own choosing — that is, to take control of a speaking situation — highlighted the relationships of power which were taken for granted in this field. A focus on talking thus demonstrates how the issues of identity, agency and field — the main foci of Chapters 3 through 5 — were interrelated.

LANGUAGE IN USE

In this chapter I am concerned principally with what Taylor (1985b) calls the 'expressive' meaning which is made available through the use of language as talk. Such a focus situates the formal 'designative' functions of language within a broader consideration of what talking achieves as a specific form of social interaction. It is concerned with the capacity of talking to formulate phenomena and bring them into view, to effect intersubjectivity, and to implicate the person as a moral agent. I outline Taylor's approach briefly.

Taylor (1985b) contrasts two basic ways of conceptualizing the relationship between language and meaning, each with its own history and adherents. He calls one of these the 'designative' view, which he suggests first emerged clearly with the nominalism of Hobbes and Locke in the seventeenth century. It was intimately tied to the development of science, and with the concomitant attempt to 'ground our picture of the empirical world in the firm foundations provided by clear unequivocal definitions of basic terms' (Taylor 1985b: 249). Such empiricism sought a semiological match between the world and the ideas it embodied. The issue of representation is basic to this tradition, with both philosophy and linguistics manifesting an ongoing concern with the rules by which an adequate image of things can be made. Different disciplines suggest varying ways in which language forms a bridge between words and their designata, concept and object, sense and reference, but they share a basic premise: that words have meaning because they stand for something, they 'signify' things (ibid: 250). Such a theory of reference informs both behaviourism and semiotics (one emphasizing natural correlation, the other arbitrary labelling): 'Both consider the question of meaning in terms of correlations between words and things, words and behaviours' (ibid).

Taylor critiques this tradition in terms of its mechanistic basis, its denial of intentionality, and its neglect of human thought. He claims that it is also falsely objectifying, relying on an 'observer's stance' (and resulting in an 'observer's theory') which sees language as an 'object observed but not participated in' (ibid: 255).[1] Most importantly, Taylor suggests (following Frege) that it ignores the activity which underlies meaningful uses of language:

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[1] Cf. Bourdieu's (1991a) critique of 'intellectualist' linguistics and philosophy which treat language 'as an object of contemplation rather than as an instrument of action and power' (ibid: 37). He aimed this critique directly at Saussure who, according to Bourdieu, revealed the structure of language from the position of an 'impartial spectator' who wanted to understand language for the sake of understanding, which is different from the interest of an agent using language in practice (see Bourdieu 1990a: 30-3). Such a spectator/analyst asks questions of language and reality that a social agent would never ask.

'Only in the context of a sentence does a word have meaning, because it takes a sentence to do what we do with words, that is … say something' (Taylor ibid: 251; see also Ricoeur 1974: 51-3). Making sense of a linguistic reference is a 'route', a journey, and an active process: 'Words are not just attached to referents like correlations we meet in nature; they are used to grasp these referents; that is they figure in an activity' (Taylor ibid: 252).

Against the designative tradition Taylor proposed another which he presents as more adequate to the task of explaining the emergence of meaning from language as it is used in social situations. Drawing on multiple sources (but principally Herder, Humboldt, Hamann and Heidegger), he glosses this second tradition as 'expressive'. This approach takes the activity of speaking as primary, within which the system of designation is constantly made and modified.[2] What, Taylor asks, is brought about in language and essentially through language? By way of an answer he emphasizes the following three aspects of language in use:

- Firstly, in language we formulate things, bringing into fuller and clearer consciousness an awareness of something (a thought, an idea, a feeling, the appearance of things) of which we formerly only had an implicit sense:

  > When I still do not how to describe how I feel, or how it looks, and so on, the objects concerned lack definite contours; I do not quite know what to focus on in focusing on them. Finding an adequate articulation for what I want to say about these matters brings them into focus. To find a description in this case is to identify a feature of the matter at hand and thereby to grasp its contour, to get a proper view of it. (Taylor 1985b: 257)

  It is success in articulating a matter, rather than finding the right designative word or the correct technical term, which is central to this task of 'formulating'.[3]

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[2] Cf. Ricoeur (1974: 52): 'Language as sentence and as discourse appears and disappears. It happens. Whereas systems of signs are merely virtual, language as discourse is actual.' See also Dilthey (1959: 224-5): 'What is given is a succession of words, the meaning of which is only partially determined; its meaning is variable. The potential meanings of words are, within certain limits, numerous; so the meaning is made clear as what is undetermined is clarified through the construction of the sentence.'

[3] Cf. Merleau-Ponty (1962: 177): '… if talking were primarily a matter of meeting the object through a cognitive intention or through a representation, we could not understand why thought tends towards expression as towards its completion, why the most familiar thing appears indeterminate as long as we

Equally, this is a source of indeterminacy (and hence ambiguity), since language has the capacity to 'apply a web of terms, and never the ability just to use a single term' (ibid: 258).

- Secondly, language is a social activity — what I have glossed here as 'talking'. It places some matter out in the open, between interlocutors, and creates the 'peculiarly human kind of rapport' of being in conversation together (ibid: 259). This is an intersubjective exercise which makes things 'no longer just a matter for me, or for you, or for both of us severally, but … something for us, that is for us together' (ibid). It is a process which subordinates the designative function of language to an expressive task — a representation can have no meaning for persons involved in a conversation unless an expressive intent or significance is attributed to it.[4] Taylor notes (ibid: 260) that such a capacity to create a 'public space' does not prevent speakers from putting severe limits on how much they will place in the common realm. Thus talking accommodates a variety of conversations from the deepest and most intimate to the most trivial, formalized or restricted. Such a function also mitigates against a 'monological model of the subject' in which all states of awareness, knowledge, belief and attention are explicated as states of individuals alone. Meaning, in this tradition, is inherently dialogical.

- Thirdly, language is the medium through which morality is articulated. It is language which allows discriminations in terms of 'right' and 'wrong', and the application of standards *qua* standards (that is, a sense of action meeting some standard, or of knowing that a behaviour is as it ought to be). It is only through language that people can be judged as moral agents — it makes no sense to

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have not recalled its name, why the thinking subject himself is in a kind of ignorance of his thoughts so long as he has not formulated them for himself'.

[4] It is for this reason that Ricoeur (1974: 52) similarly notes that the emergence of meaning from language in use always involves a hearer addressed as the second person and that, 'This I-thou structure of discourse belongs to the semantic order and has no place in semiotic systems'. Sampson (1993: 97), following Bakhtin, calls this the 'addressivity' which is present in all conversation.

> conceive of an agent recognizing standards which are neither articulated nor acknowledged. It is in this way, Taylor argues, that 'the essential human concerns are disclosed only in language, and can only be the concerns of a language animal' (ibid: 263).

The issues raised by this approach to language in use — especially its bringing phenomena into view and its equal capacity to conceal or hide them, its placement *between* interlocutors, its predication of person and agency, and its forming a vehicle of moral assessment — inform the ethnography of participants' talk presented below.

Before proceeding, however, it is necessary to set out those aspects of language which I am *not* covering in this chapter. In this way I hope to specify more clearly those aspects of language in use which are my focus here.

I do not, for example, undertake a semiotic analysis of participants' speech. After Saussure, language is generally attributed the dichotomous aspects of *langue* and *parole*: the former being an autonomous 'social institution', an 'abstract entity' and a 'collective contract', the systemic function of which transcends any individual usage; the latter being an individual act of selecting and combining language elements (as recurrent signs) into the motivated practice of speech (Barthes 1968: 14-16). While speech and its motivations are a focus of the ethnography which follows, I do not engage here in a semiological analysis in order to extract those linguistic conventions which were 'indifferent' to the content of the signals which composed it (cf. Barthes ibid: 13). It was precisely the idiosyncratic, intentional and rhetorical content of speech in which I am interested as a vehicle by which participants identified themselves as particular types of persons who entered into a relationship with me by way of our talking together. In such a context, words as a designative system of sign references were less important than the meanings which could be established between us as joint participants in an ongoing conversation.

Similarly, I do not undertake conversational analysis by way of either its ethnomethodological or sociolinguistic variants (see Ribeiro 1994: 66-8). I do not, for example, provide a microanalysis of participants' language, using rigorous transcription and placing an emphasis on speakers' inferential processes and their choice between alternate utterances (ibid: 67). Nor is it my aim to engage in a formal (syntactic or discursive) linguistic analysis of 'schizophrenic speech'.[5] While I share some of the concerns of ethnomethodology, I do not employ its techniques here. Thus, some of the theoretical interests of both Schutz and Garfinkel are pertinent to my study, *viz.*: the focus on an active search for a shared referent in everyday speech; on how accounts are shaped by the 'context of their production' (Heritage 1984: 141); the way in which descriptions are deployed to make available, maintain, transform or otherwise manage a particular social activity (in this case, the research encounter); and the need to empirically assess how these descriptions (say of psychotic experiences) are evaluated, interpreted, accepted or contested in any particular circumstance. In this context, however, I am not concerned with those methods of ethnomethodology which are used to reveal the 'machinery' making up the practices of doing (Garfinkel & Sacks 1970: 355) and which, after Garfinkel, have focused on the minutiae of conversational sequencing, turn-taking, opening, closing and categorization devices.[6] Rather, I focus on talking as a way to delineate the research situation in terms of its principal activity. I focus on this talking as an intersubjective

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[5] Language use in schizophrenia is a prominent sub-field of psychiatric research in its own right. Thomas and Fraser (1994) set out the features of 'schizophrenic speech' in a major review article. Andreasen (1979) provides a useful overview of linguistic 'peculiarities' and 'cognitive behaviours' established widely through empirical observation of people hospitalized for schizophrenia. She demonstrates how these interests derive historically from the perplexing phenomena of 'thought disorder' which has long defied definition, but which has held a central place in psychiatric models since the early 20th century when Bleuler posited 'associative loosening' as one of the four 'fundamental symptoms' of schizophrenia. Ribeiro (1994: 14-16) has critiqued the conflation of thought and language, cognition and speech, which underpins much of this literature. The historical interest in language and schizophrenia highlights an abiding psychiatric concern with the relationship between speech and thought, brain and mind, language and its presumed mental and neurological substrate (see Critchley 1994). The centrality of language to some theories of schizophrenia can be seen in Crow's (1993, 1995) proposition that the origins of psychosis may be related to the late evolution of the human capacity for language and the neural reorganization which this demanded.

[6] See, for example, the studies by Sacks (1974) and Schegloff and Sacks (1974).

project (Jackson 1998), rather than analyze the language used by either participants or myself.

Discourse is perhaps a better way of specifying my focus here, but the term is confusing because it has been used with a number of mutually irreconcilable referents and a 'purposeful vagueness' (see Abu-Lughod & Lutz 1990: 7-8). Barthes uses it to refer to the way in which a speaker actualizes the 'code of the language' in unique combinations with a view to expressing a personal thought (Barthes 1968: 15). This internal and individualizing sense is not adequate, however, to describe the dialogic process with which I am concerned here. Most studies of 'schizophrenic language' have been conducted in this way on the verbalizations of an isolated speaker, rather than on what takes place between interlocutors.[7] Another common usage of the term 'discourse' as a synonym for dialogue does in fact convey this interactional sense (see Tedlock 1983). A third usage privileges formal and artistic productions over everyday speech, especially poems, songs, laments, prayers, myths and skilled verbal duels (see Abu-Lughod & Lutz 1990: 7-8). After Foucault there is a fourth 'structural' use of the term to refer to the institutional boundaries and limits of what can be said about a particular domain of knowledge, by whom and from what positions. While I do rely on this latter usage in relating talk to the wider social structures which Foucault calls 'discursive formations' (in which what can be said about schizophrenia, for example, is embedded in the settings and institutions which constitute it — see Chapter 3), I seek to avoid the confusion of referents here. I therefore refer primarily to talk, speech, conversation and dialogue, since these terms are more ethnographically descriptive of the encounters which were the basis of this research. These are what I gloss, after Taylor, as 'language in use'.

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[7] See, for example, the 'clinical' illustrations provided by Andreasen (1979).

TALKING AS A COMPONENT OF THE FIELD

Language was already configured as a component of the field itself. The idea that 'madness registers itself somehow in language' (Cox 1996: 310) has a long history. Cox traces it to an ancient Greek tragic tradition, to a persistent theme in European literature, and to Freud's assertion that 'the unconscious is the condition of linguistics'. She suggests that the conflation of language and madness has achieved its contemporary apotheosis with Lacan's maxim that 'the unconscious is structured by language' (ibid: 307). It is also the case, however, that except for a brief, sustained confluence of psychiatry and linguistics in the early twentieth century[8], the speaking of and through madness has endured two great periods of silence: 'the silence of obliquoy of earlier times and the silence induced by pharmacological intervention in our own' (Cox ibid: 308).[9]

Sheridan notes similarly of this historical silence:

> The discourse of the madman was not treated in the same way as that of the reasonable man. On the one hand it was regarded as unimportant, untrue, or ineffective: the madman could neither sign a contract, nor perform the act of transubstantiation at Mass. On the other hand, it was attributed with strange powers or hidden truths. Either it was rejected out of hand as unreasonable or it was thought to contain a special reason more reasonable than that of reasonable men and women. In either case, no attempt was made before the end of the eighteenth century, to collect this discourse of madmen, even though madmen were recognized by that discourse. They were listened to seriously only in the symbolic form of the theatre, where madmen were acted by those who were not mad. (Sheridan 1980: 122)

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[8] Exemplified by the work of Bleuler, Freud, Flournoy and Breton. Saussure collaborated with Flournoy in recording Hélène Smith's glossolalic speech during seances in Geneva, and her 'Hindu' is believed to have influenced the genesis of Saussure's own linguistics (see Shamdasani in Flournoy 1994: xxxv-xxxvii). Cox asserts (1996: 316) that it is Freud's analysis of Schreber's language (in *Psychoanalytic Notes upon an Autobiographical Account of a Case of Paranoia*, published in 1911) that restores to the language of madness its connection with the speaking subject by validating Schreber's utterances as 'meaningful' in some way and providing them with a 'translation'.

[9] There are a small number of texts which confound this silence by way of extensive transcription. See Laffal (1979), who provides a substantial verbatim record of 30 interviews conducted over 16 months with a single patient diagnosed with schizophrenia. Ribeiro (1994) uses detailed transcripts of two patient-psychiatrist encounters to analyze the coherence of psychotic speech. See also Saris (1995).

This is not merely an historic effect, however. Brown (1993) has demonstrated how, in the context of a 'walk-in' community mental health centre in the north-eastern United States, contemporary psychiatric admission procedures function to construe patients as unreliable authors of their own illness experiences. Hospital presentations are often framed by the 'mystery' of a patient's problems, which also elicits suspicion and mistrust of their motives on the part of clinicians (ibid: 259). Patients may not know what kind of information is being sought and are uncertain about how to interpret their problems in terms applicable to the intake process (ibid: 257). They may also feel that some of the things they could say will be used against them, such that 'autobiography must be well-tailored to protecting oneself in a potentially dangerous environment' (ibid). This combination of uncertainty and guarded meanings can lead to accounts of illness being construed as incoherent or false, and therefore dismissed in the search for more 'telling' clues to hidden pathology, the 'one key piece of the puzzle' (ibid: 263).[10] Clinical encounters are thus structured by a double 'unreliability', resulting in the production of a 'mystery story' for both parties.

In this context, working with people who had already been diagnosed as mentally ill, talking had a heightened significance, just as it came with a pre-established aura of expectation and suspicion. Participants themselves knew that it was easy to dismiss what they had to say as 'crazy', 'deluded' or untrustworthy — this was a commonplace feature of their worlds. Zöe, for example, was angered by the fact that everything she said could be treated as the manifestation of a illness, rather than what it was for her: the truth of her experiences.[11] With heavy irony, Zöe once signalled the weight of clinical presupposition when she exclaimed in frustration:

> "I'm schizophrenic. Who's going to believe me?"

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[10] Sjöström (1997: 107; 131-3) provides a detailed record of these admission processes in a clinical setting, including their professional, 'everyday;' and aesthetic bases.

[11] Cox (1996) examines the history of a 'narrow medical positivism' (ibid: 312) which has reified the language of the 'mad' as a 'symptom which shows, but does not itself speak' (ibid: 315). See also Goffman (1961: 45, 367-8) on the discounting of in-mates' statements as 'mere symptoms', which is accompanied by staff attention to the non-verbal aspects of behaviour.

Talking about their perceptions, ideas, beliefs, emotions, and fantasies to psychiatrists, nurses and social workers were standard practices of the field of institutions in which participants operated. Disclosure was a prominent feature of their lives and identities. At the same time, most participants judged that much of what they disclosed in this way was not rendered credible. It was their assessment that talking of their experiences was viewed as a further symptom of schizophrenia, especially by mental health professionals, but also by their families and by other people in general. This was the discrepancy and the contradiction with which they were regularly confronted, and which they sought to counter.[12] Talking was thus a medium, a tool, and even a weapon which participants used to combat the silences and predications of the field. It was also one of the few resources they possessed which might allow them to define themselves as 'players' of worth in this field (cf. Bourdieu & Wacquant 1992: 98). In this way, talking was a principal site of struggle through which the field was both defined and contested.

BRINGING SCHIZOPHRENIA INTO VIEW

Talking was the predominant form of engagement with participants. What people said were not the only research data collected, but talking was the principal means by which relationships with participants were conducted (see Chapter 2). In the absence of a personal experience of mental illness, my own inability to hear 'voices', the spatial distance of the study from hospitals and treatment centres, and its temporal parameters[13], *talk* about the experiences of schizophrenia was often the only means to approach issues

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[12] This was also an example of the specific contradiction explored by van den Berg (1982: 157ff), following Rümke (1960), *viz.*:

> A gap … separates [the schizophrenic patient] from us. Nevertheless, the patient himself says it; … he is capable of telling us. He says something to us which at the same time means he reaches us. He bridges the gap and communicates something. One could say: the patient is sufficiently with us to communicate to us … how far he is removed from us. (van den Berg 1982: 159)

[13] Ethics approval was predicated on *not* working with people who were acutely psychotic at the time of interview because they were deemed unable to give informed consent.

which were central to participants' daily lives and sense of themselves. Talk — especially in the form of speculation as to the causes and experiential parameters of a perplexing situation, together with 'emotional discourses' which bound a personal situation to a range of social issues (see Abu-Lughod & Lutz 1990: 13) — was the most direct mode of interacting with participants and finding a commonality with their concerns. As I have already demonstrated (in Chapter 4), the potential for engaging in activities with participants was severely restricted by the latters' lack of material resources. Many spent the greater portion of their time sitting alone in their houses. Given the opportunity, talk was their principal activity. People diagnosed with schizophrenia were not alone in this respect. Corrigan, for example, has documented the centrality of talk to the 'intense activity' of 'doing nothing' in youth sub-cultures:

> The major element in doing nothing is talking. Not the arcane discussion of the TV talk show, but recounting, exchanging stories which need never be true or real but which are as interesting as possible. About football, about each other, talking not to communicate ideas, but to communicate the experience of talking. (Corrigan 1975: 103)

Schizophrenia — so variously conceived by different participants — was never straightforwardly an object to be observed unmediated by the way in which people talked about it. To apprehend schizophrenia amongst most participants it was necessary to have them point out its particularity in a set of meanings which pertained specifically to their own lives. There was no blood test or x-ray which could reveal or objectify their 'condition'; no participant in this study had seen the results of any investigation which might identify a physiological or neurological location for their 'illness'.[14] Good (1994) has shown how chronic pain similarly defies medical practices which are predicated on localizing pathology at a discrete site in the body, 'a site which can be made visible and subjected to therapeutic procedures' (ibid: 132). Chronic pain resists such objectification;

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[14] This, for participants, was one source of schizophrenia's inherent ambiguity, as well as an expression of its conceptual contradictions (see Rümke 1960). In this it is another example, like childhood leukaemia, which illustrates Durkheim's assertion (in *The Elementary Forms of the Religious Life*, p. 431) that science, as inherently fragmentary and incomplete, cannot provide an 'impetus' to everyday action — see Comaroff and Maguire (1986: 102).

thus it is proclaimed subjective, 'a functional disorder of the subjective self, now held responsible for producing its own suffering' (ibid). Likewise for people diagnosed with schizophrenia, the absence of physical stigmata meant that their 'condition' tended to devolve into an attribute of their very selves. As one participant noted: "When they can't see any physical cause they think there is something wrong with you as a person". Talking with participants about their understandings of schizophrenia and its role in their lives was often the only way of escaping this conflation of person and illness. Talking was therefore a primary means by which participants asserted and displayed their claims to be something more than 'schizophrenic', and thereby sought to escape psychiatric prescriptions (see Chapter 4). Talking objectified schizophrenia, allowing it to be separated from the self, but also allowed its relationship to personal biography and social context to be negotiated and reconfigured.

Good has noted (1994: 133) how the 'crisis of objectification' in such perplexing conditions as chronic pain leads to 'a special need for narrative' as a means to reconstitute a life-world which has been enveloped by illness: 'Disease occurs not only in the body … but in time, in place, in history, and in the context of lived experience and the social world' (ibid).[15] Stories embrace and evoke those contexts. Participants in this study sought to take control of such contexts through biographical narratives which insisted on the specific temporal and spatial placement of their experiences. They recognized the pervasiveness and depth of psychiatry's capacity to bring time, place, experience and social position into a single configuration: a diagnosis of schizophrenia. The need to explain schizophrenia — to themselves as much as to others — and to position it within their own lives was commensurate with the extent to which their everyday world and sense of self had been changed by it (cf. Good ibid: 121-4). The potential conflation of person and illness meant that more was at stake in coming to terms with this diagnosis

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[15] See also Comaroff and Maguire (1986) on the quintessential uncertainty of childhood leukaemia and the placement of a 'search for meaning' within its 'total socio-cultural context' (ibid: 101).

than there was for many other less anomalous or pervasive conditions, or for many other states of being a person. Schizophrenia's delineation and separation by way of talking was correspondingly difficult but crucial to the task of approaching what it meant for (and about) the person concerned. Self-explanation, because of the self-implication of diagnosis, was a high priority for most participants. As an instrument of explanation, talking was therefore also a vehicle of agency.

MANIFESTING EXTRAORDINARY EXPERIENCE

For some participants, language could, in itself, be manifested as a form of extraordinary experience , confronting their own and other people's taken-for-granted assumptions about its use and meaningfulness. These participants attested to the ways in which they could not take language or speech for granted. These then became a specific vehicle for reflecting on the extraordinariness of experience. The following examples, provided by Francis and Zöe respectively, highlight the problematic of language in use.

Francis and the "language of love"

During the period she was "full on crazy", Francis found language to "twist and turn" in such a way as to require her constant attention and interpretation. It began with her interactions with those anonymous "media interests" who she believed kept her under constant surveillance (see Chapter 1). She explained:

> "We used to have this dialogue. I'd sit in my bedroom — this is at my mum and dad's place — with the door closed and I'd talk to them. I called it the 'language of love' … It was all to do with twisting and distorting the English language, which was the way I got messages out of the TV set and from the radio, by twisting things around."

This 'language' was based on particularly intricate word plays, such as the following:

> "What I'd do is I'd change the English language. Like a word like "four' for instance — I'd say it backwards, which is R-U-O-F … which is like 'woof', the 'woof' of a dog, so 'four' meant 'the dog', and that was a double-edged sword— … I was the dog [when I was] in persecution mode, [but] I was God when I was grandiose — so that's dog/god. And things like … 'eight' … The number 8 was that I ate people up — 'ate' [*spelt out*] — so that became 'welcome to tea' —T-E-A [*spelt out*] — it's an anagram, see."

In time, Francis' perception of this language spread to her everyday interactions, which became so difficult that she only felt able to communicate with children:

> "I related to [children] brilliantly, and I couldn't relate to anybody else, partly because of this language barrier, because I kept on looking at what people said and mis-interpreting what they were saying …
> I became quite child-like myself I think. My capacity to hold a conversation with an adult was somewhat limited … I kept on looking for clues in what people were saying and kept on twisting and turning the English language around. I never became adept at it. It wasn't something that came to me naturally so I'd have to sit there and think about it, and as a result, any conversation with another adult was extremely stilted … I had my own sort of catch-words which I was very familiar with. But in a conversation with another adult they'd be using a whole range of words that I'd never even thought about, so it became a lot harder … I was very slow to respond. I'd sit there and I'd think about what they said, and then I had to think about my response in turn, because … whatever I said could be twisted around too. So it became virtually impossible to hold a conversation with anyone."

The label, 'language of love', was itself a play on the profoundly disturbing nature of this phenomenon:

> "It was facetious. It was because everything that I said was being twisted and distorted and turned into me saying something mean. So it [the label] was entirely facetious — it was called the 'language of love' when it was actually nothing of the sort."

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The example of Zöe highlights both the centrality and difficulty which talking posed for this project as a whole. In particular, talking was the principal means which effected and sustained intersubjectivity. It was also a major medium of interaction, a vehicle of phenomenological experience in its own right, and a tool of self-reflection by which both researchers and participants could bring into focus and explore a particular attribute of the situation at hand. It occasionally failed, sometimes dramatically, but it was also often the only means by which to approach that failure and explore it for what each of us could learn jointly.

Zöe and the "Cough Syndrome"

Despite a long history of hospitalizations beginning in the late 1970s, Zöe lived independently in a inner-city 'townhouse'. For the most part she was stridently self-possessed, buoyed by her many accomplishments (including two solo art exhibitions and some published writing), but was occasionally beset by a paralyzing self-doubt which resulted in obsequious demands for an affirmation of her talent and human worth. It was not uncommon after many hours of discussion, several cups of coffee and one or two voluble outbursts and accusations that Zöe would curl up in her chair or stand in the middle of her living room, assume a 'little girl's' voice and ask for reassurance. More often than not, however, her exuberant dress-sense was well matched by her flamboyant speech. Talking was something which she loved to do. She even attributed it with a therapeutic effect: Megan and I once stayed chatting long into the evening because, Zöe said, this got her through the most difficult part of the day — what she called the "evening blues".[16]

Zöe was nevertheless beset by a range of difficulties associated with the reception of other peoples' speech. Each of our meetings were interrupted by at least one angry outburst when, in attempting to paraphrase a topic we had been discussing, or to summarize a point, I employed words which were different from those she had originally used. The same response accompanied minor mistakes such as referring to her 'sisters' (she had several) when she had been talking about one in particular. When we discussed these problematic effects Zöe asserted that any failure to exactly mirror her speech "floored" her and "sideswiped" her, "because you are not talking about what I am thinking of", removing her words from their personal referents and appropriating them to some other purpose. Men, in particular, were always doing this to her as part of a generalized "theft" of her powers, sexuality, spirituality and creativity. I signalled this threat with the colour of my clothes, or by an involuntary cough. These sparked anger and recrimination on

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[16] On 'telling as therapy' in the context of epilepsy see Schneider and Conrad (1986: 117).

Zöe's part and threatened to bring our interactions to an end. The only thing to do in such circumstances was for Zöe and I to talk our way through the impasse. This entailed eliciting the meanings that Zöe attributed to my shirt or cough and negotiating their significance for each of us.

- Moments after asking Zöe about her 'sisters' when she had been talking about only one of them, I coughed. Zöe abruptly interrupted the story she was telling to declare that my cough was "very superficial" and that I was doing what all men did, which was to proclaim my superiority and make her feel as if she were "below" me. I was startled and appalled by this accusation. Zöe rejected my weak-sounding excuse — that I had recently had a bad cold — with the observation: "That's the excuse men always give". She went on:

  > "No, don't say any more. I'll tell you what I'm talking about. There was this nurse at [the state psychiatric hospital] who apparently had bronchitis, you see, and every time he went past me it was 'cough, cough, cough' and I thought, "well, all right, yeah, all right". And then the next time he went past me, the same thing. And the next time he went past me, the same thing. So I turned 'round and I said to him: 'Look, would you just mind not coughing around me please?' And he turned around and he said: 'I want an apology from you — not just an apology that you half mean, but what you really mean is that you are bloody sorry that you said to me to shut-up because, cough, I have, cough, got bronchitis, and you are just a nut case who deserves to be put in lockup for assuming any kind of intelligence or superiority or divorceness from men'... Anyway, I found him a couple of months later, and I went past him, and I went 'cough' [she imitates the cough, which she said had a special 'significance']. That made me feel really good. Because he couldn't do anything about it."

  In a piece of writing she gave us, Zöe had noted that 'society is coughing and laughing at me'. She called this the 'Cough Syndrome',

  > ... that seems to affect nobody else as much as it affects me. People seem to cough up my phlegm when at the very moment of self-sanctification they run off with a mouthful of my positivity.

  After another cough on my part she said to Rob and Megan:

  > "You see, that's deliberate. You see, I'm not allowed to be first. I have to be second, you know? He's the man, you know? I can't be above him ... It's so frustrating. It's like saying, you know, 'I can't be OK'. That's what it means to me."

  On this first visit to Zöe's house, her antagonism made me uncomfortable and self-conscious, so that I wasn't sure if I should speak, or what to say, since it was clear that even intimating understanding or empathy could be construed as taking something away from her. I tried hard not to cough again, but was unsuccessful. Whenever I did cough, Zöe would dart an angry look at me before resuming her point. She agreed to keep working with me, however, for the greater good of teaching us about schizophrenia. I was to be the vehicle of her "teachings". Subsequent visits were easier insofar as she did not confront me again about my displays of superiority.

Such confrontations and their negotiation encapsulated our efforts to effect some measure of intersubjectivity concerning those experiences which were disturbing both of us. Talking was the only medium by which Zöe and I could attempt the convergence toward a common understanding of these phenomena and their effects — a convergence sufficient, at least, for them to be bracketed out for the purpose of our continuing to work together.

"Alcoholic talk": confronting the vagaries of speech

Zöe's communication difficulties became prominent on another occasion when all three researchers were present. She had gone to the kitchen to prepare coffee. Rob Barrett and I stood at the lounge room window admiring and commenting on the over-grown garden which screened Zöe's townhouse from its neighbours. Suddenly Zöe rushed back into the room. Her initial question was phrased in general terms, although the look on her face betrayed a more pressing personal concern. She asked: "Why, when I leave a room, do I think people are talking about me?" Rob quickly turned this around to ask if that was what she thought he and I were doing. She looked defensive for a moment, as if debating whether or not to disclose her thoughts, and then answered definitively, "yes". Rob explained what we had been saying about her garden (emphasizing that we appreciated it as her creation) and then asked what it was she thought she had heard us say. She said that she had heard us talking in a "different language". Asked to elaborate she said that it was a "coded" language, not English, but something more like Latin. It was "alcoholic talk": "sort of an alcoholic Latin language, like the word of God would be disguised so I wouldn't know it". She asked: "Are you familiar with how alcoholics talk?" We were not. She offered the example of a word she had heard us use: "imot". I did not recognize it and Zöe could not offer any suggestions as to what it might mean. She said that this sort of thing happened to her often: on leaving rooms, on getting off the bus, or on passing other people in the street. Its emotional effect was always a feeling of exclusion:

> "It's like the truth that my [ex-]husband denied in me was replaced by these words. So every time I peeked my ear to listen hard to what was being said — so I could find out what's going on — it would be a totally different language."

Rob reassured Zöe that we were not doing anything like that, but acknowledged that it must be difficult for her when it happens. She seemed satisfied with this response and went back into the kitchen to make coffee. This was a striking example of a situation in which I could not share the language that a participant heard (even when I was held responsible for generating it), but with whom I could share in a most palpable way the breakdown of language's communicative potential.[17]

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Zöe was one of a number of participants who used analogies to foreign languages as a way of conveying the difficulties they had in interpreting speech. Thus, even when they knew themselves (or others) to be using English, they insisted that it might be German, Latin, or Japanese.[18] Many participants were confronted with what they saw as the taken-for-granted assumption that language can be used both to describe the world and to interact with it (cf. Austin 1975: 6). Their experiences of language highlighted what happens when this faculty is perceived to have failed, or when words and speech lose their ordinary meanings.

Participants' use of language to convey these effects was itself a measure of the extraordinariness of their experiences, language being a marker of what they had in common with other people at the same as marking their distinction from others. The presumed intersubjectivity of this unpredictable medium was often the only means which they could use to demonstrate intersubjectivity's failure. In this way, language itself could

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[17] It was only in this way that a true phenomenological approach was possible, in which a certain phenomenon could 'show itself' to both researcher and participant, and therefore be considered a phenomenon common to both: 'We can only speak of a phenomenology of a basic disturbance in schizophrenia, in the real sense of the word, if one and the same phenomena can make itself known just as unmediated and authentically to the patient as it does to the investigator … [and this is] determined by the realm in which two persons inwardly meet each other sharing a "between" common to all humanity' (Kimura 1982: 176-7). See also Poelman (1980: 12-20).

[18] Nick, for example, said: "It's like I think in English in my brain, but it comes out in Japanese".

manifest the extraordinariness of participants' experiences. Also to be found in this conundrum was the basis of much reflexivity.

REFLEXIVITY

Speech was as aspect of participants' everyday worlds which — like bodily deportment or the movement of people on a bus — was subjected to intense scrutiny. A greeting, or snatches of other people's conversations heard in the street, were revealed to be unexpectedly meaningful.

- Wynn, for example, pointed out that she found the rhetorical greeting 'How are you?' to be intrusive, rather than being the polite conversational opening which I had assumed in using it. She found it "confronting" in its apparent demand for a reply: "sometimes it is too scary to think about your feelings", she said. Such a question also implied to her that the feelings of people diagnosed with schizophrenia were expected to be heightened, to be in turmoil, or to be in some way the most significant thing about them, as opposed to their ideas, their roles, their relationships, or their identities. Wynn's reluctance to use the greeting objectified — and forced both of us to reflect on — the many presuppositions contained in such a everyday item of rhetorical speech.

In ways such as this, speech and language were another example of everyday practices which became the basis of a heightened reflexivity as they were constantly interpreted and negotiated. This work — which for some participants was literally a full-time occupation — required such energy and attention that it detracted from the possibility of easy sociality.

Our talking together was simultaneously a way of reflecting on talk itself. This was highlighted when Wynn told the "story of the feet" for what she said was the first time, and then later reflected on that telling.

Wynn: reflections on telling the "story of the feet"

I noted (in Chapter 1) how Wynn insisted on the significance of body movements during the course of psychosis. She said that when she was psychotic she tended not to listen to words — "whatever they are saying can get lost" — but became extremely vigilant of what she called "body language".[19] In such a state, verbal language lost its meaning while non-verbal communication became heightened. According to Wynn, psychosis demands a "special way of talking" which is attentive to such extra-linguistic phenomena as breathing, coughing, sniffing, eye movements, and especially the positioning and movement of feet. For Wynn, where feet were positioned, where they were pointing, whether they were "wagging" or still had an "overwhelming significance" that was much more important than other people's voices.

At our first meeting Wynn sought to highlight the significance that feet had for her with a story about her parents trying to admit her to hospital. She claimed that with the placement of their feet her parents could cause her to "change direction" or stop moving altogether (she demonstrated this "blocking action" for us). Eventually she "escaped" the feet by jumping into a car, after which her parents took her to hospital. Wynn said that this was the first time she had ever talked about these events. This telling seemed to distress her. She said she was becoming "dizzy" from thinking about the psychosis — she likened it to "talking about my dreams". She bemoaned the absence of an adequate language to describe her experiences; hence the need for her physical demonstration.

On a subsequent visit, one week later, I asked Wynn how she felt about having told the 'story of the feet'. She said: "I was trying to distance myself from it but, yeah, it was from the heart". As indicated earlier (see Chapter 2), Wynn was an accomplished public speaker on the topic of schizophrenia. She said that she could talk about schizophrenia "as if I am a doctor" and as an "expert". She could objectify it , like standing outside and looking at herself and her behaviour:

> "The more you talk about it the more it becomes fluid and distant and smooth, sort of like a story that you have told before. But it comes across better. The more you tell it the better it comes across [and] the more people understand it,

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[19] 'The schizophrenic ... has been ... aware ... that words are used not only to convey but also to veil ... communication. Consequently, he has learned to gather information ... from ... inadvertent ... gesture, attitude, posture, inflection of voice, or expressive movements.' (F. Fromm-Reichmann, *Psychoanalysis and Psychotherapy*, 1959, p. 174; quoted in Shulman 1968: 182).

> funnily enough. When you haven't told it before it's hard for people to see it from your point of view. The more you experience telling it, the easier it is for other people to step into your shoes. It's like telling a joke. When you first tell it it's not even funny, but the more you tell it the funnier it gets."

The point of such telling was to "give other people the experience". She explicitly denied, however, that getting the experiences of psychosis into a story form reduced their distressing qualities, or made them go away:

> "I can still feel the experience. That's why I was feeling dizzy. The experience is still there, and the pain."

Wynn had a large repertoire of these 'stories' by which she sought to convey her experiences to others and induce 'understanding' in them. Some had been rehearsed many times, refined in their telling, and made humorous or compelling. Some of her most upsetting experiences, however, such as her parent's role in her first hospitalization — which she titled, perhaps for the first time, the "Story of the Feet" — had not received the same narrative treatment. As a story it was still too new. It was lacking in distance and polish, and its emotional referents were still too 'dizzying' and painful. The narrative process, which took place with us as 'audience' and interlocutors, suggested that putting together stories about psychosis was a way of managing ineffable but frightening personal experiences. For Wynn, narrative construction was a well-rehearsed strategy for capturing and controlling her experiences.[20] This also recalled the idea of narrative as

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[20] Wynn's story-telling recalled the ambivalence of Yolmo discourses on emotional pain as discussed by Desjarlais (1992). He notes (ibid: 91) for this Tibeto-Burman people that there are only certain times when grief or pain can be expressed. Moreover, while suffering is 'hypercognized' — there are a wealth of idioms. metaphors, and images to convey states of pain and sorrow — people are very reluctant to use such phrasings because they recall feared and painful experiences (ibid: 108). What is particularly unspeakable is the 'heartache' associated with a parting or separation which effects a loss of intimacy, context and identity. While Desjarlais is referring especially to death in this instance, similar sentiments surrounded the range of losses which participants in this study associated with schizophrenia. Yolmo articulate an epistemology of 'surface appearances, inner realities, and hidden motives' which acknowledges the limitations of knowing what another person is thinking or feeling: 'As a body or house hides its contents from the eyes of others, subjective realities are considered largely unknown to the outside world' (ibid: 110). In the face of a reluctance to infer another's state of mind or body, language becomes the 'prime medium' through which people bridge empathy and understanding (ibid: 111). Yolmo work hard on achieving agreement in words, but remain ever cautious that these words may not accord with what is in their hearts (ibid). Wynn similarly acknowledged that her stories did not fully take away the pain of her experiences and loses, but she was certain that they did effect some measure of intersubjectivity, allowing others to 'step into her shoes', as she said.

therapy, broadly attributed to psychotherapy, and to psychoanalysis as the 'talking cure'. Wynn herself insisted that people could be "talked out" of psychosis, that they could be "talked back to [verbal] language", to interaction and "reality", suggesting that talking was a powerful and multifaceted device for her.

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Some participants found their problems with language objectified in such forms as written texts and song lyrics. In lying outside of their own production in speech, these experiences highlighted language as extraordinary — that is, as both familiar and strange. Such experiences were the basis of a heightened reflexivity about words and the communicative potential of language in general.

Several participants were engaged in an explicit quest for the 'true' meaning of words — quests which they indicated were occasioned by a heightened perplexity about meaning and reference.[21] Tony, for example, was in search of the original Testament texts, believing that he would find in them the transparent and unequivocal meaning of Biblical prophesy (which he saw as integral to his schizophrenia as a "spiritual affliction"). Gerald was another participant who was much concerned with prophesy, but who had undergone the perplexing experience of finding that the words he remembered (and could recite) from his Bible had changed or disappeared on subsequent readings. As a consequence of finding that texts and their meanings could transform he concluded that "words may not be real". One young participant, Jonathon, had been consumed by finding significances in certain rock lyrics which he had memorized. These indicated to him that "the world was

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[21] See Ricoeur (1974), who describes language as a 'dialectics of economy and novelty' (ibid: 55) which is inherently ambiguous and therefore initiates the 'precarious and haphazard work' of interpretation to reduce misunderstanding:

> ... there is something irreducible in ordinary language. The variability of meanings, their displacibility, and their sensibility to the context are the condition for creativity and confer possibilities of indefinite invention on both poetic and scientific activity. Here *indeterminateness and creativity appear to be completely solidary.* (Ricoeur 1974: 60; emphasis added)

based on words" at the same time as he felt that, "words had no meaning any more [because] I could never find the meaning". By the time we worked with him he could no longer ascertain what had so perplexed him about the lyrics and therefore could not account (to himself or to me) for the effect of those words.

It was the simultaneous heightening and vanishing of meaning — the perplexing conjunction of significance and vacuity — which highlighted language as a 'sheer fact of existence' (Sass 1992a: 192) for some participants, leading one to abandon its use altogether for a time and compelling others to interrogate the confrontation between what was concealed and revealed in this way. A pervasively reflexive stance toward language in its many forms was thus manifested by various participants as a searching for a 'key' to the words and images which flowed to them from advertising and the media, the discernment of something 'hidden' behind or underneath peoples' words, a perplexity about the use of both familiar and unfamiliar words, or the apprehension of foreign languages in their own speech or that of others.

EFFECTING INTERSUBJECTIVITY

Talking was often the only means with which to test that the meanings I was gleaning from participants approximated whatever meanings they attributed to their experiences. This required negotiation and rapport, which Taylor (1985b: 259) suggests are distinctively built through language in use. Identifying and clarifying the significance of events, ideas and characters constituted one of the main areas of joint negotiation; understanding could only be developed over time by having these implicit meanings revealed as a resource which could function between us. Talking was thus a specific way of effecting intersubjectivity, or at least a convergence toward a common reference world.

This required active work on the part of participants, as the following example demonstrates.

Zöe: “I’m the original Eve”

It was often not possible to follow Zöe’s conversation without a good working knowledge of several key figures, the most ubiquitous of which was the enigmatic ‘Ron Moore’. This name had multiple referents: a fellow-patient she had met once, a wraith-like figure that haunted her ‘paranoid thoughts’, and a manifestation of the Devil. More striking than any explicit reference, however, were the multiple implicit meanings which this figure conveyed and the number of subtle instances in which they were invoked. As a type of anagram (which relied on its spoken sound rather than its graphological form), ‘Ron Moore’ was reversed to become ‘moron’ — a label which Zöe attributed to all men. The character Ron Moore was also implied in the wry smile Zöe affected when she opened up a packet of ‘More’ cigarettes, extracting and then ‘consuming’ — taking into herself — the essence of this figure’s patriarchal power. She shot a quizzical glance at us when she did this, to see if we acknowledged the ‘joke’. Zöe also liked to make a play on her own surname, which contained the letters eve, from which she derived the identity of (Biblical) Eve. By a series of transformations on a religious theme (which again relied on aural keys to fully appreciate), she offered the following set of corollaries: EVE — DEVIL — DIVA — EVENING — MORNING — MOORE. By way of a partial transposition (which could occur whenever a word contained the letters ‘r’, ‘o’, ‘n’ and ‘m’), ‘Morning’ contained an implicit reference to (as she often said) “Ron Moore again”.[22] Ron Moore

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[22] Another example she gave of such a set of transpositions was the sequence Ron —> wrong —> moron —> forever more, which took on a chant-like quality as well as encapsulated her opinion of men. Other associations with ‘Eve’ included the string: revelation —> (for) ever —> devotion —> evolution —> evaluation (recited in this format). Zöe took an obvious delight in such word games. She would often voice runs of associations which transformed words into other words, thereby evoking other identities and persons. Sometimes these associations depended on the identification of recurrent letters in different words (as in the ‘Morning’ example); sometimes it involved sound associations and the subtle shifting or mutating of phonemes.

was Eve's protagonist and an ever-present destructive force analogous to an anti-Christ, or to Satan as a fallen angel.

The above set of word associations only made sense by reference to a schema of dichotomous pairings (including good/bad, light/dark, left/right) which was ubiquitous in Zöe's speech and belief system — hence the implicit transformational logic of Eve/Devil and Evening/Morning. The latter pairing encoded a number of references which were only possible to appreciate after a long exploration of her principal concerns; it included the suggestion that Ron Moore, as the archetypal man, was present at the point of cosmic creation — the "morning of the world" — and had afflicted Zöe/Eve/Womankind ever since. A trace of this figure was also 'hidden' in the name of Marilyn Monroe, posters of whom decorated Zöe's living room and a personage with whom she identified strongly (as another woman who had been "ripped off"). Ron Moore had also insinuated himself into her body, where he signified the dark, malevolent and self-destructive side of her nature. A simple but enigmatic message left on the departmental answering machine one evening — "I'm turning into Ron again" — was chilling in its implied meanings. It conveyed information to which we alone were privy, and galvanised us into a concerted effort to locate Zöe and talk to her.

Without a good deal of time and effort to tease out and become aware of these meanings (some of which Zöe did not or could not articulate, but only indicated obliquely with a nod or a look to see if we had understood), a lot of her conversation would have been impossible to follow, her major concerns would have remained opaque, and a very different appreciation of her life would have ensued. This was suggested by a reference to 'Eve' and 'Ron Moore' in her hospital case notes. The reference was contained in a recorded fragment of conversation which was included in the notes in order to demonstrate the impossibility of understanding Zöe, to confirm her manifestation of 'thought disorder', and to justify her continued treatment. The fragment read:

Zöe: … I'm the original Eve.
Dr: As in Adam and Eve?
Zöe: No, as in <u>Ever</u>ything. It wasn't Adam anyway, it was Ron Moore.
Dr: Who's he?
Zöe: The alcoholic father of all men.

These assertions were not so bizarre given sufficient familiarity with what Zöe meant by these names, their symbolic and emotional connotations, and how they fitted with other elements of her understanding. At the same time, the meaning of these referents had to be developed, negotiated and tested at a number of points before they could be 'decoded' or used with any certainty. That Zöe facilitated this decoding process for us was a measure of her trust, her commitment to having us understand her, and of her desire to work toward a common reference world.

The symbolism of Zöe's major concerns — music, language, gender, religion, the body — and their positioning within a broader framework (which in this case was almost cosmological in scope, dealing as it did with the creation of the world and the emergence of such fundamental categories as 'man' and 'woman') had to be learnt in a partial way at first.[23] The cumulative effect of our meetings was the generation of thematic sense out of what otherwise might have seemed non-sense.[24] This posed a classic methodological dilemma — the problem of unifying or over-systematizing something which was quintessentially non-unitary and fragmented. There was a certain pleasure entailed in building an understanding of Zöe's 'system', especially because it was seemingly so bizarre and elaborate. Might not this disturbing strangeness in itself generate a desire to systematize as a way of dealing with Zöe and her assertions? Might not the attempt to

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[23] Cf. Douglas (1966: 89-90) who observed: 'As business man, farmer, housewife, no one of us has time or inclination to work out a systematic metaphysics. Our view of the world is arrived at piecemeal, in response to particular practical problems.'

[24] Cf. Swartz and Swartz (1987) who concluded similarly regarding a sample of 'psychotic' speech full of 'enigmatic exchanges'. Employing a discourse analysis which focused on conversational repair and context setting, they found that apparently incoherent speech could be made considerably more accessible by attending to internal references about the talk itself (such as the negotiation of what was expected from the interaction) and to the setting in which it occurred (including the physical location, the social and cultural rules which pertained there, the 'surrounding discourses' of which the example was an instance, and the history of such exchanges). See also Ribeiro (1994) for an extended case study of referential meaning and topic coherence at the level of 'frame' in psychotic speech.

'understand' Zöe be prompted by my own discomfort and lack of understanding, thereby erasing the particularity of the situation at hand and obscuring or romanticising the pathology for which she had been treated for so many years? These questions themselves became the focus of various attempts to check on the reliability of whatever understanding emerged between us. While it was possible to over-determine the unity of her world-view, Zöe herself affirmed that there was overall 'system' to her thoughts: "there is method in my madness", she said wryly. She often engaged in a parallel commentary which was geared to making sure that we were following her "logic", picking up on references, recognizing the import of characters and events, and so on. It was also possible to introduce items to the conversation in order to gauge responses and test the system's parameters. Once the lineaments of Zöe's system of references had been glimpsed it was possible to start making predictions using its terms, and to negotiate one's way through it.[25] In itself, this task was appealing to Zöe — it indicated that we were taking her seriously — as it was to a number of other participants who were grasping for an understanding of their own situations. By establishing some ground rules of cooperation through dialogue we were able to join them on that quest. It was all right if we did not fully understand where this exploration was going, because they did not necessarily know either.

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Searle's (1975) analysis of 'indirect speech acts' and Grice's (1975) notion of 'conversational implicature' were both attempts to account for the discrepancies which can occur between what is said and what is meant.[26] Thomas and Fraser (1994) provide the following example:

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[25] The dual processes of 'conversational repair' (consisting of questioning, commenting, prompting and clarifying) and 'hypothesis testing' comprise what Swartz and Swartz (1987) call 'metacommentary'.

[26] See also Garfinkel (1972: 4-5), who illustrated the discrepancy between speech and meaning by way of a segment of conversation in which there were many matters that the partners understood they were talking about but which they did not mention — what was said was a sketchy, partial, incomplete, masked, elliptical, concealed, ambiguous or misleading version of what was actually talked about. In

> Husband: “Have you seen my car keys?”
> Wife (who is in bed): “I’m not getting dressed.”
> This exchange appears incoherent, but in responding the wife may have drawn on contextual knowledge and assumptions accessible only to the speakers. It is only by taking this into account that we can understand more clearly the inference made by the wife as well as the significance of her response (that, for example, he is going to visit his mother, with whom his wife has fallen out). (Thomas & Fraser 1994: 586)

Grice’s ‘implicatures’ refer to the meaning which is implicit in conversation, rather than to what is stated, and do not follow logically from any given premise; they are also accompanied by a ‘cooperative principle’ by which conversationalists exchange instructions as to the relevance, quality and clarity of their talk. In this way, conversation emerges as a form of cooperative social behaviour in which participants must work to make sense of responses which might otherwise appear meaningless. This was the essence of our conversations with Zöe, many of which, no doubt, would have sounded ‘meaningless’ to an unengaged auditor.

Developing on the work of Austin, Searle and Grice on the cooperative principles and ‘felicity conditions’ of speech[27], Goffman (1997) proposed an overarching ‘Felicity’s Condition’ for verbal interactions. With this concept he broadened the earlier ‘micro-analyses’ to suggest that it is the presuppositions contained in speech which serve as the conditions for apprehending sanity and intersubjectivity:

> For when the ‘literal’ … content of an utterance makes no sense in the context, *and* neither do conventional [maxims], then a drastic interpretation must be made: namely that the speaker is temporarily incompetent, or, if

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addition to their ‘specific vagueness’, many expressions in the conversation were such that, ‘their sense cannot be decided by an auditor unless he knows or assumes something about the biography and the purpose of the speaker, the circumstances of the utterance, the previous course of the conversation, or the particular relationship of actual or potential interaction that exists between user and auditor’ (ibid: 5). See also Shotter (1993: 26-8).

[27] Goffman (1997: 169) provides a brief history of this work. Austin proposed six ‘felicity conditions’ which would render an utterance effective at doing something (that is, operate successfully as a performative). Searle later re-classified the types of performatives (which he called speech acts) and explicated the felicity conditions (or ‘sincerity conditions’) presupposed by them. This work merged with an analysis initiated by Grice who produced four maxims which must guide speakers if their utterances are to be maximally usable by recipients. A breach of these conditions or maxims is a ‘culturally recognized signal’ that something ‘unserious’ of ‘fey’ is taking place (ibid). They provide ‘a systematic convention-based means for shifting from what is more or less literally said to what is meant’, as well as an ‘interpretive repertoire that introduces much flexibility in the presuppositional bases of reference and inference’ (ibid).

> there is no corroborating evidence for that, that she or he is deranged. (Goffman 1997: 169)

Goffman proposed that the felicity condition behind all other felicity conditions is,

> … any arrangement which leads us to judge an individual's verbal acts to be not a manifestation of strangeness. Behind Felicity's Condition is our sense of what it is to be sane. (Goffman 1997: 170-1)

Thus, we are obliged to display that we are sane during spoken interactions through the management of our own words or the display of our understanding of the words of others (ibid: 171). There are 'normal' ways of saying one thing and meaning another, or acting as if the speaker has been misunderstood, but when these cannot be sustained then one or other partner to the exchange may conclude that 'either their mind is fully and fixedly where it should not be or they presume the other's is where it is not reasonable to expect it to be' (ibid: 170).

The heightened significance which speech had for Zöe seemed to hint at these conditions for establishing sanity. Her speech was, she insisted, her 'truth' and she demanded that we recognize its own conditions. This was why she got angry when its reiteration back to her was 'incorrect'. Others used her speech to judge her 'mad', but having us understand her talk was, for her, a validation of her sanity. This was imperative to Zöe, and its whole weight rested with her talking.

It was imperative for Zöe that we understood her references, concerns and meanings. It was only on this basis that we could hope to build a relationship which effected some measure of rapport and intersubjectivity. This was a mere inkling, however, of the relationship she had maintained with her brother over many years. That this relationship was based on similar procedures for establishing and maintaining intersubjectivity was made clear when he described their interactions:

> "… it was just the point where [Zöe] would be talking about something, and then go off on a tangent, and I'd lose her … And I realized that — 'Oh well, that's what the illness is' … She was up here [indicating 'high'] and I couldn't be up here with [her] to sort of completely follow it. So, I realized that what I had to do was to just listen and try and understand as much as I could. And it

> worked. It worked quite a bit, even when we were young. I remember coming home late at nights … everyone else would be asleep and [Zöe] would be up, sort of on her own and having a coffee or, I don't know, watching TV or something … [Zöe] couldn't sleep. After we'd come home, I don't know, 12, 1 o'clock or whatever … I'd make something to eat and we'd just sit down and talk
>
> …
>
> I think the late nights, the talking about whatever … like, we'd start talking about one thing, and [Zöe] would jump over to another and I'd follow, and, you know, we'd talk about that, and then she'd jump on to something else. And I got used to that. And … because I got used to that, and allowed [Zöe] to go off and talk about whatever, and continued talking with her, that's another reason why our relationship has just kept going. Because I, at times, think like that as well. I might go off on a tangent because something interests me …"

Francis: not just words

Establishing intersubjectivity did not always entail explicit instruction in an idiosyncratic referencing system. It was possible for rapport and understanding to emerge, not just from participants' words as such, but from the embodied social experience of our being together.[28] This was the effect of our first meeting with Francis, as encapsulated in the notes I wrote afterwards:

> *Despite the undramatic, almost dead-pan delivery (or maybe because of it), I found Francis' narrative to be the most compelling I have yet encountered. It was the mis-match between form and content — between what she said and how she said it — which held my attention throughout. I was never sure what would emerge next, and the (contradictory) anticipation of the unexpected was particularly engaging. Images stayed with me for hours afterwards and even the next day I was having trouble getting them out of my mind. In this respect the effect was very like our first meeting with Zöe. The sense of an 'altered reality' in Zöe's case, however, came partly from her appearance and her physical surroundings (as well as her more openly antagonistic stance, particularly toward me on that occasion). With Francis, the effect was achieved entirely through our talking together, since her appearance and behaviour were anything but startling.*

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[28] See also Merleau-Ponty (1962: 361-2) for whom perception is not, in the first instance, either objectification or contemplation, but 'communion' with a world of others which calls forth a response and a dialogue. The other as a 'body-subject' (Crossley 1997) is an expressive being, even when he or she is silent or immobile: 'Perception of others is not a matter of contemplating an object, but rather of being 'moved', quite literally, by the meanings of their actions' (ibid: 26), including their speech.

> *Listening closely to the tapes later I am struck by the fact that this compelling quality is not a product of the formal structure of Francis' speech. Her timing and phrasing is sometimes difficult to follow. Certainly it is difficult to transcribe, requiring the imposition of punctuation which is not really evident in her speech. She pauses in the middle of sentences, and often runs the endings and beginnings of sentences together. Alternatively, she links sentences and phrases by attenuated 'ands' and 'yeah's'. This becomes confusing when you try follow it word for word on the tape. The overall effect of her speech is clearly greater than its technical performance. It is impossible to render the quality of her voice which is deep and resonant, with long drawn out vowels. Some words stand out for their exquisite enunciation, almost as if they are being savoured. These aural qualities do not (and probably cannot) appear in the written transcript.*
>
> *Although Francis spoke largely in a monotone, it soon became obvious that this was spiked with a cutting and perceptive humour. What was therefore also enjoyable was being able to laugh with her about certain things — a marked contrast to what had been possible with [some other participants].*
>
> ...
>
> *Her humour is of the driest kind one can imagine, but once recognized it is easy to follow and devastatingly effective. It was only when I recognized the sarcasm in a particular comment, reversed it and 'played' it back to her that Francis appeared to relax and we all began to enjoy ourselves.*

This pleasure in being together was facilitated by the words we exchanged, but it was not found in those words alone.[29] Francis' irony is barely discernible in the transcripts, and the sarcastic remark that I 'caught' and parried is meaningless on paper. Language was certainly a medium for us coming to understand each other, but it was our being in conversation and laughing together that established whatever intersubjectivity emerged between us.

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[29] Taylor (1985b) calls this 'expressivity', as when a certain rapport or style of participation is established through gestures, signs, non-verbal displays or conversational codes: '... the nature of the rapport established — friendly, intimate, casual, easy; or on the contrary rather formal, cold, distant, or barely polite, or slighting, or ironical, or subtly contemptuous — is determined by the expressive dimensions of my speech: the way I stand, look at you (or away), smile (or not), my tone of voice, manner of speaking; as also by my choice of words' (ibid: 265). Cf. Merleau-Ponty's (1962: 183) description of how, in the expressivity of artistic performance, 'meaning swallows up its signs'.

REVEALING AND CONCEALING: THE LIMITS OF INTERSUBJECTIVITY THROUGH TALKING

Success in bringing about rapport and understanding varied considerably with different participants, just as it changed over time as some individuals (perhaps for their own reasons) wholeheartedly embraced the potential of those interactions. This was not always the case, however, as a number of participants — Adam in particular (see Chapter 7), but also Shaun — seemed to delight in a use of language which was geared to confusing and disorienting the listener. It often felt as if the effect was intentional, as if their purpose was to subvert, conceal or adorn the process of sense-making. This was a tangible expression of the limits on establishing a 'common world' with some participants (cf. Taylor 1979: 51; see also Chapter 2). Such encounters could not be said to generate a clearer view but to open up a labyrinth of evasions, metaphors and poetry, which at times had a certain appeal in itself.

It was also clear that participants were monitoring their disclosures and making pragmatic judgements which meant that this process might change over a series of encounters (cf. Brown 1993: 272; Schneider & Conrad 1986: 115-18). It often happened that parts of a story would be withheld for a while, only to emerge in a later context — almost, at times, as if it were a prize being offered, a reward for attentive and sympathetic perseverance, or a sign of trust. Some things were always withheld, and we respected that.[30]

I also engaged in this strategic failure to share certain types of information and responses. Many participants were interested in what we had learnt from others, but a sharing of this information beyond generalities was restricted by ethical constraints on disclosing

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[30] This especially related to episodes of childhood abuse, but could also apply to the more 'esoteric' elements of a belief system. Shaun requested that the centrepiece of his belief system (which he had talked about in great detail) be left unrecorded and undisclosed in any form. This was the most definitive of any such request received during the course of the research, and has been respected.

'personal' or 'medical' details.[31] A number of participants requested that we tell them what was contained in their hospital case notes; these requests were denied on the basis that such disclosure would have contravened the conditions of our own access to those records. There were also times when I needed to conceal a view, a reaction or an opinion, usually in order to avoid what I saw as a potentially embarrassing social situation. One such moment came at the end of several weeks work to record the elaborate system of characters and references by which Gerald oriented himself in the world (a schema which embraced both world history and an apocalyptic future). After finally completing this revelation (for this was how he conceived of it), Gerald paused and directed me and Megan a quizzical look. I sensed that the long-anticipated moment had come when we were required to give our assent to this remarkable tale of truly cosmological proportions. There was silence. I did not know what to say. I was directly confronted with the confusion and limits of my own understanding in the context of a well-developed empathy for Gerald and his concerns. Always the most polite of hosts, Gerald smiled as if to acknowledge the difficulty and quietly reassured us that it did not matter if we believed him or not: it was sufficient for us to have had the story told because in this way we too were now protected from the momentous events which were soon to unfold. In this circumstance, Gerald's assumption of intersubjectivity was greater than my own and he acknowledged this with his reassurance. Other demands for confirmation and belief were not so easily managed, resulting in many improvised and insufficient exclamations of neutrality and 'professional' scepticism. Other forms of response among the researchers — laughter, outrage, or the compulsive reiteration of a striking image or a challenging

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[31] Guidelines for the conduct of medical research in Australia (to which this study was obliged to adhere) emphasized that 'a person should be able to exert an appropriate measure of control on the extent to which his correspondence, communications and activities are available to others in the community, and he should be able to control the extent to which information about him is available to others in the community' (Australia. NH&MRC 1995: 3). Section 95 of the Australian *Privacy Act 1988* (Cwlth) covers use of personal information (held by government agencies) for the purposes of medical research. 'Personal information' is defined under the *Act* as 'information or an opinion … whether true or false, and whether recorded in material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion' (ibid: 31).

assertion — were similarly concealed, held off until we were safely in the car going back to our own everyday worlds.

No disclosure was ever complete; it could hardly be otherwise when a participant saw their entire life as refracted through schizophrenia. Nor could any discussion of mental illness be entirely unaffected by tactical motives. Most encounters had a validatory aspect to them, as participants sought to have us affirm the 'reality' of their experiences, the validity of their interpretation of those experiences, and their value as persons. Many participants agreed to work with us for a stated philanthropic purpose: the desire to help others who have had similar experiences. I never anticipated that there could be a value-free narrative in this context. Shaun signalled this at our very first meeting when he said: "All patients think about their position a great deal [and] a lot of [what I am saying] is justifying my own position". It was a preliminary warning that his account was necessarily biased because he was justifying his interpretations to us, and perhaps to himself as well. His narrative could never be value-free because it was quintessentially about himself, his experiences, and how they had placed him amongst others in society. In proposing that psychosis was an "alien thing" or an "alter-intelligence" which overwhelms him, Shaun simultaneously commented on this representation as a "rationalization" which could be used to distance himself from illness and (as he said) "absolve" himself of responsibility:

> "I was really hoping for a time that it wasn't in my own mind. Maybe it isn't, you know. There could be something about my life that I am perfectly normal … I mean, doesn't every patient hope that they are not actually ill, that in a sense it's being done to them? Because, therefore, they're OK … it might prove you're not your own worst enemy like your friends say you are."

Shaun and the problem of "referencing"

There was a danger attached to some disclosures. Again, the case of Shaun is illuminating. One morning Megan and I arrived at Shaun's flat an hour after a telephone call in which he had sounded in good spirits and looking forward to our visit. He appeared uncomfortable and agitated, and quickly became angry at the direction our conversation took. There were two televisions on in the lounge room, each with the sound turned down. Our conversation turned to what he was watching and to the "referencing" phenomena (in which, he said, the televised images related directly to him) that he had talked about previously. Shaun took great offence at this conversational turn and accused us of focusing on a "problem". He said that anyone over the age of thirty could come up with more and more "life problems" if pushed to do so.[32] He said that this was the danger of psychiatry: that if you asked someone to bring out problems they will. He implied that "referencing" was not a problem until constructed as such by the psychiatric profession. Shaun did not consider what he called "referencing" a problem. To him it was "natural". He insisted that he was "the innocent party, so there's no point in me proving it". He seemed to be responding in terms of a past experience in which psychiatrists had sought to have him disclose more and more information about himself until they uncovered what was "really wrong". The implication was that something terrible (punishment, committal) was the only possible outcome of such disclosure.[33]

On a previous occasion Shaun had talked of psychiatrists waiting for him to incriminate himself: "Truck loads of rope are delivered for you to hang yourself". On this day he applied the metaphor to us as well: he said that Megan and I had come in "with lots of rope". Like psychiatrists, we were sitting and waiting for him to divulge something pathological and actionable — except, as I pointed out, we did not have the power of psychiatrists to do anything to him, or even to pronounce on whether something was a 'problem' or not. We tried to be encouraging and supportive, while pointing out the limitations of our role and the restricted nature of our interests. Shaun acknowledged this,

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[32] Commenting on the types of information found in hospital case records, Goffman (1961: 159) noted: 'I think that most of the information gathered in case records is quite true, although it might seem also to be true that almost anyone's life course could yield up enough denigrating facts to provide grounds for the record's justification of commitment'.

[33] At another time Shaun stated that his "whole history is voluntary", referring to the fact that he had never been forcibly detained for psychiatric treatment and underscoring that he had so far escaped what he saw as the punitive power of the state and/or medicine (the conjunction of which he referred to as "state hygiene"). Hannan (1990: 302-3) noted that the 'clients' she studied in Sydney believed that the psychiatric system was potentially as harsh as the criminal justice system, and that detention in a psychiatric hospital acted as 'a terrible symbol of [their] fate'.

but it did not ease the situation. He responded: “I’m aware that you’re not psychiatrists, but there are links to psychiatry and I just want to be cautious”. With this final comment Shaun had, of course, pointed to the fault line which ran through the heart of the research. In the event, his suspiciousness on this occasion did not hamper a prolonged engagement with his concerns, his beliefs, and the routines of his day-to-day life (which we would enter and exit from for a further year). But it did highlight the feelings of vulnerability and scrutiny that people diagnosed with a mental illness might harbour concerning disclosure, even within the ‘privacy’ of their own homes.

For Shaun, there was a clearly perceived danger of collapsing his experiences into a psychiatric frame. He readily used words like ‘paranoia’ and ‘referencing’ to encapsulate and convey his own experiences, but this same language risked medicalizing them: “you’re forced to keep referring to fear as your paranoia, and that’s bullshit — that’s medical”. In order to avoid “trapping” himself, Shaun insisted on a series of working definitions by which we were to interpret him: referencing was “natural” and all around us, a product of the human mind as an instrument of communication and of culture as a “communications web”; paranoia was “possession of the facts” which resulted in a justifiable fearfulness. He got angry when he suspected that the distinction between these ‘natural’ phenomena and psychiatric understandings of the same processes was not being maintained. This also highlighted a more encompassing danger associated with the language used in many of these settings. All participants had some idea of what psychiatry meant by the term ‘schizophrenia’, and could identify ‘symptoms’ presented in psychiatric terms. These terms were rehearsed again with each participant through delivery of a PSE, but this neither exhausted what they meant by ‘schizophrenia’ or even necessarily indicated what they understood about those symptoms as personally experienced. Participants may have been using commonplace medical terms (for which a consensus of understanding might have been presumed), but this usage could often defy and subvert their clinical sense. Shaun was well aware of the dangers associated with this strategy. He said:

> "You talk the way that your enemies have taught you, like prisoners. I have to be careful how I talk."

With this observation, Shaun intimated those issues of language and power addressed by Bourdieu:

> … the constitutive power which is granted to ordinary language lies not in the language itself but in the group which authorizes it and invests it with authority. Official language, particularly the system of concepts by means of which the members of a given group provide themselves with a representation of their social relations … sanctions and imposes what it states, tacitly laying down the dividing line between the thinkable and the unthinkable, thereby contributing towards the maintenance of the symbolic order from which it draws its authority. (Bourdieu 1977: 21)

Shaun liked to confront the authority encoded in clinical language. He also reflected upon his right to appropriate this language and attribute it meanings of his own. He recognized the dangers entailed in each of these projects. Finding out about these meanings, and finding my own 'pitch' in relation to them, were intrinsic to working with Shaun. To some extent, the ambiguity and conflicts of my own relationship to psychiatry (see Chapter 2) mirrored Shaun's own ambivalences. They became crucial resources for working toward a common reference world which acknowledged and embraced the distances which each of us sought to maintain. In this way too, intersubjectivity could be said to embrace a recognition of its limits.

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Many participants were highly conscious of and objectified the equivocal potential for language to conceal or reveal, illuminate or cloak their experiences. These were people who had experienced the failure of language as a taken-for-granted instrument of meaning but who struggled, nonetheless, to talk about and demonstrate these effects through dialogue.[34] They highlighted the contradictory facilities of language to disclose and conceal, to express without representation, to create a 'public space' of rapport, or to screen oneself from unwelcome intrusion. The tension between concealment and revelation (as well as the power to designate or express, clarify or obscure) which is evident in methodological and philosophical debates is also present as a potential within language itself (and further, in what language facilitates and restricts between people). Taylor (1985b: 248) notes that language — and the possibility of meaning which it seems to offer — is itself a domain of uncertainty in which the 'fact that words and other signs have meaning can seem incredibly deep, enigmatic, [and] difficult to understand':

> The sense of depth comes from the realization that language is somehow essential to human life, that is, to whatever we unreflectingly want to identify as essential to being human; and also from the very pervasiveness of meaning in our lives, the difficulty of getting the phenomena in focus. We are in a sense surrounded by meaning; in the words we exchange, in all the signs we deploy, in the art, music, literature we create and enjoy, in the very shape of the man-made environment most of us live in; and not least, in the internal speech we rarely cease addressing to ourselves silently, or to absent others.
>
> The sense of depth can easily turn into a sense of mystery. (Taylor 1985b: 248)

This enigma was an abiding concern for some participants. Within the framework developed by Taylor, this very difficulty can be seen as intrinsic to language and meaning as social phenomena. It is neither an aberration, nor a conundrum to be explained away or ignored (as occurs, for example, in various phases of philosophy, in logic, and in various attempts to create — or recreate — artificial, scientific or otherwise 'perfect' languages — see Ricoeur 1974: 59-60; Taylor 1985b: 267; Eco 1997). Nor is it a 'pathology' specific

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[34] See Sass (1992a: 186ff) on the theme of 'loss of faith' in language which is explored in a number of literary and philosophical traditions. According to Sass, language use in schizophrenia exemplifies two approaches to this loss. For some patients, the most profound experiences are those which are uniquely personal or particularistic. This is where a publicly available language fails, as Wittgenstein has demonstrated, because it is too abstract and categorical (ibid: 186). For others, the most profound experiences are those in which they confront what is fundamental and universal. Here language fails, as Heidegger has demonstrated, because it is too concrete (ibid: 190). Those artists and writers 'afflicted' with modernism, like those who suffer schizophrenia, employ an obscure language that is remote from a pragmatic concern for everyday communication. Both modernists and schizophrenics, Sass suggests, are struggling with the ineffability of the profoundly idiosyncratic, and the ineffability of the profoundly ontological.

to schizophrenia. Language, as a 'web' of interchangeable terms in use (Taylor ibid: 258), is intrinsically ambiguous and necessitates an interpretive stance.

Participants often indicated, with varying levels of frustration, the hidden, incomprehensible and ineffable dimensions of their experience for which words were incommensurate. For many, this was the originary experience for the heightened reflexivity concerning language and talk. For those who experienced difficulties with the everyday function of language to formulate and communicate meaning, this presented a double conundrum whereby language became both the objectification of, and a means to explore, a perplexing situation. Some developed special and elaborate codes for discerning meaning. Others like Lawrence abandoned the attempt altogether and used abstract expressionist painting techniques to convey his experience of a reality which was, as he said, "without language as a receptacle of understanding". The fact that he had to say this in order to convey it highlights the facility, but also the strictures and duplicity, of language itself.

'BETWEENNESS': LOCATING SCHIZOPHRENIA DIALOGICALLY

For participants in this study, schizophrenia was not primarily a linguistic phenomenon. Indeed, its most striking and ubiquitous feature for many was its inability to be represented by words, despite their persistent attempts. Its non-objective character — especially its absence of physical stigmata — nevertheless meant that *talk* about schizophrenia was its dominant means of expression. The ascendancy of talking over manifest illness itself was another of the numerous contradictions to which participants attested.

There were already words available to talk about these experiences. There were vocabularies, concepts and classifications — 'hallucinations', 'delusions', 'ideas of reference', 'paranoia' — which every participant had encountered and which could have been used between us. I avoided this route as much as possible, however, because it would have been too easily to substitute a presupposition of meaning where one did not necessarily exist. The very term 'schizophrenia' itself was avoided, certainly after initial contact with a participant (unless he or she used him or herself it, usually with an idiosyncratic inflection which also had to be taken account of). In any case, there was no obvious resolution of ambiguity in using such a term; even its clinical use involved a multiplicity of referents. Thus, 'schizophrenia' condenses a long history of institutional and academic practices, including confinement, description, diagnosis, treatment, experimentation, the documentation of cases, and the production of classificatory schemas (Barrett 1996: 178ff). These encoded meanings are as much focused on technologies, the body, writing conventions, the growth of clinical professions, the state's organization of medicine, and the spatial location of certain types of persons in society, as they are on any simple act of designating a discrete illness of the mind. Participants' identities as 'schizophrenics' were shrouded in an indeterminacy which arose from these multiple referents, exemplified by both reductive popular misconceptions (a 'split personality') and the polysemy of clinical meanings. This ambiguity of reference — even for the label which sought to define the whole of them — was also a ubiquitous feature of their everyday worlds. Similarly, language mirrored the necessarily interpretive and creative circumstances of their lives, which made talking the most appropriate vehicle for our being together.

It was through talking that some measure of intersubjectivity was established between us, not as my penetration into the mind of another (or hers into mine), but as a shared exercise which was irreducible to either one of us.[35] Merleau-Ponty — for whom, like Schutz, intersubjectivity is already given to us by the 'cultural world' or the 'human world' which is the 'seat' and 'homeland of our thoughts'[36] — suggests that the grounds for such an engagement beyond solipsism are to be found in dialogue itself:

> In the experience of dialogue, there is constituted between the other person and myself a common ground; my thought and his are interwoven into a single fabric, my words and those of my interlocutor are called forth by the state of the discussion, and they are inserted into a shared operation of which neither of us is the creator. We have here a dual being, where the other is for me no longer a mere bit of behaviour in my transcendental field, nor I in his; we are collaborators for each other in consummate reciprocity. Our perspectives merge into each other, and we co-exist through a common world. (Merleau-Ponty, 1962: 354)

It is by being together and engaging in dialogue that we may both find out what the other thinks, in the same way and at the same time: 'There is, then, a taking up of others' thought through speech, a reflection in others, an ability to think *according to others* which enriches our own thoughts' (Merleau-Ponty ibid: 179; original emphasis).

Tedlock has emphasized the 'betweenness' of knowledge constituted in this way:

> The anthropological dialogue creates a world, or an understanding of the *difference between* two worlds, that exists between persons who were indeterminately far apart, in all sorts of different ways, when they started out on their conversation. The *betweenness* of the world of the dialogue is something I want to keep before us, or between us ... (Tedlock 1983: 323; original emphasis)

Whatever could be known of schizophrenia in the present project had to be surveyed across this breach of difference. The concept of schizophrenia itself marks a state of profound 'difference' — a world which is 'indeterminately far apart' — while the prospect of mediating an understanding of it between patient and clinician has been an abiding

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[35] This was also the motif of Schutz's (1964) analysis of music making as a 'living through a vivid present together [and] experiencing this togetherness as a "We"' (ibid: 177). It is this irreducibility which underpins Schutz's social phenomenology, exemplified by his rejection of Husserl's transcendental derivation of intersubjectivity in which, 'The creation of a universe of monads and of the objective world for everyone proves to be impossible within the transcendental subjectivity of the meditating philosopher, a subjectivity which is supposed to subsist for him, and for him alone' (Schutz 1975: 84). Rather than treat intersubjectivity as a philosophical problem of the operations of a transcendental ego, Schutz treats it as a practical achievement and a 'datum of the life-world' (ibid: 82), the problem of which is routinely solved by social actors in the course of their dealings with one another.

[36] See Merleau-Ponty (1962: 24, 362) and Schutz (1975: 75-6).

concern.[37] Indeed, the clinical concept itself has historically been formulated as a problem of dissociation, disarticulation or 'splitting' within the person. Minkowski (1987) noted the history of characterizing *dementia praecox* as 'discordance' (Chaslin), 'dysharmony' (Urstein), loss of unity (Kraepelin) and splitting (Bleuler's 'schizophrenia'), and concluded: '... the essential disorder does not affect one or more mental functions ... but is to be found among them all, in the 'interstitial space' [between them]' (ibid: 190). At each level, from the intra-psychic to the inter-personal, schizophrenia has been formulated as a problem of 'betweenness'.

I emphasize and appropriate the methodological space of 'betweenness' here because of its aptness for characterizing the ethnographic task at hand:

> Dialogic anthropology reminds us that ethnography occurs in that intersubjective space between the ethnographer and the people studied, just as culture exists in the intersubjective realm of imperfectly shared expectations and communications ... Ethnography, and all interactions, occurs not between a subject and an object, but arises from the meeting of two or more agents interacting in particular settings, just as the sound of a piano emerges not from one pin or the other but from the piano wire stretched between, which further resonates with the soundboard.
> (Roseman 1991: 174)

Minkowski (1970: 182) used a similar musical metaphor to describe his alternating affective engagement with a patient in whose house he lived for two months; he wrote: 'It was like two melodies being played simultaneously; although these two melodies are as dissonant as can be, a certain balance becomes established between the notes of the one and the other and lets us penetrate a little further into our patient's psyche'.

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[37] The liminality of this 'betweenness' was where early European phenomenological psychiatrists — especially Binswanger and Minkowski writing in the 1920s, and later Rümke — located the fundamental disturbance, *le trouble générateur*, of schizophrenia (Kimura 1982: 175-6). It was precisely the supposed inaccessibility of patients — their emotional distance, their 'repulsion', 'strangeness', the impossibility of empathy which they evinced — that marked the 'peculiarity of the interpersonal encounter' which was schizophrenia (ibid: 176). For these psychiatrists, '... schizophrenia manifests itself as a striking event in the interhuman world or as a pathology of "between", in the most unmediated and unequivocal way' (ibid: 178-9). Kimura rejected the inevitability and finality of this breach on the basis of his own clinical experience. It is with schizophrenia and its interstitial location — its 'betweenness' — that the theoretical space shared by philosophy, psychiatry and anthropology comes into clearest view.

Desjarlais (1992: 18-19) has also noted the 'hybrid' character of ethnographic knowledge which is established 'betwixt and between': 'it is precisely in the clash between world-views, in the tension between symbolic systems (how reality is defined, the body held, or experience articulated), that some anthropological insights emerge'. Such a positioning is neither detached, nor completely assured of penetrating another's sensibility, but is wholly interactive, 'with neither foot on solid ground' (ibid: 30).[38] Although derived from a very different ethnographic context, this imagery aptly conveys the sense in which schizophrenia functioned as an imprecise, destablizing and disorienting lens by which to jointly view that which was unique and that which could be shared about another's life.

Similar approaches are to be found in phenomenologically inspired clinical writings in both psychiatry and psychology. Indeed, Merleau-Ponty's account of his method is strikingly congruent with that deployed here:

> I am sitting before my subject and chatting with him; he is trying to describe to me what he 'sees' and what he 'hears'; it is not a question either of taking him at his word, or of reducing his experiences to mine, or coinciding with him, or sticking to my own point of view, but of making explicit my experience, and also his experience as it is conveyed to me in my own, and his hallucinatory belief and my real belief, and to understand one through the other. (Merleau-Ponty 1962: 338)

Merleau-Ponty put this forward as the only possible position which would avoid a reduction to either subjective or objective extremes (which was his aim for phenomenological description). Commenting on the impossibility of producing an accurate, objective account of one's past, or of apprehending the entirety of another's experience, Merleau-Ponty noted:

> What is being sought is not a fictitious coincidence of myself and others, of my present self with its past, of the doctor with the patient; we cannot take over another person's situation, relive the past in its reality, or illness as it is lived through by the patient. The consciousness of others, the past, or illness can never be brought down in their existence to what I know of them. But neither can my own consciousness ... be made to amount simply to what I know of it. (Merleau-Ponty 1962: 337)

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[38] Cf. Rabinow (1977: 119, 155) on an intersubjectivity which is 'neither quite here nor quite there', resulting in knowledge which is a 'translation' of variable quality. Geertz (1983) asserts that such 'translation' is a moral, as much as a methodological imperative.

This interstitial 'betweenness' of knowing and unknowing — of representing and obscuring — reflected participants' experiences most tellingly, as well as my experience of them. Moreover, this 'betweenness' has widespread resonances with other findings of this study. I have already shown (in Chapter 4) that participants' everyday lives were located in the interstices between structure and experience. This is equally a way of describing language and its use.

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In evoking a dialogic approach, I do not intend to suggest that schizophrenia consisted solely of our talking about it. Nor do I assert that schizophrenia existed simply as the sum of innumerable dialogues taking place (often over many decades) between participants and their family members, between participants and their treating clinicians, or between participants and other patients. Such a history-taking was not possible, and no participant identified a single 'cause' of their schizophrenia in such a set of dialogues. In addition, such an emphasis would mask the force of perceptions which defied representation, the inarticulateness which participants attributed to their experiences, the external power of institutions to name, shape and treat those experiences, and participants' diminished capacity to have their speech counted.[39] Nor could a holistic way of being in the world — a 'culture' — be said to emerge from such dialogues (cf. Mannheim & Tedlock 1995). Most participants accepted the psychiatric label 'schizophrenia' as being applicable to some

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[39] Critiques of dialogic approaches from similar bases are canvassed by Abu-Lughod (1991: 139-40), Crapanzano (1992: 189) and Desjarlais (1997: 264n). Mannheim and Tedlock (1995: 19) reject the criticism that a dialogic approach creates 'an illusory levelling effect, disguising or glossing over the context of power relationships within which all field dialogues must take place', arguing that such politics are always present within dialogue itself. They argue also (ibid: 20) that dialogues have the potential to liberate previously suppressed voices. Attinasi and Friedrich (1995: 34-5) note that the 'actual exchange and sharing of words' is as liable to result in antipathy and antagonism, hatred and aversion as it is in harmony and order, and that differentiation is as crucial to dialogue as is identification. They emphasize the political content and transformative potential of dialogue: 'since two interlocutors are never completely equal and since they are often politically nonequal, the sort of dialogue we are adumbrating often involves a fundamental change in power, with one party becoming more empowered or at least the power structure between the two changing deeply' (ibid: 35).

'practical purpose' of communication (such as our introductory meetings), but few appropriated it to encompass all of their experience, their circumstances, or their identity.

Disclosure through talk was this study's principal methodological tool because it was a central concern of the participants themselves. Their engagement in the project was often explicitly geared to placing something between us on which we could work together to extract a meaning: a set of experiences, located within a life history (of abuse or neglect, for example) and set within a social context (of medical diagnosis and treatment, of 'living in the community', or of social labelling). Our dialogues were aimed at formulating a clearer view: bringing an idea or an explanation into focus and finding articulation for experiences which were often hard to grasp for both speaker and listener. Sometimes it was only a feeling or a vague image which was placed between us, rather than a fully formed concept. On many occasions this was a tentative and fraught process, displaying all of the potential for distance and closeness, obfuscation and clarity suggested by Taylor. Vagueness, indeterminacy and obscurity were key features of this world which had to be embraced and shared.

Conversations with some participants were more intimate than with others as rapport was dependent on the ability and preparedness of each person (myself included) to generate meaning together. The moral intent of these dialogues was also conspicuous, as many accounts were explicitly formulated with the aim of convincing me of their veracity, and therefore of the intrinsic capacity of the participant to 'speak the truth' about their experiences — in short, to be accepted as a moral agent. In this way, a participant presented themselves as the type of person who could, as we say, be 'taken at their word'.

Many of our conversations were centred on the minutiae of daily life — incidents, individuals, gossip, television programs — and could be profoundly trivial, at least to an unengaged observer. Such talk was not for the purpose of gleaning specific information or focusing on schizophrenia. Rather, it was to be sociable — to engage in the type of activity which most people in our culture do together (Sampson 1993: 97) — and to be 'doing nothing' in particular except sharing the experience of being together.

Chapter 7

VOICES, LANGUAGE, TEXTS
REPRESENTING SCHIZOPHRENIA

> I cannot remember how much … Harry Kitchings told me and how much I have made up … stitching together the scraps a man offers of himself. There are certain details which he surely did not mention, which I must have deduced later, based on my bitter knowledge of the ways of men. It has occurred to me since that perhaps his whole past was my invention; that I recited these events against his silence over and over in my head until they became real, in order to convince myself that we were close; that he may have worked deliberately at vagueness, keeping himself as distant and insubstantial as a cloud, flinching from my feelings, watching with pity as I tried to give his words a shape. Even now I am unable to bear this thought — that he may have told me nothing of his life.
>
> *The Service of Clouds* (D. Falconer, 1997)

This chapter looks in detail at one extraordinary experience which, in many popular understandings, is synonymous with schizophrenia: auditory hallucinations or 'voices'. It examines how these phenomena were represented by participants in their verbal accounts and in their own writings. It also explores the limits of those representations, since as many participants asserted, 'voices' often escaped encapsulation and exegesis by way of language. Other cultural forms — such as music and literature — are also examined for their affinities with such ineffable experiences. The chapter then addresses the dialogic possibilities for rendering idiosyncratic experience potentially meaningful to both participants and myself.

The term 'voice' is inherently ambiguous in this context. As the first section of this chapter demonstrates, the 'voices' which are often taken as emblematic of schizophrenia were, in participants' experiences, frequently not voices at all as this term might be understood in an everyday context.[1] Specifically, the 'voices' associated with schizophrenia lacked certain tones, they were 'whispers', or they were 'pictures' and 'feelings' which defied description. This indeterminacy often meant that these experiences were difficult to classify, even for the person who experienced them. This made them quintessentially anomalous (see Chapter 1). It also meant that they were hard to recall or articulate by means of everyday language. They defied language itself, even while it was sometimes their vehicle.

This ambiguity meant that, at times, I had to struggle to interpret the voices of participants in much the same way that they struggled to interpret the 'voices' associated with schizophrenia. Both types of voice were sometimes positioned at the edge of understanding. This was exemplified in the case of a participant I have called Adam, who perpetually intrigued and confused me. A large part of this chapter comprises an account of my exploratory and ultimately unsuccessful attempts to understand what Adam said and wrote about his experiences. Adam's talk about 'voices' and about language itself never fully explicated either of these phenomena for me. The chapter traces my realization that this situation served Adam well, and might, from his perspective, have been the point of our encounters. The example suggests the way in which the supra-linguistic dimensions of our being together conveyed more about Adam's world than anything he could say about it. What Adam said about 'voices' was not as revealing of his identity and everyday world as that which was conveyed by the performance of his perplexing talk.

The motif of perplexity attends every level of representing 'voices', from participants' accounts (and my difficulty, at times, in comprehending them), to clinical and theoretical debates. I argue that a principal source of that perplexity is that 'voices' are transforming phenomena, the experience of which has ramifying, transformative effects. In participants' experience, 'voices' were not discrete phenomena but marked a

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[1] It is for this reason that I designate them with single quote marks (''), following the example of Bleuler (1950).

transformation from one modality (say, thought) to another (speech or emotion). Moreover, the experience of 'voices' was itself transfiguring — in the sense set out in Chapter 1 — of a person's perceptions and beliefs, opening them up, as several participants said, to other possible worlds and to other ways of viewing the world and the self.

The capacity of 'voices' to intrigue by way of perplexity is, I suggest a measure of their extraordinariness. They intimated aspects of the everyday world — such as talking, communication and representation — at the same time as defying these processes. Van den Berg (1982) has described this quality for hallucinations in general. He notes that most schizophrenic patients make a distinction between their hallucinations and their perceptions: 'He perceives *and* hallucinates, and both are often clearly distinguished' (ibid: 160; original emphasis). Perception is, in essence, intersubjective:

> Seeing is to see what another sees [or] what another could see [in the same circumstances]. Exclamations like 'Come and look here' … are really close to every visual perception. Hearing, in the same way, is almost immediately 'Come and listen here' … (van den Berg 1982: 160)

In hallucination, such intersubjectivity is lacking:

> The hallucinating person does not think and does not say 'Come and look here' or 'Come and listen here', nor is he afraid that another will be able to hear it or that another will be able to see it. He hallucinates alone. (van den Berg 1982: 160)

Yet these two states are inseparable:

> The hallucinating person hallucinates in the midst of his perceptions. The suspicious stranger who sneaks over the staircase every day and whom nobody sees apart from the patient, sneaks *over the staircase*, over the staircase which everybody sees. The suspicious ticking in the other room is ticking inaudible to everybody in a room that we all know, in the midst of actual sounds that we hear. I have never seen a patient who hallucinated exclusively, not do I know of a published report of an exclusively hallucinating, non-perceiving patient… Hallucinating, according to its nature, is to see (hear etc.) that which another does not see, amid that which everyone, including the patient himself, sees. (van den Berg 1982: 160; original emphasis)

Again: 'The patient … is surrounded by healthy existence and determined by it; he hallucinates amidst perceptions; he lives his delusions amidst logical connections' (ibid:

162).[2] This conjunction — or what van den Berg emphasizes as the 'amidst' — is what I have termed 'extraordinariness'. In this chapter it is exemplified by participants' 'voices' which both separated them from the everyday world, and also drew them back to it by way of understanding and accounting for these perplexing phenomena.

In this way as well, 'voices' return us to the issue of intersubjectivity and its limits. The impossibility of experiencing another person's experience is one of the central problematics of much phenomenological philosophizing and theorizing (see Laing 1967; Kapferer 1986). Schutz addresses this issue as the central methodological problem of his social phenomenology. He noted that the meaning which any other person attributes to their own actions (their 'intended meaning') is neither accessible nor comprehensible, since it is impossible for me '... to explicate the other person's lived experiences in the same way that he does' (Schutz 1972: 99). This is the inherent limitation of human intersubjectivity:

> The postulate ... that I can observe the subjective experience of another person precisely as he does is absurd... I should have to be able to remember all his experiences and therefore should have had to live through these experiences in the same order that he did; and ... I should have had to give them exactly the same degree of attention that he did. In short, my stream of consciousness would have to coincide with the other person's, which is the same as saying the I should have to *be* the other person.' (Schutz 1972: 99; original emphasis)

Having thus philosophically dismissed the possibility of intersubjectivity, Schutz went on to explore in great detail how it nevertheless becomes a taken-for-granted element of the everyday world (what he called the 'natural attitude'). He notes (after Weber 1978) that the phenomena of the social world are meaningful and a matter of intersubjective

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[2] Cf. Jaspers (1963: 150; original emphasis): '... the patient lives in two worlds simultaneously, the real one which he can see and judge for himself and his psychotic one. He acquires a certain *double orientation* and can move among live realities more or less correctly, in spite of his cosmic experiences ...' See also Schwartz and Wiggins (1992: 307; original emphasis): '... the schizophrenic is oriented toward *both* his psychotic world and the real world. At times the patient may be consumed in his delusional world and sustain no awareness of the other world, the consensually validated world... At other times, however, the schizophrenic lives in both spheres simultaneously... [E]ven when the consensually validated world is experienced as an illusion by the patient, he can still correctly survey its features ... [and] he still maintains an accurate understanding of its workings and properties.'

agreement in the same way that people in their daily lives take for granted that there is a lawful and predictable external world that conforms to the concepts of their understanding:

> For in the simple process of living we directly experience our acts as meaningful, and we all take for granted, as part of our natural outlook on the world, that others, too, directly experience their action as meaningful in quite the same sense as we would if we were in their place. We also believe that our interpretations of the meanings of the actions of others are, on the whole, correct... In experiencing them as *others*, as contemporaries and fellow creatures, as predecessors and successors, by joining with them in common activity and work, influencing them and being influenced by them in turn — in doing all these things we *understand* the behavior of others and assume that they understand ours. (Schutz 1972: 9; original emphasis)

Thus, establishing the essential inaccesssibility of another's intended meaning did not lead Schutz to deny the possibility of ever understanding another person's experience:

> We are asserting neither that your lived experiences remain in principle inaccessible to me nor that they are meaningless to me. Rather, the point is that the meaning I give to your experiences cannot be precisely that same as the meaning you give to them when you proceed to interpret them. (Schutz 1972: 99)

The natural attitude — the world of the everyday — allows for simultaneity: that is, 'the basic and necessary assumption ... that your stream of consciousness has a structure analogous to mine' (ibid: 103). This allows me to assume that you are seeing, for example, the same table as I am seeing (ibid: 105). It also allows for the dialogic apprehension of expressive acts as communicative acts, such that it is only when I regard '... *your* subjective experiences as flowing simultaneously with *my* subjective experience of you, that I really grasp or "get with" *your* anger' (ibid: 117). Such intersubjectivity is a practical accomplishment of social living[3], and it relies on calling a practical halt to the search for subjective meaning:

> In ordinary life we call a halt to the process of interpreting other people's meanings when we have found out enough to answer our practical questions; in short, we stop at the point that has direct relevance to the response we shall make ourselves. The search for the other person's subjective meaning will very likely be abandoned if his action becomes evident to us as objective content in a manner that relieves us of any further trouble... [T]he overt meaning is sufficient for us to respond appropriately; we do not therefor try to interpret the other person's behavior beyond a relatively superficial level. (Schutz 1972: 38)

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[3] Cf. Jaspers (1968: 1315): 'We understand other people, not through considering and analysing their mental life, but by living with them in the context of events, actions and personal destinies'.

Schizophrenia appears to highlight the essential inaccessibility of other people's experience that Schutz says is a condition of all intersubjectivity. As an historical and clinical construct, schizophrenia directly confronts the 'natural attitude' — especially those assumptions concerning analogous structures of consciousness (ibid: 103), or the existence of established and common codes of interpretation which can lead directly through expression and bodily movements to another's underlying lived experience (ibid: 100). Schizophrenia can be seen to confound the simultaneity and dialogic transparency of everyday sociality as a practical achievement. Participants in this study, for example, demonstrated that they did not call a 'halt' to the search for subjective meaning at a point which was merely practical, or at point which was consistent with others in their world (relatives, friends or psychiatrists, for example). They were relentlessly troubled by meaning (cf. Binswanger 1963: 252; see also Chapter 1). They continued to 'trouble' phenomena and other people in a continuous search for meaning. They 'troubled' themselves to explore and elaborate on the meanings of their own subjectivities.

It is for these reasons, I contend, that schizophrenia makes an especially pertinent case study in the social construction of intersubjectivity. In this chapter I address such a project through a limited case study which draws principally on my work with one participant. The example of Adam illustrates some of the barriers to meaning and understanding which resulted from a discussion of his 'voices', suggesting that there were elements of his experience which went beyond representation and intersubjectivity. I go on, however, to demonstrate that there were some widely available cultural forms — especially in music and popular culture — which address this very issue and which were invoked in Adam's own narrative. His account of 'voices' therefore points to other expressions of the ineffable and the inchoate in human experience, and to ways of assigning such experiences a cultural and intersubjective niche.

'VOICES'

'Voices' are recognized by psychiatry as a form of auditory hallucination. According to the DSM-II-R (American Psychiatric Association 1987), these are voices which a person perceives as coming from outside his or her head, which may be single or multiple, which may be addressed directly at the person or which comment on his or her ongoing thought and behaviour. As an aberrant perception[4] they are one of the elements which make up the 'characteristic symptom picture' of schizophrenia (ibid: 188), although they are not invariably present or seen only in schizophrenia. Hearing 'voices' can also occur in chronic alcoholic hallucinosis, affective psychoses and temporal lobe epilepsy (Sims 1995: 85; Trimble 1990). There are also various studies which report on the occurrence of 'voices' in psychiatrically 'normal' populations, especially in response to sexual abuse, trauma or bereavement, or under conditions of anxiety and stress.[5] A study of voice hearers by Romme *et al.* (1992) found a small group of people who were 'paranormally gifted' and 'clairaudient'[6], as well as another group whose hearing of voices did not lead to psychiatric treatment, resulting in the authors' conclusion that, 'hearing voices does not always lead to a psychosocial handicap' (ibid: 102). Nevertheless, the hearing of 'voices'

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[4] As a perception, 'true' hallucinations appear as a normal sensory experience; even in the absence of an external stimulus they have the 'full force and impact of a real perception', are 'unwilled', and cannot be readily controlled by the percipient (Sims 1995: 83). Aggernæs (1972) formulated and tested a constellation of 'reality qualities' which demonstrated that most hallucinations resembled normal perceptions. Rojcewicz and Rojcewicz (1997: 9) criticize such 'empiricist' definitions of hallucination on two grounds: firstly, for the 'philosophical' assumption that hallucination is a passive sensory process in which 'intentionality is deleted'; and secondly, for ignoring evidence that the hallucinating person does *not* hear or see 'in the normal sense' (see also Merleau-Ponty 1962: 339).

[5] P. Thomas (1997: 96-101) reviews of a number of such studies dating back to the late nineteenth century. See also Rojcewicz and Rojcewicz (1997: 11) and Boyle (1990: 198-200). These studies variously report the occurrence of auditory hallucinations in 1 - 30% of the 'general' population, 13% of a sample of widowed people, 28% of a sample of women who had been sexually abused in childhood, 34% of a sample of non-psychiatric medical patients, and up to 70% of a sample of college students. Boyle (ibid: 197) also reviews studies that suggest significant cross-cultural differences in the evaluation and solicitation of these experiences (which may be induced through socially-sanctioned techniques such as sleep deprivation, fasting, pain or social isolation). See also Andrade *et al.* (1988).

[6] One of the participants in the present study, Tony, explicitly canvassed 'clairaudience' as an explanation for his 'voices'. He had found the term in a book about runic divination (T. Willis, *Discovering Runes*, The Aquarian Press, 1991) where he had heavily annotated the section on clairaudience as a technique for intensifying one's intuition: 'The student is aware of a word, a name, or even a whole sentence being spoken, and ... may have difficulty in distinguishing between physical sounds and astral sounds. Likewise, the type of voice, its clarity and volume, may differ from one occurrence to another; at times it may give direct information while at others it may speak symbolically' (p. 35).

is attributed 'supreme diagnostic significance' (Sims 1995: 85). According to Rojcewicz and Rojcewicz (1997: 16): ' The significance of hallucinations in pathological conditions is that they are symptomatic of a pathological way of relating to the world, an abnormal way of being.'

While the designation of 'voices' as hallucinations has itself been questioned[7], this remains a cornerstone of clinical practice and a powerful influence on the way in which the hearers of 'voices' come to understand their experiences. The influence of psychiatry in rendering 'voices' as 'unreal' perceptions was evident in the fact that many participants debated the 'reality' of 'voices' as an object of their own experience. Thus, while many participants were certain that they experienced the hearing of 'voices', they found it much harder to specify what this 'hearing' was and what this experienced *object* was (see Aggernæs 1972: 226). 'Voices' were both known and difficult to articulate; their combined familiarity and strangeness, intimacy and alienation, marked them as quintessentially extraordinary. This uncanniness existed despite the clear impact of these phenomena on individual lives and their pivotal role in orienting experience and belief.

For many participants and their relatives, hearing 'voices' was synonymous with schizophrenia. As one participant said: "My only understanding of schizophrenia is the hearing of voices". Another, when asked what he meant by his self-identification as 'psychotic' said: "Well, I hear voices don't I?" For James' mother, 'voices' were the encapsulation of schizophrenia: "It's the voices over-powering his brain. There's not much we can do about that."

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[7] In a collection of papers aimed at influencing revision of the DSM-III-R, Lynn Stephens and Graham (1994: 180) argue that 'voices' should be reclassified as 'disturbances of the subject's sense of self' rather than auditory hallucinations. Based on the research literature they suggest two alternate models. The first suggests that 'voices' arise from the awareness of inner or subvocal speech which is misrecognized as coming from outside: 'The subject is talking (silently) to himself or herself but feels that someone else is doing the talking' (ibid: 182). They call this the 'misattributed act theory' of voices. A second body of research suggests that various forms of non-speech (running water, the drone of an air-conditioner, etc.) are misrepresented as the sound of someone speaking. Voices are therefore elaborations of genuine perceptual experiences which function as hallucinations — they call this the 'functional theory' of voices (ibid). Both theories posit a problem in the 'intentional stance' of the self toward its own mental life.

Whenever participants mentioned their 'voices' I would ask what these were like — what was their quality? A representative sample of participants' responses are set out in Appendix 2. They are listed there under the following headings:

- **Speech**
  which is like a 'real voice' which calls, commands or comments, which could come from 'inside' or 'outside', or moves between these locations;
- **Whisperings**
  barely audible sounds intimating speech, but at the edge of comprehension; a "silent message ... like someone whispering in my ear";
- **Thoughts**
  communications which interact directly with thoughts, or "involuntary thought patterns";
- **Visions**
  'voices' which have a visual component, or which 'show' themselves;
- **A combination of more than one modality**
  in which 'voices' are an inextricable mixture of thoughts, speech and 'pictures' which generated an emotional response — "you don't hear it, you feel and know it in your mind";
- **Distorted forms of language**
  everyday speech which is modified in tone or pitch, which is undeveloped or 'childish', or is perceived through a non-verbal medium such as bird song;
- **Another consciousness, being or agent**
  in which 'voices' intimate the presence of other people, other beings, or other forms of agency; 'voices' as "companions" and "inner friends";
- **From another place**
  in which 'voices' represent a spatial displacement, coming from somewhere distant, another place or dimension;
- **From another time**
  'voices' which intimate another time;
- **Sleep/dreams**
  communications occurring during sleep, but which are distinct from dreams;
- **Noises, objects and background effects**
  in which 'voices' or other significant communications emerge from everyday non-verbal phenomena; also the identification of 'white noise', a 'cosmic hum' or 'music of the spheres' as significant in some way.

It should be noted, however, that these were not mutually exclusive categories: the same participant could experience 'voices' in a number of ways, either contemporaneously or at different times during the course of their schizophrenia. The fluidity of this experience — together with the transformation of how a 'voice' was apprehended over time — was exemplified in the following account in which Christopher reported that 'voices' appeared first as another sort of being ('angels'), evidenced by an altered aural tone on the radio, but then as his own thoughts interacting with what he heard. He made the point that his understanding of these phenomena was predicated on how he felt about himself at the time, and on his belief system:

> "I had these experiences where I [thought I] was a bad person — I was evil. And I experienced these angels on the radio. They wouldn't actually do it [i.e. speak] directly but they … just appeared on the radio, and then I thought, 'I must be bad' … I thought of 'angels' because that was my mental set-up at the time.
> *What happened on the radio that you thought there were angels there?*
> It's like it changed the normal sound [of what you hear on the radio] to something different, and I then interpreted it as something different, so that it was given out as punishment or something like that.
> *Can you give us an example of what became different?*
> The tone of the voice. But all these thoughts came into my mind too, so it could have just been the thoughts that was creating a projection off the radio, almost could be like that, my thoughts projected onto the radio. So it was not necessarily [that] the angels were against me. It might have been my own thinking at the time.
> *What do you think in retrospect?*
> Well there was a difference in the radio, yes, [a] definite difference in the radio. Whether there were angels or not, I don't know now."

Diagnostic criteria or schedules of psychopathology could have been used to delineate and separate out these phenomena as 'delusions of reference' and 'thought projection', for example. This would have denied, however, the unity which they had in Christopher's experience (at least as this had been reflexively constituted over a number of years) — a unity which was only evident when these phenomena were viewed in the context of his wider understanding of the nature of thought, spirituality, and the role of the media in everyday life. Moreover, the abiding perplexity of these phenomena was itself an orienting and unifying component of his overall experience which had led to various religious practices (such as meditation) and philosophical investigations.

The common sense term 'voices' masks the heterogeneity and complexity of people's experiences of these phenomena. In part this manifest heterogeneity arose because most participants did not necessarily make the distinction which psychiatry makes between 'elementary hallucinations' — unstructured sounds such as whirring noises, rattles, whistling, the sounds of machinery, and so on — and other more complex hallucinated perceptions which are known as Schneiderian first-rank symptoms: hearing one's thoughts out loud, hearing a running commentary on one's thoughts and actions, or hearing 'voices' arguing or discussing the hearer in the third person (see Sims1995: 85; Trimble 1990). It is these latter — as discrete and highly delineated phenomena — which are sought by way of the Present State Examination (PSE) and which are of paramount diagnostic and research significance to clinicians. Participants did not share this imperative to delineate, and did not necessarily attribute these latter phenomena with a greater significance or meaning than other more 'elemental' ones.[8] Indeed, some participants saw these as forming a continuum, or as one transforming into the other, within the context of a specific belief system.[9] Christopher, for example, saw as a single phenomenon the development of his own thoughts into a "mantra" endlessly repeating inside of him and then into a 'voice' outside of himself (see example 5(b), Appendix 2). Adam described the onset of what he called the "total explosive experience" of psychosis in terms of whispers turning into voices. Kate asserted that the 'voices' were indistinguishable from her own breath. Billy found the rhythmic footfall of pedestrians in the street turning into a 'voice' (see example 11(a), Appendix 2). The 'clicking' of a radio signalled to Oscar that a 'voice' was about to 'come through' (see example 11(c), Appendix 2).

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[8] Bleuler (1950: 99) called the unstructured sounds 'elementary auditory hallucinations' and noted that they sometimes had a significance for his patients: 'rustling sounds mean danger; shooting is done either for their salvation or to their detriment'.

[9] Cf. Strauss (1969) on the 'continua of experience, not discrete phenomena' found amongst subjects in the WHO International Pilot Study of Schizophrenia (IPSS): 'Although it is possible to create a dichotomy between abstractions like "normal" on the one hand and hallucinations and delusions on the other, such a dichotomy does not reflect accurately the difficulty in determining presence or absence of the phenomena in the many patients who present intermediate kinds of experiences' (ibid: 581).

This heterogeneity of reference is acknowledged in many classical and clinical accounts. Bleuler, for example (1950: 96), listed blowing, rustling, humming rattling, shooting, thundering, music, crying, laughing, whispering and talking as comprising the contents of auditory hallucinations. All of these, except crying, were to be found amongst participants' reports in the present study. Bleuler went on to state that 'voices' were predominantly apprehended as speech, but also noted their reported physical effects on the body, together with their occasional embodiment and personification:

> The voices not only speak to the patient, but they pass electricity through his body, beat him, paralyze him, take his thoughts away. They are often hypostatized, either as people, or in other very bizarre ways. For example, a patient claims that a "voice" is perched above each of his ears. One voice is a little larger than the other but both are about the size of a walnut, and they consist of nothing else but a large, ugly mouth. (Bleuler 1950: 97)

Bleuler also noted that 'voices' were sometimes indistinguishable from thoughts: they were 'such vivid thoughts', 'audible thoughts' or 'soundless voices' (ibid: 110).

Rojcewicz and Rojcewicz (1997: 11) assert that the quintessential auditory hallucination is a 'voice' apprehended as speech. They note that such a 'voice' is heard in isolation from other sensory phenomena, that 'patients do not hear persons, they hear voices', and that there is no interplay with other sounds and phenomena (ibid: 17). Accounts by participants in this study indicated that their experience of 'voices' frequently contradicted these characterizations. 'Voices' were entailed in a range of sensory modalities. In several cases they penetrated the body, sometimes in a sadistic way, sometimes in a sexual way.[10] As the 'voice of sex' (see the example of Adam, below) they induced multiple orgasms. Occasionally they were indistinguishable from other persons (see examples 7(a), (c), (d) and (f), Appendix 2).[11] And in some examples they emerged from other sounds and phenomena, especially by way of aurally modified radio signals or television transmissions (see also examples 11(a) and (c), Appendix 2).

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[10] Here intimating the 'continua' of psychiatrically defined hallucinations and (somatic) delusions noted by Strauss (1969).

[11] Cf. L. S. Benjamin (1989), who documented the experiencing of 'voices' as loving and nurturing — that is, as possessing quintessential properties of person — in the context of integrated, well-articulated and interpersonally complementary 'relationships' with auditory hallucinations.

RESPONDING TO THE PERPLEXITY OF 'VOICES'

As well as emphasizing the fluidity and heterogeneity of 'voices', participants' accounts also stressed their abiding perplexity. Many of these accounts were framed by a profound questioning of the reality of 'voices'. Some participants had oriented their daily lives around a quest for understanding their 'voices'.

- In the context of a question as to why he had two 'voices' in his head, James himself queried the "physical" possibility of the scenario he had just presented:

  > "I can hear a baby and an old man. They've been in there for years ... up here in my head. But it couldn't be, physically. I don't know. Never gone that far into it. All I know is there's two voices, that's all. You've got me stunned now [with the question] ... You get used to it after a while ... If it was my own thoughts how come I am getting two extras? ...
  > If somebody could tell me why I would understand it a lot better than I do now. The doctors can't tell you why, the nurses can't tell you why. All the time you think, 'Why me? Why me?'."

- Christopher stressed the imperative to understand the 'outside voice' which was personified as a young girl:

  > "She'd repeat what I was saying and sometimes she would make a comment on what I was saying to myself, what I was thinking — negative comments ... The voice started to make comments that I'd done something wrong in my life. Somehow it appeared as though I had a connection with it, 'cause I was going to say something to myself, and it would say it instead ... I try to understand it because I need to understand it ... I need to understand this voice and why it does those things."

- Like Christopher, Evelyn had heard angels and devils 'modifying' the sound of the radio. The "weirdness" of these 'voices' led her to investigate "all this rubbish". She said: "That's when I realized I had to start investigating. I wanted the truth." Firstly she consulted psychiatric textbooks borrowed from the library and then she made an appointment with a neurosurgeon.

Lawrence attempted to distinguish what he called 'real' voices — of other people, of actors on the television or announcers on the radio — from 'imaginary voices', the basis for which he was uncertain:

> "With a voice that's real, I have no doubt that it's an actual thing that is existing. With one that's unreal, I'm not sure whether it exists or it doesn't exist. Whether it's in the imagination or whether it's the lived experience of the real. So, that's the difference. With the unreal one, it might be real, but it might not

> be real. Could be imagination. Yeah, and sometimes they sound very, very strange."

He characterized 'imaginary voices' in terms of their "irrationality" and their "repetitiveness"; he said that they were like "aggressive prayers". Nevertheless, he found "comfort" in their persistence and repetition. 'Real' voices, however, were subject to perplexing transformations:

> "I was at the theatre one night, and the sound became very, very unusual to listen to, and very disturbing as well — [the voices] of the people on the stage. And that experience was the same as the hallucinations I have when I'm trying to go to sleep ... You know, it's just a very unpleasant sort of experience."

In this transformed state the 'real' voices made direct references to him and attempted to control his thoughts. It was a particular problem with voices on the radio and television, both of which media Lawrence tried to avoid.

Questions concerning the location of these phenomena 'inside' or 'outside' of the self — and their concomitant 'ownership' by the self — were also an abiding concern. Christopher's example of angels appearing on the radio, cited above, is again illustrative. The 'voices' were initially external beings which were decidedly 'not him' before he began to apprehend them as his owns thoughts; later again these thoughts transformed into speech which came from outside of himself (see example 3(a), Appendix 2). Moreover, this thought/speech which was no longer his and came from outside himself was also transformed in respect of its gender (example 6(b), Appendix 2). Such an example might be presented as evidence of the 'permeability' of the self in schizophrenia in which the 'barrier between the individual and his environment' breaks down in a way which is seen as pathological (Trimble 1990: 195). However, what Christopher's account evinced more strikingly was a *passage* between 'inside' and 'outside' the self — a flow which was reversible and in which the phenomenon itself was transformed (from aural effects, to thought, to 'voice') by its passage. The fact that throughout his account Christopher continued to delineate the positions of 'inside' and 'outside' as reference points would suggest that the 'barrier' itself did not disappear, although it might change, becoming more susceptible to passage. Indeed, it was the *transformation* that voices effected between the 'inside' and the 'outside' as they themselves transformed which was their most significant quality, and the source of their great perplexity. Ordinary categories — such as 'inside' and 'outside' — did not disappear in a florid erasure of the self and its 'healthy' barriers, but remained as anchor points by which to measure the extraordinariness of transformation.

One might have expected that, for many participants, medication would have diminished the clinical 'symptoms' of schizophrenia to the extent that 'voices' were no longer as compelling, disturbing or 'important' (Sims 1995: 39) as they had been previously, and therefore no longer as puzzling.[12] Education programmes in hospitals or at the Schizophrenia Fellowship might also have been expected to diminish the perplexity of 'voices', rendering them, for instance, epiphenomenal to faulty neural transmission (see example 1(e), Appendix 2). Yet Christopher's puzzlement persisted despite both of these inputs, as was the case for a number of other participants. Even when people were no longer hearing 'voices' regularly, these were not easily expunged from memory and the fact that they had occurred at all was a source of ongoing wonder and speculation. The literature also suggests another possible trajectory. Rojcewicz and Rojcewicz (1997: 13-14) note research findings which posit that the 'progress' of schizophrenia is marked by 'voices' which are initially critical, threatening or negative becoming comfortable and even enjoyable. Romme and Escher (1989) also report changing responses to 'voices' over time, beginning with a 'startling' and frightening phase which is followed by a period of 'organization' involving selection and communication with the 'voices', followed by a phase of 'stabilization' in which the 'voices' are accepted as part of the person, who enacts coping strategies to reduce or contain their intrusiveness. Both these proposed trajectories imply that 'voices' become less puzzling over time. While this trajectory was observed

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[12] Clozapine was widely reported by participants to have a muting effect on 'voices', pushing them "to the back of my mind", as one participant said. Thus, James said that with Clozapine (which he had been taking for 4 months) the 'voices' had become "like a whisper" — "I'd say the voices are still there ... like always, but they're more of a background, not what you'd call strong". Christopher similarly reported that with Clozapine the 'voice' had gone "into the background": " it's like there is a cushion there that is putting her in the background".

among some participants in the present study, many remained quizzical as to the nature and ultimate significance of 'voices'. This was certainly the case with Gerald who had first heard 'voices' thirty years before. Adam, who had been listening to 'voices' for more than twenty years was no longer puzzled by them at all. Instead, he employed their abiding strangeness and indeterminacy to render himself and his world quintessentially perplexing.

CONFOUNDING TAKEN-FOR-GRANTED ASSUMPTIONS

In the course of a PSE interview, when asked if the voices talked directly to him or just referred to him in the third person, Adam responded by querying the logic of the question, saying: "Your use of words differs from mine". He stated that he did not acknowledge the "binary distinction" created by the question because it denied the role of his own consciousness in soliciting and engaging with the 'voices'. His 'voices' were intrinsically a part of his heightened perception of the world. While he could appreciate the everyday referent of words like 'voice' and 'talking', this was not how Adam experienced his 'voices'. His response highlighted the way in which the PSE presupposed that 'voices' operate through everyday speech patterns, grammatical structures (second and third person, for example), and have a relationship to the self which is like two interlocutors engaged in conversation. That is, the question is based on a model of two or more discrete individuals having a conversation, and therefore assumes a separation between self and (heard) 'voice'. Adam rejected such a separation: the 'voices' were as much a part of his capacities to see, feel and imagine as they were manifestations of an hypothesized 'other'.

This example reveals some of the taken-for-granted assumptions about 'voices', especially the separation and distance which is assumed to exist between hearer and speaker (a separation which is collapsed when 'voices' are 'heard' inside one's head), and the facilities of 'talking', 'hearing' and communicating more generally. Even the presumption that 'voices' were 'heard' (cf. Rojcewicz & Rojcewicz 1997: 17) is brought into question by the multiple modes — thinking, picturing, feeling and looking (at television, for example) — through which participants asserted that they became aware of 'voices'. Moreover, this was not a passive reception: these were all modes through which 'voices' could act directly on the person, especially by way of transforming sound, vision, thoughts and emotions. Ultimately they could transform a person's understanding of what it was to be a person.

BEYOND REPRESENTATION?

Not only were the 'voices' often difficult to grasp, but they confounded attempts to represent them. This too reflected their peculiar content and quality. No participant asserted straightforwardly that the 'voices' which they associated with schizophrenia merely 'spoke' to them in intimation of everyday speech, or engaged them in conversation like I did. Rather, the 'voices' commanded, insinuated, whispered, induced feelings, or caused 'pictures' to form in the mind. Likewise, participants rarely engaged with them by way of everyday conversation. Responses to the 'voices' were more likely to take the form of an admonishment, a request to be left alone, or an abusive "fuck off". Often a 'voice' conveyed only a single word, a name, or a phrase which lacked any discursive context[13]; sometimes this single item was repeated endlessly to the point of meaninglessness.

The representation of 'voices' was structured by a contradiction. In one sense they were not manifested in anything other than themselves — they could not be 'heard' by anyone other than the person receiving them — and to this extent defied collective apprehension and representation.[14] At the same time, they had effects which were graspable and therefore capable of serving as symbols (that is, as vehicles for communicating meaning)

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[13] Cf. Bleuler (1950: 99): 'As a rule ... the patients hear short sentences or single words which in themselves need not always make sense'.

[14] Cf. Aggernæs (1972: 232), who found that the quality of 'publicness' — the sense that anybody else would be able to perceive the same thing — was markedly absent in the perception of hallucinations.

in particular ways. Goodman (1978) has addressed this contradiction in respect of pictorial works, identifying two instances in which apparent non-representation can be meaningful. I suggest that the conditions he identifies in each case might equally be applied to 'voices'.

Firstly, 'voices' did not point to anything in the everyday world in a very particular sense: even as I sat with someone as he or she was hearing 'voices', I could not hear them myself. They were not phenomenologically present to my experience, although patently 'real' to my interlocutor. Thus they were like certain types of depictions which can never be tested: "Bosch's paintings of weird monsters, or the tapestry of a unicorn, represent nothing; for there are no such monsters or demons or unicorns anywhere but in such pictures or in verbal descriptions' (Goodman 1978: 60). To say that such a depiction 'represents a unicorn' says nothing other than it is a 'unicorn-picture' (ibid: 61); equally, participants' accounts of their voices (whether *in situ* or *post hoc*) could be nothing more than 'voice-accounts'. Such visual depictions accrue meaning, however, when constituted by particular settings as 'art', or altar pieces, or heraldic designs. Similarly, accounts of 'voices' accrued value when they were produced in certain settings: either to engage us as researchers, or to effect psychiatric intervention when presented in a clinical setting. The imperviousness to verification is what epitomized 'voices' as quintessential strange and inimical to intersubjectivity — this was another source of the indeterminacy which made them of such value to some participants (see Chapter 4). At the same time, their defiance of empirical veracity and their inability to be grasped as a common experience was what made them of value for psychiatric diagnosis (since they differentiated and substantiated psychopathology). Interestingly, some participants draw on the same representational examples to convey their own experiences, as when Lawrence likened his schizophrenia to a Bosch painting:

> "There's some fairly unpleasant things about schizophrenia, but I find it very difficult actually putting them into words. But it's like you see the depths of a very unpleasant world… I can't describe it, but you've probably seen Hieronymus Bosch. Yeah, it's that sort of material. And it is … very distressing, basically. It's just unreal. It's horrible."

Secondly, Goodman notes that some non-representational forms of art are capable of expression, and hence symbolization: 'An abstract painting that represents nothing and is not representational at all may express, and so symbolize, a feeling or other quality, or an emotion or idea' (1978: 61). Thus, a work of art can give expression to something outside of itself: a painting does not itself sense or feel or think (ibid), but can induce these responses in viewers. I found participants' accounts of 'voices' to be similarly structured: although the 'voices' did not 'speak' to me and often defied representation and classification, participants attested to their capacity to evoke emotional reactions — especially fear and anger, but also wonder and curiosity — and they could produce similar responses in me as well. For participants, such emotional responses had wide-ranging practical consequences. These were palpable in people's social withdrawal, in their efforts to explore and document these phenomena, in the impulse to philosophical speculation, and in various expressive projects such as storytelling and painting. It was this quest for expression that fuelled Lawrence's pursuit of abstract expressionist painting. While such painting did not, by definition, depict his experiences of 'voices', it was his art's capacity for expression beyond representation which most patently evoked for me Lawrence's stance toward those experiences. He said that abstract "mark-making" was a direct response to his schizophrenia and the limitations on its representation.

'Voices' had both these self-referential and abstract qualities which are, according to Goodman, problematic for a theory of representation. In this they were like many other common experiences:

> We believe that visual media such as paintings, sequences in film, etc., are 'texts' which convey emotions and feelings that could not be expressed verbally: we cannot represent by mere words Mona Lisa to a blind person. The meanings that such texts can express are multiple, because there is no universal code: the rules of representation (and of recognizability) for an Egyptian mural, an Arab miniature, a painting by Turner or a comic strip are simply not the same in each case. (Eco 1997: 169)

'Voices' transgressed taken-for-granted categories and pointed to experiences at the cusp of understanding. As initially strange and unfamiliar phenomena, they demanded their own modes of representation and their own 'rules' of recognition: hence their altered tones, their counter-intuitive registers (whispering from a long way away; shouting from very up close), and their caricaturing of everyday speech.[15] In this way 'voices' were frequently aligned with other phenomena, especially forms of expression which seek to convey meaning without words (such as painting or film), or which use linguistic forms to convey a meaning beyond words (as in certain forms of poetry, opera and rock music, where the lyric content is often less important than its performative effect).[16]

A WORLD OF 'VOICES': THE EXAMPLE OF ADAM

Adam was aged forty when we began seeing him. Divorced, he lived alone in a suburban 'unit', one of six identical dwellings on a single large block of land. After graduating from university he had worked for six years in a professional occupation. He had given up work after a brief hospitalization (but not his first) because the 'voices' told him that he was "prostituting" his mind. He gave his present occupation as 'self-education'. Adam said that his main interests were religion, mathematics and the 'voices' which he had heard for as long as he could remember. As a child he had apprehended 'spirits' in his dreams. At primary school he recalled worrying about how everyone (human and non-human alike) would fit into the classroom: "[I] thought that if angels were not floating in the air above then it would be pretty crowded on the ground". He was aged in his teens when he discovered that other people did not listen to 'voices' as he did, a disparity which he found "emotionally disturbing".

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[15] One participant recalled a 'voice' which called out to him in a picture theatre. He described it as "strange" and "completely unreal" — "like a Walt Disney character, stuff like that".

[16] The appreciation of an opera performed in a foreign language (especially one not spoken by the listener) is clearly dependent on the supra-linguistic qualities of its performance — such as emotional evocation or theatrical spectacle — even whilst the words of its libretto are unintelligible. This is implicit in the ironic characterization of opera by Said (1992: 59) as 'overweight and disturbed people who sing unintelligibly and loudly'.

One thing which stood out about Adam was his positive — almost evangelical — attitude toward his 'voices', which was part of a broader commitment to extract what he saw as a "positive world within schizophrenia". For Adam, 'voices' manifested a "a desired state of being". At one point he pitied us for not hearing 'voices' ourselves, and told the story of a friend who had only experienced them for eight days and who then set out on a programme of activities for recapturing them, or at least the quality of experience which surrounded them:

> " ... he spent a couple of years being a real dreamaholic, to sort of get back into that feeling because it's like a dream in many ways ... if you know what a dream's like. The sort of non-verbal experience, that sort of feeling [of] what a dream's like, rather than verbalising it."

Adam intimated that a world without 'voices' would be deficient in a number of ways: pale and unimaginative for a start, if not unbearable — what he called a "horror of silence". This also reflected his representation of schizophrenia as an evolution of consciousness, or, as he put it, the "evolution of a new sense". He intimated that he was in possession of a great gift to which few other people were a party.

Adam's world was predicated on the irreducible 'reality' of 'voices'. He had given us an extensive autobiographical manuscript detailing the genesis of his schizophrenia; in it Adam described a period two years after his initial hospitalization: 'I had not withdrawn from the world but I was beginning to make my mind up that the voices had a life of their own and that therefore it was important that I listen to them'. This conviction grew until he decided to, as he said, "live full-time in the voices". Accepting 'voices' as a fundamental reality was the basis for a number of other stances toward the world. It had implications for his relationships with other members of his family, as was evident in the differences which separated Adam from his father:

> "I'm not allowed to talk about [schizophrenia at his house] and he's starting to think that I'm a sad case. He's into status and prestige ... and making lots of money and being generous to me, certainly. But I prefer a good spiritual conversation to anything else. Therefore we don't really relate in any true sense."

More fundamentally, this acceptance had implications for how he saw himself: as an "energy using sounds to convey feelings", or as "an item of language". He wrote:

> Light, time, word and spirit. These are the components of an individual. At least to me, it seems that that is basically what we are made of.

In this and other ways Adam denied his own materiality, together with a boundedness in time and space (which for him constituted other people's mortality). He said: "I'm not into being a mortal and therefore I deny the flesh and observe various spiritual behaviours". He had, he said, abandoned sexual relations before his marriage failed; in his autobiography he had written:

> Sex was an heavy aroma in the air ... Memories were heavy with tactile experiences. Mating games, signals and cues filled me with horror of recognition.
> I saw heaven talking and heard sex breathing. God! It was an agony. It was a blistering heat for me to bear ... Sex was in the air for a few months. I decided to become celibate so that I would not have to listen to the voice of sex. It seemed to work as I seem to have survived so far without it re-arising.

Given that he often characterized his 'voices' and himself in terms of energy and light, it was revealing when Adam characterized us, his interlocutors, in similarly disembodied terms:

> "Well, I haven't touched you. All I know is that you are a reflection of light and of sound. That's how I deal with the voices".

In this way too, 'voices' were like other 'ordinary' experiences, such as viewing a televised image. As Aiden observed: "TV is a window into the world of light and shadow".

Like several other participants (especially Zöe, Tony and Gerald), Adam's account of his experiences was so detailed, elaborate and astonishing that it seemed to open up a truly alternate world. In particular, these various accounts entailed the disorienting conflation of time, space and identity noted by Overing (1990) for shamanic chant.[17] They recalled the 'constructionalist' definition of a 'world' outlined by Goodman (1978). Goodman was

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[17] I do not imply by this an analogy between shamanism and schizophrenia as such — see the discussion in Lucas & Barrett (1995: 310-13).

concerned with the ways in which versions of the world (the different perceptual, pictorial or literary versions put forward by science and art, for example) actually share common processes of construction, even though the 'facts' of which these worlds are made may be very different. Goodman asserts that whether there is one world or many depends on our way of talking (ibid: 2; 119) and is not a relevant question since all that we can know are versions of worlds which are always tied to frames of reference. A multiplicity of world versions reflect the various processes through which we come to know, perceive, understand and therefore experience 'the world' (ibid: 3). According to Goodman (ibid: 94), truth is not a correspondence with a ready-made world. Rather, a description or a representation is only right for a world that it fits (ibid: 125ff). Most importantly, worlds are always made out of other worlds that are already at hand; worldmaking is a putting together and a taking apart (ibid: 6ff). Contrasting worlds can be created through the differential weighting, ordering, deletion, supplementation and deformation of their elements (ibid: 10ff), leading to conflicting purposes and accents.

Goodman's model provides a way to conceptualize a process in which common items are rearranged and resorted to create a new world according to practical need. The image of world versions being built out of other worlds is a useful way of thinking about the elaborate accounts constructed by participants such as Adam, Zöe, Gerald, Christopher and several others — accounts which were extraordinary primarily for the way in which they drew apparently ordinary but disparate domains (such as science, religion, myth, fantasy and popular culture) into encompassing schemas of understanding (cf. Fernandez 1986: 40ff).[18] In accounting for his 'voices', for example, Adam drew on a number of sources including physics (especially ideas of light, energy and relativity), rock music and its popular culture referents (these are examined in detail below), as well as the Bible, the Koran and the Bhagavad Gita:

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[18] See also Fernandez (1986: 179-82) on the Fang propensity to 'cosmogonize' — literally to 'knit the world together' through 'miraculous' and 'subtle' words, in sermons which are neither didactic nor expository, but spontaneous and free-associative.

> "Say for example if you hear voices, then it's good to go and read the books about voices. Like the Bhagavad Gita for example, as between Krishna and a mercenary called Arjuna. It's set in the middle of a war, and there's the sounds of elephants screaming and men and death cries and, you know, it's really noisy mayhem. And suddenly, Arjuna's thinking 'Is this the right way to live?', and a god called Krishna [comes] from the sky and talks to him. And so I go, 'Yeah, I identify with that'. You know, like it overpowers the physical noise and replaces it with something that — I don't know if we can identify it. But I thought 'Yep', the relationship with Krishna as a persuasion in sound appearing from the sky, coming down to earth, is very much an experience I identify with. Then, for example, the Bible. Every single author there, except for the New Testament, has heard the voices, or the creature, or whatever. And then the Koran is a dictation from the voices in the sky to Mohammed."

Goodman also points to the way in which multiple and conflicting world versions can legitimately co-exist. This possibility was evident in participants' responses to popular science as well as psychiatric knowledge, both of which they drew on to supplement or amend their own explanations of schizophrenia. Similarly, they took from the many other versions of perplexity and mystery which were available in their everyday worlds. More generally, Goodman's image of a simultaneously constructed and deconstructed world has a striking resonance with the way in which many participants asserted that their worlds were necessarily reorganized by the extraordinary experiences they associated with schizophrenia, as well as by the processes and consequences of diagnosis (see Chapter 4).

The 'fact' of voices was pivotal to Adam's world. It was the complex and pervasive 'reality' of voices which rendered his perceptions, knowledge and understandings into a particular world version, and which gave his experiences priority in this construction. In their multi-dimensionality (as physical, mental, perceptual and spiritual phenomena), 'voices' were the frame of reference which unified other aspects of his world. Thus Adam's distinctive perceptual abilities, his exploration of religion and philosophy, and his 'spiritual exercises' of celibacy and seclusion all 'fitted' together and had an aesthetic 'rightness' within this particular world version. The pivotal 'weighting' of experience allowed Adam (and many other participants) to develop accounts of their worlds which contradicted other 'authoritative' versions, such as those provided by their psychiatrist, or by their families, for example. Moreover, this facility allowed them to deploy conflicting accounts for different purposes — as occurred, for example, when a rendition of a person's experiences varied significantly between our conversations and their responses to a PSE. This capacity to compose and decompose worlds (Goodman 1978: 7) and to deploy contrasting world versions according to practical need were distinctive features of Adam's identity, and a source of considerable power.

TALKING ABOUT 'VOICES': THE LIMITS OF EXPLANATION

Most participants distinguished between 'voices' and their own thought processes, or rather, the words that they formulated in their heads and which were like the flow of words in everyday speech. Adam went beyond this simple distinction to describe three types of 'voice':

- Most importantly for Adam, 'voices' were located "in the spiritual domain". They existed outside of himself as spirits, wraiths, light, mists and 'plasma'. Some had specific identities such as Satan, the Beast of Revelation, the Whore of Babylon; or they were mythic figures, such as a Valkyrie. They entered his body, inflicting pain, pleasure or "revelation". Although listening to these voices "sounds like listening to yours and mine", they were also "perplexing and a source of wonder". Their quality betrayed a lack of physical presence: "Just imagine if I am talking to you on the telephone but I didn't have a telephone: that's what I call a voice".

Other 'voices' appeared to be parts (or aspects) of himself:

- Adam said that he had a distinctive 'mental voice' which talked to God. He could not say what the sound of this voice was because it was not under his control: "I cannot use it, it's within the domain of God". Adam felt it and thought it, yet described it as "not a thought process". He said that it was located "just on the outside" of his head (he indicated this position, in front of his forehead, with his hand), and could describe the history of its relocation from inside his head to various points on the outside, before coming to rest in its present locale. He said it was akin to "the mind's voice as a child would have one" before the full acquisition of language. It need not use words in the usual sense. It was (for Adam) consciousness, awareness, Being; also thought, feeling and visualization as a indivisible package. It was an intuitive form of 'knowing' beyond words, in contrast to a mode of 'hearing'. He described it as "the ghostly squeak of my mind", a form of "whispering" which was "unrecordable" — a testament to its ephemeral (and for him, God-like) nature. In being "unearthly" and "religious" it represented a "desired state of being".

- Behind the 'mental voice' was another which Adam described as "my soul voice, the one that complains at night when [the mental voice] is talking too much". Adam went on to state: "When [the mental voice] doesn't stop talking and I'm really tired and want to sleep and beg for dreams and [the mental voice] is just squeaking [then there] is a voice which I call the voice of the soul saying, 'I wish it would shut up' [and] begging for sleep".

Adam would not necessarily agree to this schematization because, he insisted, these were not mutually exclusive categories and, as he said: "There are all sorts of levels to experiencing voices".

In another context, Adam distinguished between the "mind voice" (the words he used to think with) and the "sound voice" (which he associated with schizophrenia and may be wordless). These designations — their referents and distinctiveness — never became clear to me, and there was a limit to which Adam was prepared to explicate them. On a third attempt to clarify the meaning of 'the mental voice', Adam said that "you either know it or you don't", thus signalling an end to his preparedness to discuss the matter.

Amongst these bewildering accounts I glimpsed one element which I thought might lead me to some sort of understanding. This occurred when I recognized fragments of song lyrics in Adam's discussion of his 'voices'.[19] He had earlier talked about how he had once believed that the song 'Free Money' from Patti Smith's *Horses* album (Arista Records, 1975) referred directly to him, and meant that he was going to get 'free money' for hearing voices. Again, on reading his autobiographical manuscript I found fragments of Patti Smith's lyrics incorporated into his reported interactions with an other-worldly entity (such interactions constituting his principal representation of schizophrenia). In this document the words were consistently attributed to a 'wraith' that had first appeared as 'a voice glowing white in the darkness' and calling herself 'Pat'. Adam records that he was initially shocked by this presence. The voice/wraith said she was a 'whore'. Patti Smith had made the same identification on a recited poem called 'Babelogue' from the album *Easter* (Arista Records, 1978).[20] For Adam, Pat was associated with a 'whore' in the Book of Revelations; he wrote: 'She rides a beast of seven heads and ten horns. I felt like

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[19] This was a feature of a number of participants' speech. In particular, Zöe's conversation frequently incorporated lines from popular songs; sometimes she would stop and acknowledge them and signal that she was using them knowingly and ironically; at other times they went unmarked by any sign of reflection on her part. The ability to recognize (or 'read') them was thus often dependent on the listener's own knowledge of contemporary popular music.

[20] The text of this poem is contained in the collection entitled *Babel* (P. Smith 1978: 193).

that beast.' For Adam this meant that Pat was 'excluded from communication with God'; again, the recorded version of 'Babelogue' ends with the apparent cry: 'I have not sold myself to God'. At another point in Adam's manuscript, Pat's reported conversation included the famous line of the opening track of *Horses* (a version of 'Gloria' which had been a commercial success at the time of the album's release): 'Jesus died for somebody's sins, but not mine'. There were other such examples. Later I found in the case notes a record of Adam's 'telepathic experiences' with Patti Smith, who he saw at one time as his 'life partner'. Also in the case notes was the observation that 'Patti Smith is his self-mirror'.

With these fragments I thought I had detected a way to grasp at least one aspect of Adam's 'voices'. My initial recognition of the lyrics and their elaboration in his manuscript suggested that a part of his everyday world (the music he listened to) was being incorporated into his account of 'voices', to the extent that these fragments were being reported as the 'voices' themselves. This suggested that the seemingly bizarre and elaborate world which centred on this phenomenon was, in part, made up of identifiable elements which were 'already on hand' (Goodman 1978: 6) in his daily world. The process suggested an un-selfconscious absorption and later projection of popular culture fragments as a way to express subjective experiences which were otherwise extremely difficult to represent.

I also thought that I had detected in this material the opposite trajectory: not simply a taking in of referents, but also a movement outwards toward a 'world' of significations which seemed particularly apt to Adam's concerns. My apprehension of these was based on my own knowledge of Patti Smith's music and the broader history to which it referred.

At the height of her popularity Patti Smith's work and persona had combined elements of outsiderness, iconoclastic Christianity, and a claim for the revolutionary power of transcendent experience. This had a striking resonance with the content of Adam's narratives. A reviewer in *The New York Times* emphasized the range of influences on Smith's work:

> Her sensibility is one that borrows and embraces Gnostic-tinged, heterodoxical ideas and feelings that have appeared in the cosmogony of William Blake, the ritualism and paranoia of Baudelaire, the illuminations of Rimbaud, the menacing sexual fantasies of Lautréamont, Bataille and Genet. And her esthetic [sic] program is one that owes an incalculable debt to Antonin Artaud's ... amalgam of theatrical style, occult and esoteric knowledge ... anti-literary pronouncements, drug cultism and revolutionary rhetoric without politics.[21]

Smith had packaged a constellation of themes involving rebellion, excess, intoxication and transgression into a popular performance mode.[22] This was a discourse of images, products and references which emphasized a number of themes which had a striking affinity with the experience of many participants, including a valorized individualism, heightened emotional responses, and the transcendence of personal limits by way of extreme psychic states. Popular culture, and music in particular, articulates and packages these themes for widespread consumption. It was hardly surprising, therefore, when some participants drew on such analogies to locate and validate their concerns.

Patti Smith encapsulated a history of rock music which ran from Bob Dylan to Jim Morrison to punk by explicitly incorporating all of these references into her own work and self-presentation. There was, however, one figure who especially pervaded her work: the poet Jean-Nicolas-Arthur Rimbaud (1854 - 1891) whom she had invoked on the title track of her first album (*Horses*, 1975). In 1871, aged 16, Rimbaud produced a manifesto, the *Lettre du voyant*, in which he set out his revolutionary theories of poetry and life. The

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[21] J. Cott, [Book review of *Babel*], *The New York Times*, February 19, 1978. Smith was a published poet before achieving a public profile as a rock performer in the mid-1970s. This list of names and influences is strikingly concordant with the canon of modernism which Sass (1992) employs to illustrate schizophrenia.

[22] Huxley, in an appendix to *Heaven and Hell* (1994: 114-25) constructs a brief history of 'vision-like effects' and 'vision-inducing devices' which have long been elements of popular entertainment: 'In the masques of Elizabethan and early Stuart times, divine descents and irruptions of demons were a commonplace; so were apocalypses, so were the most amazing metamorphoses' (ibid: 118). Such devices included fireworks and pyrotechnics, pageantry, theatrical spectacle and, increasingly over the past century, artificial lighting, film and cinematic techniques. Each of these elements have continued to be elaborated and extended in popular forms, especially rock music.

voyant was to be a poet-prophet-visionary who practices 'a long, immense and reasoned *deranging of all his senses*':

> All forms of love, of suffering, of madness; he tries to find himself, he exhausts in himself all the poisons, to keep only their quintessences. Unutterable torture in which he needs all his faith, all his superhuman strength, in which he becomes among all men the great invalid, the great criminal, the great accursed one — and the supreme Savant! For he arrives at the *unknown!* ... He arrives at the unknown, and although, crazed, he would end up by losing the understanding of his visions, he has seen them! Let him die in his leaping through unheard-of and unnameable things: other horrible workers will come; they will begin on the horizons where the other collapsed! (Rimbaud 1973: 7-8; original emphasis)

In addition to the 'derangements' he sought through alcohol and drugs, in the *Lettre* Rimbaud also advocated a dissociation from the authorial 'I' and the centred ego of everyday consciousness:

> For *I* is another person ... I am witness to the birth of my thought: I look at it, I listen to it: I draw a stroke of the bow: the symphony makes its stir in the depths, or comes with a leap upon the stage. (Rimbaud 1973: 8)

This proclamation annexes the first person subject to a third person verb (I/is), reflexively separating the persona from the author. According to his translator: 'Dialoguing with his other roles (of which there are many), criticizing their flights of fantasy, the voice of reality, the brutal and ironic "I" will generate much of the dramatic tension in Rimbaud's poetry' (Peschel in Rimbaud ibid: 8-9). In *A Season in Hell*, for example, the first person narrator with multiple voices and personalities dramatizes his sufferings and attempts to find stasis 'in a precarious balance between reality and reverie' (ibid: 22). Patti Smith's use of her own multi-tracked voice on the album *Radio Ethiopia* (Arista Records, 1976) attempted a similar effect electronically, especially on tracks which sought to invoke the effect of drugs ('Poppies') and visionary experiences ('Ain't It Strange'). Again, this recalled in a striking way the very form of Adam's manuscript, long sections of which were made up of the purported speech of various 'voices' and in which it was often difficult to tell who was narrating and who was speaking. Of the wraith or 'voice' called Pat he wrote: 'She was a flood of voices when she chose to speak'.

The liner notes accompanying the album *Easter* (1978) contained a photograph of Arthur Rimbaud and his brother Frédéric as communicants in 1866. The accompanying text makes an explicit link between Smith's own name and the poet Rimbaud's creative project, 'smith' being the artist-craftsman who brings the previously unrealized idea into concrete form:

> i am the sword / the wound / the stain
> scorned transfigured child of cain
>
> the word cain means worker — slayer — smith. a smith is one most wretched and blessed. picture two such smiths in the faces of arthur and frederic. one a vagrant and one a vagabond. both of them condemned to babble and battle. thru the heart of a map or the stop of a bottle.
> one morning about a hundred years before little richard baptised america with rock n roll, arthur and frederic and their sisters isabelle and vitalie laboured thru the streets of charleville in white ribbons and cloth of blue to receive their first communion. close to the church it was arthur who broke formation and called to the other rimbaud children to come run with him thru the field, past the chapel off a bridge into the cold and infinite waters of a river that led to the warm and infinite blood of christ. [sic]

In his autobiography, Adam had similarly wrote of his own direct communion with God. He also argued that people with schizophrenia have a privileged access to this realm by way of visions, hallucinations and a predilection for symbolic codes; he wrote: '*our* God is a smith of great craft who designed reality for us to appreciate'. He saw it as a duty to explore these domains as diligently and extensively as he could.

Careful attention to Adam's narrative thus revealed a set of broader cultural references which could be used to locate and make sense of his visions and hallucinations. These phenomena were deeply personal and idiosyncratic, at the same time as they at least partly incorporated certain apposite domains, persons and themes of a popular culture which was widely available to Adam, as well as others. They looked like the type of 'worldmaking' — a putting together and taking apart of elements already at hand — described by Goodman (1978: 6). This incorporation seemed possible because these ideas and idioms were already structured by the same concerns about the edge of experience, the transgression of social categories, and the limits of language which pertained in many participants' own lives. Whether or not Adam had read Rimbaud, he had access to a popularized form of Rimbaud's aesthetic programme in a direct and personal way through the music of Patti Smith.[23]

I emphasize here that the imperative to understand the references contained in Adam's account was my own. It was precipitated by the challenge to understanding which each of my encounters with Adam confronted me with. It followed the threads of suggestion which were already contained within Adam's words, together with aspects of my own knowledge and experience upon which I had to draw in order to converse with Adam in order to develop an understanding of how he framed his experiences. This was not simply a process of eliciting a statement of Adam's beliefs; it required that I supplied my own references and interpretations to the work of negotiated understanding (which remained, nonetheless, partial and unresolved).[24] Some of these fragments were long submerged within my own conscious knowledge and required significant work to draw them forth. Nonetheless, it was possible in this way to make connections between our disparate knowledges and experiences. It was this dialogic engagement between researcher and participant which highlighted the quintessentially social nature of whatever understanding arose between us.

This was not, however, a sufficient account of Adam's 'voices'. They were not mere fragments of songs or other spoken or written texts appropriated and re-presented. They were also, as Adam insisted, a "non-verbal experience"; they felt like a dream; they were physical and metaphysical. To better grasp Adam's representation of 'voices' it is necessary to consider his understanding of language itself.

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[23] One of Rimbaud's biographers recounts a similar familiarity before he had read the poet's works:

> ... what I heard about him was that he was Bob Dylan's favourite poet... [H]ow I got to hear of it, five thousand miles away in a Buckinghamshire boarding school, I have no idea... Whatever the source, I have it firmly in my memory that this mysterious name Rimbaud was in the air as I sat up illicitly at dawn listening to 'Visions of Johanna' and 'Sad-Eyed Lady of the Lowlands'... Had I read my Rimbaud then I would have known how profoundly those songs were steeped in his influence. (Nicholl 1997: 321)

[24] Cf. Rabinow (1977: 119) on the social and historical location of the analyst, and the consequential betweenness of 'intersubjective construction' (ibid: 155).

"LIVING FOR CONVERSATION AND LIVING AS CONVERSATION"

Adam acknowledged the difficulty of talking about 'voices' and the different ways in which he apprehended them when he commented: "no other human being that I've met talks about things like that". Even at the Schizophrenia Fellowship Adam had found that people "have their own private use of words and there's very rarely a complete meeting of minds". As predominantly emotional and spiritual phenomena, 'voices' went beyond the apprehension of words, often to the point of not being reclaimable by words. They had to be intuited by other people, and Adam had ample experience of this process having failed, beginning with his father for whom he had originally written the autobiographical manuscript. When we were meeting with him he was dismissive of our attempt to elicit understanding. Talking and writing did not 'explain' his experiences. As he said, "using language to fully expose a feeling is impossible"; something always escapes the attempt.[25]

Adam asserted that language occurs before life forms, an assertion which had religious and ontological connotations, as in the Biblical account of creation to which he referred: 'In the beginning God created the heavens and the earth ... And God said, "Let there be light"; and there was light ... God called the light Day, and the Darkness he called Night' (*Genesis* 1:1-5). According to this Biblical model, creation itself arose through an act of speech; it was only through the calling forth of things (day, night, heaven, the seas, living creatures) that they achieved an ontological status. Although the Bible itself does not describe this language of creation, there is a long history of speculation as to its nature:

> Tradition has pictured it as a sort of language of interior illumination, in which God, as in other episodes of the Bible, expresses himself by thunderclaps and lightening. If we are to understand it this way, we must think of a language which, although not translatable into any known idiom, is still, through a special grace or dispensation, comprehensible to its hearer. (Eco 1997: 7)

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[25] In this way, Adam intimated the impossibility of fully apprehending another person's lived experience, or of entering the other's durée — these being the inherent limits of intersubjectivity as set out by Schutz (1972: 99ff).

These are the same terms in which Adam talked about some of his 'voices', especially the indescribable, wordless 'mental voice' which is within the realm of God and which he once described as "the hearing of thunder in my head".

His overall approach to language was focused on the interiority of emotional expression (what he called "feelings"). He wrote in his autobiography:

> I thought that I was in a condition of being a living relationship in God's Kingdom. I was a physical empath, I breathed metaphrenically (by the mind drawing in words, understandings, feelings and meanings, and digesting them) and contacted God with my heart ...
> I am religious and see that my language is alive within me. I adorn myself with words. The words carry my feelings and my feelings search for words.

This apparent interiority did not necessarily exclude other people, since one of the things Adam sought from language was an indication of another's emotional state:

> "Words are walls. Definitions are doors. Knowing what a word means indicates that you travel into the emotional domains of the Other."

But it was also the case that his interest in other people was often restricted to the "feelings" or "spirituality" which they exuded by way of the words they used.

Adam's belief in domains outside of mortal life helped to explain his 'orientation' or understanding of words and language: the dictionary, he said, "is oriented towards the expression of immortality as the real condition of language". This seemed to deny that a dictionary is also a social product: a cultural and historical record of language in use. He said:

> "I look for the truth. It depends on how you know the word 'truth' to be defined. Truth is a relationship of the Archangels. Truth is what they share as energy systems. Truth is love and happiness and respect of the condition of being able to talk. Talking is called 'having a word' — transferring a meaning or understanding. Truth according to the Egyptians was two angels talking to each other, so it was a kind of content experience to the fact of their being. Truth is a relationship with language, rather than an object or the status of an individual."

Adam's definition and use of language eschewed it's practical, everyday purpose as dialogue and interaction. He pointed to the failure of language as a mere instrument of thought and communication. He was principally interested in the definition of words, and their etymology in particular, rather than how they might be used as a vehicle of everyday speech. This is vividly conveyed by my abiding memory of him ensconced in his lounge chair, a two-volume dictionary on the floor beside him. On a subsequent visit several dictionary volumes dominated the kitchen table.[26] Also on another subsequent visit with his brother it became clear that the dictionary was a major means by which they interacted. They played games with each other to discover new words and new contexts for their use — Adam jokingly referred to this as "dictionaries at twenty paces". He took an obvious pleasure in using obscure and unusual words, but often the effect was one of obfuscation rather than nuanced understanding. I gleaned the impression that this was a very studied and purposefully used conversational tactic: either to distinguish "mortals" from "immortals" amongst his interlocutors (his basic criteria for judging the value of social interaction), or as a device which stopped others from intruding on the richly imagined realms of his schizophrenia.

For Adam, language was not simply words put to pragmatic use to represent objects or relationships in the world. It was more importantly:

- a "persuasion", by which he meant a message which is based on a fabric of belief, and which is predicated on its own mode of interpretation and justification. A "persuasion" or an "attitudinal basis" was, for Adam, a package which entailed a message, a belief, a preferred interpretation and a vindication of the speaker's own position:

  > "It's like the psychiatric medical model: that's your persuasion. That's your belief system. That's how you operate in your interpretation, and it's [your] self-vindication. It's like I have my own persuasions too, as a schizophrenic."

- an "orientation", a perspective or a mode of being in the world which had consequences for the relationship between people, between people and words, and between words themselves. Adam said, for example:

  > "Your orientation is in relation to the way in which you react to language, or colours, or temperatures... I'm really into telling

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[26] Adam was not the only participant with a fascination for dictionaries. Tony's kitchen was dominated by dictionaries in a number of languages — French, Spanish, Italian, German and Latin — as well as English. These provided the basis for his numerological investigations of language. On our first visit the kitchen stove-top supported a massive concordance to the Bible in English and Ancient Greek.

> stories and that's my orientation. My stories deal with the imagination and fantasy of content within the fact of hearing voices."

- a "force" (or a power, or an agent) which could have material, emotional and supernatural effects:

  > "Language is a sword whereby a sound in your mouth entertains the attention of others."
  >
  > "A word can make or break a day for many schizophrenics. It can insult, or disconfirm, threaten, alienate, ridicule [or] mock."

Adam viewed speech as the "transference of definitions and meaning". His use of language did exactly that, transferring the everyday meaning of words to a set of significances which reflected his interior world of spirit visitations and communion with God. Language was "sound upon sound in pitches and tones and hearty aspirations", a "system of rules by which we shape noise to convey whatever energy system operates within you". It was, therefore, profoundly personal and, to this extent, lacking intersubjective intention. It was the abode of his true self. Moreover, it embraced other sensual modalities as well. Adam asserted that like wavelengths, language could include colours: "whenever I feel the word 'honest' I see a pink colour"; "whenever I hear the word 'fantasy' I see a golden light — it's like a light bulb going 'flash' in gold". He called such words "colour feelings". In his autobiography he had written:

> Synesthesia develops and grows … It is like a flower bud slowly being teased open to shine fragrantly inside of me.
> If I could see words I would love to be able to smell words. I already touch words, hear words, see words. Tasting and smelling words were the future for synesthesia. It would be a time of great feasting. When food for thought would be total stimulation of all the faculties and the love which one felt for one's other would be totally miraculous.
> … Synesthesia … has an awesome beauty of its own. I have spent days in golden showers just listening to a voice.

Synesthesia, for Adam, "is the light which flickers in the word". Movement, colour and visual elements were thus given equal prominence in Adam's characterization of language:

> Words are shining crystals to my vision. I have a flow of yellow green light in a geometric crystal shape from left to right at the front of my temple. I have a blue silver hiss of sound guiding me on, over my left ear. I hear thunder at the back of my head.

Such statements — and much of our recorded conversations with Adam — could be seen as evidence of what Sass (1992a: 181) has called the 'oddities of schizophrenic language'. He lists several such 'oddities' including:

- a 'poverty of speech' which refers to the restriction of in the amount of spontaneous speech, often resulting in periods of muteness;
- a 'poverty of content' in which speech conveys little information because it is vague and either overly abstract or overly concrete; psychiatrists typically describe such utterances as 'empty philosophizing', 'fruitless intellectualizing' or 'pseudo-abstract reasoning';
- 'blocking', when speech seems to halt in the middle of a train of thought; and
- a 'bombastic' or 'precious' quality in which pretentious figures of speech and verbal mannerisms result in 'emptiness' or 'pathological whimsy'. (ibid: 180-1)

As Sass demonstrates, psychiatric accounts of these features of language posit two basic causes. Psychoanalytic theories suppose a regression, either to a child-like or primitive egocentricity, an instinctual reaction to experiences which are themselves 'too primitive in nature' to be captured by the conventions of adult language, or to an early stage in the development of language itself when the sound of a word was supposedly fused with its referent and could not therefore be used to construct an abstract meaning. Cognitivist and information-processing perspectives, on the other hand, stress a deficit or dysfunction as the cause of language difficulties in schizophrenia.[27] These postulate a general disturbance of cognition, such as an inability to integrate perceptual and cognitive processes, a failure of selective attention, or the disturbance of feedback mechanisms between information and intention. It is often assumed that such problems have a biological substrate yet to be found or specified. Sass cogently argues (1992a: 182) that these speculative theories 'tend to downplay or even to deny the intentional and meaningful aspects of such language' and

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[27] Just as these processes are also used to account for schizophrenia as a whole. See, for example, Carr and Wale (1986) for a perspective which posits an 'information processing paradigm' as accounting for both the clinical manifestations of schizophrenia and the various research models which attempt to account for it. They propose an 'attentional model' of schizophrenia in which disorders of perception are related to a dysfunction at the level of 'preattentive processes' ('perceptual grouping', 'pigeonholing', etc.) which cause people with schizophrenia to 'view the world differently' (ibid: 141), together with a failure of 'filter mechanisms' ('gating') in the acquisition and processing of sensory inputs and the development of 'psychotic disorganization' (loss of organizational capacity, lack of structure, and high levels of noise or entropy in the informational system). The emergence of hallucinations, delusions and 'negative symptoms' are viewed as restorative, 'compensatory' or 'self-correcting' operations of a disordered information processing system.

therefore do not help us to understand 'the *experience* of language' or the uses to which it can be put.

For Adam, language was barely referential in an everyday sense, but it was neither a pathology nor an affliction. Indeed, he described it as his natural "home" and "a way of life". He described himself as "living for conversation and living as conversation". He insisted that language was the essence of who he was — and of his 'condition' — in an existential sense. He also pointed out that words were both the basis and the defining limit of our own relationship with him, and of our attempts to establish intersubjectivity:

> "Words convey states of mind. They also convey the emotional condition of the speaker. You only know me by the words which I share with you."

His world and his relationships was thus constituted around language. This 'language' was not simply the referential and denotative capacities of words, however, but a physical and emotional interchange of energies, perceptions and knowledges. Language, for Adam, incorporated the performance, action and effects of talking together.[28]

In another sense, Adam's emphasis on language was a further example of the intense questioning of, and reflection upon, the everyday which was engaged in by many participants (see Chapter 5). Adam struck me as being involved in an elaborate exploration of the circumstances, limits and paradoxes of something (in this case, language) which most people use pragmatically and take for granted. He also liked to play a semiotic game in which words were suddenly stripped of their referent and their arbitrariness was emphasized, as in: "ME is a mental process, 'me' is a two letter word". What could be diagnosed as the 'impoverishment' or 'pathology' of Adam's language could equally be seen as an expression of interpretive scepticism toward a pervasive taken-for-granted

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[28] In this way, Adam's pronouncements on language intimated the work of Austin (1975) on the action and force of linguistic acts. For Austin, language is a putting forward of words, sentences, arguments or theories with a certain 'locutionary' or 'propositional' meaning (that is, a certain sense and reference) — what Adam called a "persuasion". Simultaneously, the speaker is doing something in speaking these words, sentences and arguments: his or her utterance has a certain intended point — what Austin called the 'illocutionary force' of a linguistic act (ibid: 98ff). This 'force' was what Adam sought to elicit from other people's speech, and also to effect with his own.

component of the everyday world. His playing with the capacities of language was equally a strategy for signalling and maintaining his perplexity.[29]

THE MADNESS OF THE TEXT: READING AND MODERNISM AS ANALOGIES FOR SCHIZOPHRENIA

A number of commentators have attended to this difficulty of representing the experience of schizophrenia in language and texts (see Keitel 1989; Felman 1985). In his encyclopaedic *Madness and Modernism*, Sass (1992a) addresses this difficulty by way of an analogy with the reading of certain 'difficult' works of literature.

Sass turns to the history of literary modernism in order to 'illuminate' the supposedly delinquent use of language associated with schizophrenia. He suggests that modernism is an age in history marked specifically by a 'crisis of language', a 'loss of faith in words' and a 'language of difficulty that, both in structure and intent, has profound affinities with the language of schizophrenia' (Sass 1992a: 184-5). He identifies three domains of this 'crisis' which he says serve as analogies for schizophrenia:

- First, a preoccupation with the uniqueness and particularity of unverbalized experience and ineffability, 'as if the very ineffability of an experience had come to be the true sign of its significance' (ibid: 185). Sass also finds similar analogies in twentieth century philosophy, especially in Wittgenstein's meditation on 'private language' which concluded that language, which must rely on shared categories, is incapable of referring to the private and unique sensations of an individual (ibid: 186).
- Second, a move toward 'inner speech' which is felt to be more authentic than conventional language. Such works highlight the device of juxtaposition — 'setting elements beside each other without explicit causal, logical, or narrative connectiveness' (ibid: 193) — as a means of freeing words from the constraints of rationality and public communication. It is this 'desocialization' which Sass suggests as an analogy for language use in schizophrenia: 'a

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[29] On the propensity of people diagnosed with schizophrenia to 'play' with, 'deconstruct' and 'reopen' language, see Corin and Lauzon (1994: 27-9). They also link these 'language games' to a 'strategic' dimension of self-description and self-identity.

turning away from communal themes and modes of expression … toward the concerns and processes of the inner life' (ibid 196).

- Third, a recognition of the independence of language as a semi-autonomous system — what Sass calls the 'apotheosis of the word' (ibid: 198) which epitomizes a 'withdrawal' and an 'autonomization' which resembles the use of language in schizophrenia. This tradition focuses on the linguistic medium itself, highlighting both its sensory components (the phonology of speech and the graphology of writing) and its potential for multivalent meaning. Its logical extension in philosophy is to be found in the work of Derrida, who emphasizes the look and effect of writing, the acoustic qualities of words, the vestiges ('traces') of meaning which a signifier may have had in other contexts, and the multiplicity and ambiguity of conventional signifiers.

Each of these characterizations propose a different trajectory for how language is supposed to function in modernist texts. The examples used by Sass suggest that language is 'afflicted' by (at least) the following:

- an anti pragmatic turn based on dissipation and fragmentation which released thought from the strictures of old language forms and thereby opened up revolutionary possibilities for representing what had previously been excluded from art, literature and other various forms of 'high culture';
- an anti-rationalist turn toward inwardness which was aimed at a more accurate rendering of interior emotional states, the fleeting play of thought, or the unconscious; and
- a contrary 'automatonic' turn which rarefied language as a self-referential system which had little to do with thought as an historical, progressive and collective endeavour of dialogue between minds, with human emotion, or with individual intentions.

What are we to make of these contradictory developments, these disparate forms and aesthetic programmes? Some of these trajectories reach inward (to a representation of what goes in inside a person or the self); another points outward (to the fragmented contexts of post-war European societies, to politics and revolution); and the third reflects only itself. There is no unity to these developments, as if they were themselves a reflection of the post-modernism which Sass also seeks to diagnose as an expression of crisis. But what have they to do with schizophrenia *per se*? It is not clear if Sass is proposing that all of these trajectories are operative at once in schizophrenia (thereby invoking the common image of schizophrenia as an excess, either of incoming information, of thought processing or — his own preferred option — consciousness itself), or whether these are separate options or possibilities which arise variously in different cases (thereby invoking the image of schizophrenia as disintegration and fragmentation). Far from offering a radically new account of schizophrenia, Sass — in respect of language at least — concludes by reproducing two of its most stable and enduring characterizations.

With his broader project, Sass replaces the 'pathology' of language in schizophrenia with the 'affliction' of modernism (which, amongst other things, embraces alienation, secularization, bureaucratization, industrialization and, most pertinent of all for Sass, a state of 'hyperreflexivity'). He replaces the tendency of psychiatry to pathologize individuals with a critique which employs the same language to diagnose culture as a whole (especially an amorphous, undefined Western culture). There is no discussion of how this cultural 'affliction' influences or informs individual experience. In attempting to reclaim the language used by people with schizophrenia from a medicalized pathology, Sass aligns it with an equally distant, obscure and difficult avant-garde. He characterizes the 'epoch of modernism' and its products as 'off-putting', 'hard to understand', 'alien', 'introverted' and 'paradoxical' (Sass 1992a: 8-9).

Sass uses a textual device of juxtaposing a literary quotation with apparent first-person comments from numerous anonymous 'patients', thereby suggesting at least a formal analogy between the ideas and images so selected and the experience of these individuals. He does not address the mechanism by which these disparate forms of representation are brought together in peoples' own experience. His analogies remain as remote from this experience as are the deficits or regressions posited by psychoanalysts and cognitive psychologists. With *Madness and Modernism* one is left with a plethora of aesthetic images and philosophical ideas which might be taken up to explicate schizophrenia, but without any sense of imperative as to why such images are more appropriate than any others, or how (if at all) they relate to the analogies that people themselves make and use. The technique creates a powerful impression, but an ethnographically and experientially empty suggestion of semblance which is seemingly only limited by Sass' own formidable breadth of reading.

PRIVILEGING THE TEXT

It is as a reader of texts and paintings that Sass creates his analogies, implicitly suggesting that those who have the experiences associated with schizophrenia 'read' those experiences in the same way that one might read *Nausea*, appreciate *Waiting for Godot*, or view Picasso's *Violin and Fruit.* The latter is one of the very few visual analogies suggested by Sass (1992a: 138) which, compared to the range of literature he refers to, are conspicuously under-represented in his vast survey.[30] Despite the asserted 'crisis' and even disappearance of language in schizophrenia, in order to explicate it Sass relies overwhelmingly on *words,* especially those which go to make up highly structured, self-conscious works of literature.

I do not wish to imply that a reading of such works cannot produce interpretations which are worthy of exploration in respect of schizophrenia. Thus, one participant became aware of Sass' work by way of the present study and began applying its frameworks to his own reading. But what I am interested in here is the way in which Sass' text — with its emphasis on the formal properties of language — creates its own way of reading other texts, and then offers this as a comprehensive model for reading the experiences of schizophrenia. Other ways of reading, especially in the area of psychopathology, are stressed by Keitel (1989: 85-9; 112-14) who suggests that accounts of psychosis rely on extra-textual strategies (such as emotional responses and empathic 'repercussions') which she calls their 'virtual dimension':

> Psychoses and the therapeutic treatment of psychoses are areas of experience which implode our ordinary frames of reference for understanding and interpreting our world. Talking about such phenomena in a literary or a theoretical text in itself suffices to instigate phantasies

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[30] Other examples used include Goya, Tanguy, de Chirico and Magritte, with attention being paid to only one work by each of these prodigious artists.

> which are founded in the reader's personal, subjective disposition, which are free-floating and expansive, and which defy systematization ... (Keitel 1989: 86)

This dimension is 'virtual' because, 'although it is stimulated by the text, it is not contained in any definite textual strategy, and must be supplied by the reader, who may well feel lost in the infinite' (ibid: 112).[31] Thus, Adam insisted that the meaning and emotional content of his experiences were not adequately conveyed by his speech or written words, but were to be found in the extra-textual, empathetic and subjective effects that those words might have on me.

Just as the visual is downplayed in Sass' analysis, so the aural is ignored altogether. There is no discussion of a musical work which could carry the same weight of analogy and 'illumination' as the many literary texts upon which Sass draws: works by Stravinsky, Berg or Scriabin would seem to offer possibilities, as do some popular musics (as Patti Smith did in my attempts to understand Adam's 'voices'). The example of Mallarmé advocating 'a poetry that would approach the condition of music' (Sass 1992a: 199) is telling of this reduction of all artistic and performative modes to textuality. By contrast, music was a persistent referent for many participants in the present study and could act as a vehicle for exploring their experiences, just as it was a pervasive component of their everyday worlds.

In privileging the written text, Sass' analysis seems to rely on what Bourdieu has identified as a 'theory effect', or the 'scholastic fallacy' which induces analysts

> ... to think that agents involved in action, in practice, in life, think, know and see as someone who has the leisure to think thinks, knows and sees, as the scientist whose mode of thought presupposes leisure [to read, for example] both in its genesis and its functioning, or at least distance and freedom from the urgency of practice, the practical bracketing of the necessities of practice. (Bourdieu 1990b: 112)

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[31] This also recalls the phenomenology of 'following a story' as a dialogic act of emplotment and an engagement with imagined outcomes (see Good 1994: 144).

Such a 'theoretical vision' is an external vision: 'one above all without anything practical at stake' (ibid: 60).[32] In this way, Bourdieu seeks to highlight the gap which exists between the aims of theoretical understanding and the 'practical and directly concerned aims of practical understanding' (ibid). He seeks to 'avoid giving as the source of agents' practice that theory that had to be constructed in order to explain it' (ibid). By way of contrast with Sass' analysis, therefore, I will briefly examine the practical role that reading and writing played in participants' lives, especially in constructing and reflecting upon those lives.

READING, WRITING AND POPULAR CULTURE IN PRACTICE

Sass does not correlate his reading with that of his 'patients'. We do not get an image of any of Sass' 'patients' as either readers or writers. Nor is it clear how the images drawn from various texts become available to those who lives are suffused by the experience of schizophrenia. Many participants in the present study both wrote and read, but they did not get these activities confused. They did not perceive texts as 'mad', and did not gravitate toward certain types for that reason.

Sass' analysis emulates the views of the writer Nerval (who Sass also uses to illustrate schizophrenia[33]) and thus invokes a long history which concerns itself with the relationship between madness and reading:

> Every reading, says Nerval, is a kind of madness since it is based on illusion and induces us to identify with imaginary heroes. Madness is nothing other than an intoxicating reading: a madman is one who is drawn into the dizzying whirl of his own reading. Dementia is, above all, the madness of books; delirium, an adventure of the text. (Felman 1985: 64)

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[32] Cf. Schutz (1962a: 36): '[The] attitude of the social scientist is that of a mere disinterested observer of the social world. He is not involved in the observed situation, which is to him not of practical but merely of cognitive interest. It is not the theatre of his activities but merely the object of his contemplation. He does not act within it, vitally interested in the outcome of his actions, hoping or fearing what their consequences might be but he looks at it with the same detached equanimity with which the natural scientist looks at the occurrences in his laboratory.'

[33] Gérard de Nerval (1808-1854) who Sass (1992a: 426) notes had a psychotic illness which 'seems to have been at least in the schizophrenic spectrum' and who wrote about his experiences in *Le Réve et la Vie* (1855), a 'narrative of his madness' that he was working on at the time of his suicide. Sass uses this work to illustrate apophany, a state of psychosis characterized by an abnormal awareness of meaningfulness and significance.

At a superficial level, many participants *did* appear to have an affinity with works of fantasy, mythology and heroism (although few had any interest in surrealism, cubism or Artaud's Theatre of Cruelty, for example). Certainly, genres such as Arthurian legend and books such as *Lord of the Rings* were the most frequently mentioned texts. Adam's autobiography includes the following injunction:

> Read fiction and get an idea of what is real in fantasy. Look into the projections of the future. Read about telepathy and other spiritual fantasies. Get a grip on the stuff which will take you into forever.

But Sass' model does not account for how participants interrogated the meaning of the various texts which they did read, not as sources of madness but as a verification of the non-pathological reality of their experiences — for 'what is real in fantasy' as Adam put it. Nor does it take into account the range of writing forms (diary entries, autobiography, fiction, poetry, analysis, submissions to government and funding bodies) with which many participants were actively engaged.

Throughout the two years that we visited another participant, Aiden, he was always involved in creating a single large work of fiction which had evolved in a series of drafts over a number of years. Its plot involved the perilous adventures of a young hero who battles 'psycho-technological adversity' in a mixed mediaeval/futuristic domain.[34] The action of the story takes place in an imaginary land which was envisioned complete with its own history, mythology and geography (which Aiden had graphically mapped in meticulous detail, the map itself being affixed to his bedroom wall). According to a diary entry, the purpose of this work was 'to take the reader … on a spiritual adventure through a sequence of dreams', and thereby to induce in them some appreciation of Aiden's own experiences: 'It's basically about a young man who goes through the awakening of schizophrenia but [who] holds onto his sense of reality and therefore becomes very powerful'. With this multi-dimensional project (which he hoped to translate into an

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[34] Such conflations of disparate times being popular in a number of writings collected from participants, somewhat in the style of the *Mad Max* films, a reference that one participant once used jokingly and ironically to characterize what he saw as the incongruous elements — future/past, civility/barbarity — of his own everyday world.

interactive computer program), Aiden was constantly at work constructing and reflecting upon his ‘world’. From his perspective, he was not creating images of, or analogies for ‘madness’; he was exploring the ‘truth’ and veracity of his unique experiences. This work was a way of formulating and playing with those diverse elements which could be made to illuminate his experience to himself, and then to others. It was the accomplishment of a ‘practical understanding’ (Bourdieu 1990b: 60) of his experiences for which Aiden felt some necessity, as it was also the focus of his everyday practice.

Aiden was fascinated by Wim Wender’s film *Until the End of the World* (1991) in which technology is used to capture and re-make visual images stored in the brain, in which computers are used to ‘suck out our dreams and look at them like television’, in which a ‘dream tap’ makes it possible to look at the ‘human soul singing to itself’, and in which isolated figures abandon everyday pursuits and live only to watch their dreams. Aiden claimed that all of these images reflected his own experiences with the electronic media. They were not sources of illusion or heroic identity; Aiden’s certainty about the ‘reality’ of his own experience was such that he had no reason or desire to confuse it with other imaginary worlds, people or places. He could generate these latter directly out of his own experiences. Moreover, such sources were not simply illustrative of his experiences, but were the focus of intense interrogation for what they might reveal in the way of evidence concerning how mind, thought and image work in a society dominated by electronic generation and mass communications. His watching and reading of this material was not passive but entirely active, focused as it was on explaining his situation to himself and others. The same stance was implicit in Adam’s assertion that the ‘voices’ were ‘real’ and that the circumstances of their production and reception needed careful exploration. Language was therefore Adam’s principal *activity*; his day was organized around acts of writing and talking. His explorations on the edges of language had a serious intellectual dimension (which was both religious and philosophical), as well as a playful aspect of fun and whimsy (embodied in the fantasy and children’s stories he created). His stories for children emerged from his remarkable experiences and the imaginative vistas which they opened up, but he did not confuse those stories and those experiences.

Most participants had never heard of, let alone read, the many obscure modernist texts from which Sass derived his 'parallels' with 'schizophrenic thinking'. None had seemingly read Rimbaud's *A Season in Hell* or *Illuminations*, but many used precisely these images to convey aspects of their experiences. In describing certain visual phenomena, for example, Adam said that he saw "scenes of heaven and hell, demons and angels, spirits, forces and mist, colours and sounds". Lawrence had not read Robert Musil's *The Man Without Qualities*[35], but his knowledge of popular physics and the effects of hallucinatory drugs such as LSD was sufficient for him to create analogies with a world of perceptual forms dissolving into an immaterial whirling of atoms and sub-atomic forces. Lawrence had read Sartre's *Nausea*, but he was more interested in the Dali painting ('The Triangular Hour') of a melting clock which appeared on the cover of the Penguin edition. It was this image which recalled for him the altered perceptions of time and the "interminable periods of nausea" which he associated with schizophrenia. He had also read Huxley's *The Doors of Perception*. No-one else seemed to be aware of this work, nor of William Blake (from whom the title was derived[36]), but several participants talked about the 1960s rock band The Doors (who had derived their name in the same way) and by means of this reference used the image of 'opening the doors of perception' as a description of their experiences. Such images also formed the basis of new metaphoric combinations (cf. Goodman 1978) which highlighted the logical confluence of ideas about psychic openness, unusual perceptual capacities and certain religious propositions, as when Michele said: "I don't know if I believe in hell, but the voices keep talking about the gates of heaven and hell". As far as I was aware, no participant had read Breton's *Naja* (see Sass 1992a: 65), but some may have seen the quotation from it on the

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[35] For Sass (1992a: 142-3), this work exemplifies the 'vertigo' of modernist relativism, expressed through the 'inhuman distances of stellar space' and the 'inhuman construction of the atom world'.

[36] The book is introduced by an epigraph from Blake: 'If the doors of perception were cleansed everything would appear to man as it is, infinite'.

cover of Patti Smith's *Radio Ethiopia*. Without direct or even conscious access to the various portrayals of 'psychotic' states in literature and art, participants were able to utilize a practical knowledge of their culture to create such analogies for themselves, using the more prosaic material which was readily to hand.

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It would have been easy to gloss the impenetrability of Adam's speech in terms of thought disorder or 'poverty of content', and to extrapolate from this that he could only offer a diminished commentary on himself and others. Many of the textual features of modernist language that Sass identifies were discernible in Adam's speech: the ineffable nature of experience, the interiority of referent, a diminished social context to language use, the recontextualization of words, the sensuality of sound, and the physicality of writing[37] are all obvious resonances. But none of the three hypothesized 'crises' of language, or Sass' broader project to 'illuminate ... the modern condition' by means of 'the most exaggerated or pathological of examples' (Sass 1992a: 12) adequately account, either individually or in their fractured collectivity, for how Adam viewed or used language, as revealed by our interactions. To pathologize him in such a way would ignore the dazzling dexterity with which he manipulated images through words, and the extent to which he could draw others in to the complexity and enchantment of his speech. This speech was intriguing and seductive, and perhaps for this reason was far more effective as a performance than as written text. In imitation of his own theories of language, Adam was adept at creating a mood or an atmosphere which said more about his world than did his words captured on tape and later transcribed.

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[37] This physicality was exemplified in Adam's statement that, "To me, writing is the most explicit body language".

PERFORMING PERPLEXITY

Reading the transcripts of our conversations with Adam some period of time after our actual meetings I am struck by the difficulty I have making sense of them. They do not *read* well. I am made intensely aware of the disjuncture between what it felt like to be engaged in those encounters, and the diminished traces which appear in their record. In particular, the words on paper make far less 'sense' than even our conversations did at the time. What has been lost in this transition from conversation to text, and with the passage of time?

Like Gerald, Adam remained ensconced in an chair throughout our meetings, his movements restricted to rolling and smoking cigarettes or drinking coffee from an enormous beer stein. Unlike Gerald's focus on the middle distance, Adam maintained almost constant eye contact. Indeed, his eyes, which betrayed a remarkable humour and gentleness, were often the most animated thing about him. Like a number of other participants but especially Francis (see Chapter 6), Adam's humour was darkly sarcastic and cutting, and was easily turned against us when we made what he considered to be a frivolous comment or asked a naive question. His conversation was commanding and engaging by way of its dazzling (if confusing) use of allusion and metaphor. What is missing from the transcripts is the performative dimension of our talking together: the non-verbal markers of our engagement, the tone of our discussions, the emotional tenor of my interest and expectations. What is also missing is my constant sense of being 'thrown' and kept 'off balance' by the seemingly improvised play of Adam's references and tropes. In particular, the transcripts, as texts, fail to capture the 'rhythming and cadence' of our being together — that is, of our placement within a common rhythm which is intrinsic to dialogic acts (Taylor 1995: 62; see also Schutz 1964). According to Taylor, all such acts, including conversation, proceed at the very cusp of linguistic representation. Their performance requires attentional markers, bodily movements, head nodding and "uh-huhs" that signal a semantic turn-taking that passes from one interlocutor to another in a 'common movement' (Taylor 1995: 63).

It is obvious with hindsight that Adam's way of talking was often more compelling than the words that he actually spoke. The capacity of his talk to draw one in and 'persuade' (one of his favourite words, implying belief and its 'vindication') was powerfully engaging. At the same time, the mere scope of his conversation was disorienting: on our first meeting, for example, Adam made reference to religion, mysticism, psychology, etymology, classical literature, fairy tales, science fiction, fantasy and children's stories, while canvassing such topics as evolution, metacommunication, reincarnation, telepathy and the limits of language itself. This was captivating, but also bewildering. It intimated more than it delivered. I found myself grasping for his meaning which often seemed just beyond reach — it sounded like there should have been a meaning there, but I struggled to pick it up. Psychiatrists might have suspected 'thought disorder' at this point, but I did not presume to immediately understand someone who we were effectively meeting for the first time, as if my own professional culture and language were the measure of (sane) clarity. Given Adam's obvious desire to talk I found it little wonder that things should come out somewhat confusedly. I was also pre-disposed to treat his talk sympathetically: I had come in the hope of obtaining insight and understanding from it and was projecting an anxious, anticipatory attention to all that he said. Conversing, listening and being together were sufficient to the task at hand; understanding, I thought, could come later. In fact, this understanding never did come.

Adam's experiences were the most remarkable of the many extraordinary experiences I heard recounted during the course of this research. Like some other participants, Adam's experiences encompassed the broadest possible vistas of time, space and causality; they were predicated on the existence of other worlds and other dimensions; they involved interactions with a range of beings including God, Satan, spirits and wraiths. But the consequences of these experiences, their centrality to his identity, and their effects on his everyday life were all heightened and elaborated to a remarkable degree. Adam exemplified that indeterminate experiential realm which I have argued was available to all participants, to which they had a recourse according to their needs or purposes, but especially to effect evasion and inaccessibility (see Chapter 4). With Adam I felt my exclusion from that realm most acutely. His experiences filled a 50,000 word manuscript which I thought would provide me with a unique encapsulation on which I could 'work' at understanding. But it too was just more words (the bulk of it comprising reported conversations with God, Satan, the spirits, etc.) and no more illuminating than the record of our conversations. It was this extraordinariness and, in particular, its accompanying perplexity which propelled me to return, both to Adam himself, and to my record of his experiences. But I have never understood either. There was little in his experiences which resonated with mine, and I could find nothing in my own experience with which to make that resonance begin. Apart from the superficial recognition of a few song lyrics, I could not achieve a common reference world with Adam and his 'voices'. Whatever understandings I gleaned from our being together did not result in me feeling an interplay, a mutual recognition (J. Benjamin 1995: 21) or a commonality with Adam and his concerns. I could witness and read about Adam's experiences being meaningful for him, but this did not answer my questions concerning what they could mean for me. The point at which our intersubjectivity halted was not one which relieved me of further trouble; I felt that whatever interpretations I could make did not allow me to respond appropriately to Adam (cf. Schutz 1972: 38). Each attempt at exegesis (performed either with him or with the record) perplexed me more. I came to realize that it was this very perplexity which drew me (and draws me still), which was enticing and effective.

I came to realize that understanding Adam's experiences was *my* imperative. For his part, he offered understanding, but on his own terms. Understanding in my terms did not matter to him. Adam made it quite clear that his identity and sense of self-worth were in no way linked to my appreciation, or to the assessments of the psychiatric profession. Quite the contrary, in fact. Escaping such understanding seemed to afford him a particular pleasure. Adam's experiences certainly solicited interest and attention. We had been drawn to Adam after an initial meeting in the waiting room of a Clozapine clinic, during which he asserted that his 'voices' were "very real" and that the circumstances of their production and reception needed careful exploration. Visits to his home were initiated by the intrigue of this proffered invitation to explore.

Adam actively facilitated our interactions: inviting us into his home, talking about his experiences, demonstrating the board games he had invented, showing us family photographs, introducing us to his brother, lending us cassette tapes of his stories and handing over the single copy of his manuscript. He offered us hospitality and lively conversation. Equally, however, the impenetrability of his accounts meant that he was able to maintained significant barriers to availability.[38] In this he exemplified the contrary movements toward involvement and withdrawal which many participants displayed (see Chapter 2). His actions and communications both promised connection and repelled a joint construction of meaning, allowing him to maintain significant levels of control over each of these processes. He resolutely remained the arbiter of his experiences. Likewise, his obfuscation regulated our social interactions, as it was simply impolite as well as exhausting going over the same material again and again. His obscurity gained him privacy and solitude, which he said he valued highly. Cultivating an aura of enigma was important to Adam. He said he was not interested in the views of 'mortals'. He only valued what he called "spiritual conversations". His view of schizophrenia as the "evolution of a new sense" confirmed his superiority; hence his pitying of us for not hearing 'voices'.

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[38] I adapt this concept of 'availability' from Henry (1965: xviii) who argued that the 'availability of human beings to one another — of parent to child, of husband to wife, of clan to clan — is a necessity of social existence'. Only another person, or a series of others, can transmute the possibility of being human into the actuality of social practice (ibid: 289). Adam tested and played with this social and intersubjective potential, drawing us in but keeping us distant; intimating understanding and empathy, but also escaping it.

While the contents of Adam's talking appeared to obliterate the self (turning it into light, spirit and language, for example), his practical stance of simultaneous engagement and withdrawal evinced a strong and protective self. His narratives therefore appeared as both subversive and ironic.[39] What he was able to achieve by employing his talk in this way confounded taken-for-granted psychiatric prescriptions of the person with schizophrenia as amorphous and unbounded[40], as well as more general notions of the person which exclude the subjective reality of psychotic experience:

> Western notions of a unitary, individualist, permanent self ... impermeable to spirituality and otherworldliness, leave no social space for the experience of psychosis. The image of the 'normal,' rational individual that underlies the supposedly atheoretical classificatory systems of American psychiatry denies the subjectivity of persons experiencing schizophrenia, thereby diminishing the range, even the very possibility, of communication in clinical settings as well as everyday relations. In this cultural context, persons labelled schizophrenic are, conceptually, placed outside the realm of shared symbols and notions of self, and hence beyond the possibility of reciprocity and exchange ... (Lovell 1997: 356)

Our encounters demonstrated that Adam was not so easily located outside the realm of 'reciprocity and exchange', at the same time as they revealed this as a strategic possibility which he was ever ready to invoke. This highlighted the central contradiction which was manifested by many participants, but exemplified in Adam: the tension between a socially appropriate engagement which promised some level of intersubjectivity, and a subjective withdrawal predicated on an inaccessible experiential realm.

I ceased seeing Adam because I could not escape the perplexity which he caused in me. While there were intimations of connection and understanding (such as I was able to forge through a familiarity with the music of Patti Smith and the references to a wider world which that music invoked), at each meeting Adam seemed to cast out more astonishing

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[39] Cf. Lovell's (1997: 359) account of how stories about delusional property ownership 'counteract damaged, stigmatized selves hewn from homelessness and the experience of ... illness... Delusional property, then involves becoming the dominant Other, trading images of exclusion, poverty, and anticommodity for hegemonous ones of normalcy.' With the example of Adam I propose that the opposite projection (toward an 'obliterated' self or ungraspable otherness) is equally a resource.

[40] Sjöström (1997: 153-7) has demonstrated how the perception of patients as 'boundless' and the practical task of 'bounding' them through treatment regimens is a central focus of psychiatric work in a clinical setting.

material with which to wonder. I remain confused. I remember interpreting his ever-present smile as an indication of his pleasure at this effect: I had not understood; he had not been explained; everything remained a mystery. He had even provided a framework by which to account for this: he was immortal; I was mortal (which meant material, logical and limited) and therefore ontologically incapable of appreciating his world.

CONCLUSION

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In this Conclusion I present some summary statements which are oriented to the principal themes of the dissertation. Thus I begin with the major findings concerning schizophrenia as a particular type of experiential and social phenomenon. Based on the ethnography already presented, I outline a set of contradictions which emerge from, and are elaborated by, the circumstances, daily lives and biographical histories of people diagnosed with schizophrenia. I formulate a specific disjuncture from the everyday which I see as combining the social and personal dimensions of these people's experiences. This formulation is contrasted with Laing's image of schizophrenia as an existential and strategic rupture. I go on to argue that such a disjuncture problematizes intersubjectivity at the levels of both practice and analysis. Schizophrenia, I propose, has been shown throughout the dissertation to represent a case study in the possibilities, limits and transgression of intersubjectivity as a tool for apprehending the meaning of another's experience. I then use these social, experiential and intersubjective components of the thesis to reflect on the theoretical frameworks I have used to grasp schizophrenia both methodological and analytically. I focus on the role played by agency and identity — other key themes of my ethnography — in these theoretical frameworks. Finally, I place these findings within a broader context by suggesting ways in which an ethnography of schizophrenia could be further developed in line with issues — most particularly reflexivity — raised by cross-cultural comparison.

CONTRADICTION AND DISJUNCTURE: SCHIZOPHRENIA AS A SOCIAL PHENOMENON

Regardless of what its aetiology might be, schizophrenia had specific experiential and social effects. People diagnosed with schizophrenia negotiated a fundamental disjuncture: their experiences were not articulated with the *habitus* given by their backgrounds, their socialization, or their everyday worlds (which is what made their experiences extraordinary, even to themselves) and were not, as a consequence, easily aligned with the values and regulatory principles of a wider society (which is what rendered them 'mad' to others). This was the double source of schizophrenia's extraordinariness. It was also a configuration which specifies schizophrenia as a specific social and human phenomenon.

Participants attested to how they had no choice but to acknowledge the experiences which "hit" and "bombarded" them. They also could not fail to notice how these phenomena were disparaged and discounted by the organizations and processes which comprised the 'mental health' system, to which they had been co-opted on the basis of those experiences. This system provided a series of determining structures which had the power to predicate their identities, shape their material circumstances, and influence their relationships with other people. Being diagnosed with schizophrenia meant living with this conjunction of idiosyncratic experiences and social structures in the most direct way possible (since both were focused on their person). The conjunction itself rendered participants in this study quintessentially reflexive about the status of their experience (its veracity, it communicability, its value as a form of knowledge, and the uses to which it could be put), and about themselves (their moral worth, what consideration and understanding they were due from others, their ability to make choices, and their capacity to be agents of their own lives). In particular, the nature of participants' experiences meant that some of the most basic parameters of their everyday lives — where they lived, how much privacy they enjoyed, how much money they could command, what opportunities they had for changing their circumstances — were mediated by a range of institutions with the power to interpret, diagnose and represent those lives. This mediation had its own consequences which were not pre-determined by a 'natural' disease process.

A diagnosis of schizophrenia registers a singular breach of intersubjectivity and common sense understanding. Participants recognized and reflected upon this breach as a direct result of their experiences. The process of diagnosis also effected a further separation from everyday sociality by highlighting the distinctiveness of these disconnected subjectivities. Both these extraordinary experiences and the diagnostic response of the psychiatric profession were sources of on-going breakages in participants' worlds. I have shown throughout the dissertation that these disconnections were amplified and ramified by a range of everyday settings, clinical practices, social processes and pragmatic contradictions. That such disjuncture was neither singular nor static but perpetually generated and reinforcing meant that schizophrenia was quintessential 'unstable' and destabilizing, not as pathology *per se*, but as a concept and a social condition. It existed as (and served to focus) a 'figure-ground' relationship with other modes of social being, each defined by contact and comparison with the other (cf. Turner 1982: 50). The dual sources of this disjuncture in experience and in the social response to that experience meant that schizophrenia — whatever else it was in biological, neurological or genetic terms — was a specific experiential and social component of the human (historical and cultural) world. As Glass (1989: 15) has noted: '... what exists beyond brain chemistry or genetics are persons who express feeling, who assimilate experience, and who live among other persons'. This juxtaposition and its social mediation is what I have explored as schizophrenia's extraordinariness.

The themes of rupture, strategy, and evasion of institutional determination which recur throughout this dissertation recall aspects of Laing's 'anti-psychiatry'. Clearly, these are persistent and substantial issues in the lives of people diagnosed with schizophrenia, whether Laing's patients of the 1950s and 1960s, or participants in this study. Here I set out how contextualizing these themes with a specific social setting reveals them as having a different basis to that which Laing suggested.

In *The Divided Self* (1965) Laing declared schizophrenia to be a fundamental 'split' between a person's body and self: 'The individual's being is cleft in two, producing a disembodied self and a body that is a thing that the self looks at, regarding it at times as though it were just another thing in the world' (Laing 1965: 162; see also pp. 174-5). He then employed an existential framework to map this 'cleavage' on to a more encompassing division between a 'false' self and a 'real' self. I note similarly that the self's existence and its relationship to the body were issues of intense interest to many participants in the present study. But rather than elaborate on the philosophical implications of that relationship, I have suggested that such processes are located within specific experiential and social processes. Thus, the 'splitting' which was manifested as distancing and separation was, first of all, an effect of the heightened reflexivity which was generated by attention itself — an attention which was brought to bear by both diagnosticians and those diagnosed. In particular, the apparent distancing from self and body was a consequence of extraordinary experiences, their very extraordinariness being constituted by their not fitting into normative and cultural schemas which, for the most part, allow the self and body to be taken for granted. Thus, the distancing and breakages entailed in this reflexivity implied not just an existential breach (although many participants apprehended them in this way), but a disjuncture which was socially located and generated. This was an effect of participants' everyday confrontation with the 'socialized subjectivities' of the *habitus* (Bourdieu & Wacquant 1992: 126), both their own and other people's. This reflexive effect was heightened by a diagnosis which located pathology in the inaccessible recesses of bodies and brains, one participant registering this image as: "my mind is at war with myself". Because of this, participants could recognize themselves as damaged, broken or "not right" in some way, but the mysterious location of this damage rendered their own bodies and selves equally perplexing, thereby perpetuating the reflexivity which their experiences evoked. Diagnosis in turn accentuated a distinction from other people (since it offered a designation of a whole person as 'schizophrenic'), as well as from the self as experientially and historically known ("I'm not just a schizophrenic"). In these and other ways explored throughout the dissertation I have sought to locate the breakages and divisions of schizophrenia within recognizable social processes — processes which may have philosophical implications, but which in themselves were practical rather than theoretical and speculative.

For Laing, schizophrenia was also a mirror for an 'alienated' and 'mad' society in which no authentic 'inter-human life' was possible. In one version of his famous formulation, Laing (1967: 95) pronounced schizophrenia to be, '... a special strategy that a person invents in order to live in an unliveable situation'. Its untenability was not intrinsic but reflected a life trapped in an untenable position (ibid). Laing's 'anti-psychiatry' was an attempt to heal that breach at both the practical and philosophical levels. Thus, two recurrent themes of *The Politics of Experience*, Laing's major sociological and philosophical treatise, were the impossibility of love and of religious transcendence within the inauthentic conditions of contemporary capitalism (ibid: 12). For Laing, accepting and embracing the apparent (that is, distorted) aberration of schizophrenia was a model for developing the capacity to love, itself a therapeutic instrument (see Laing 1965: 165). Similarly, he saw psychotic experience as 'breaking through' to 'those experiences of the divine that are the living font of all religion' (1967: 108). Laing seems to have posited the embracing of schizophrenia as a test for (and an experiment in) reconstructing the mutuality of human beings, for recovering the 'communal meaning' of human existence, and for reconciling the various divisive categories of 'us' and 'them' (ibid: 65ff).

In this dissertation I have explored the social and dialogic conditions by which intersubjectivity approaches such mutuality and sometimes confounds it. I have explored the limits of intersubjectivity within the context of a specific research project which was itself an experiment in the possibility of mutual understanding. The motif of 'betweenness' has been shown to recur at various levels: as a register of psychopathology specific to schizophrenia; as the condition of our talking with participants; as their social location at the interstices of institutions; and of my own location between academic settings and disciplines. 'Betweenness' was therefore, by definition, not a singular attribute. It was a point of negotiation, strategy and perspective. Its multiplicity suggests a complexity which is not embraced by the therapeutic mutuality which Laing sought with individuals alone. I have also shown that there were specific experiential and social conditions which resisted, and allowed people diagnosed with schizophrenia to resist, such mutuality.

Moreover, Laing's critique of both capitalist society — itself a 'world gone mad' (Laing 1967: 55) — and the 'counter madness' of psychiatry was not grounded in an ethnographic analysis of any particular social setting (at least insofar as this critique was crystallized in *The Politics*). I, however, have sought to explore the bases of participants' isolation, withdrawal, and apparent 'alienation' in specific social circumstances, settings and processes. Thus I have demonstrated in Part I that participants comprehended and communicated the experiences associated with schizophrenia using various tropes which drew on a range of everyday cultural understandings. In this way, their experiences were both alienating and understandable to some extent. In Part II I focused on the social conditions and substantive structures (of realignment and deinstitutionalization) which created and sustained possibilities for escaping the 'alienating' effects of the field of schizophrenia in which participants were enmeshed. In Part III I explored the extent to which participants both facilitated and resisted the 'mutuality' which Laing sought with schizophrenia; such 'mystical' communion did not accord with what participants either experienced or wanted. This was most clearly apparent in participants' effort to both construct and confound intersubjectivity.

INTERSUBJECTIVITY AND ITS TRANSGRESSION

Chapter 7 demonstrated schizophrenia's sometimes intransigence to understanding and empathy. Jaspers' (1963: 577ff) characterization of schizophrenia as 'ununderstandable' is the classic psychiatric formulation of this quality, which has been elaborated and explored in a number of ways (see Rümke 1990, Sass 1992a). I retain this sense of enigma as a key aspect of schizophrenic experience, but have placed it within the social context of *habitus*, as well as resistance to dominant institutional predications. I have also shown how the structures of mental health — the forces and organizations which made up the field of schizophrenia — facilitated schizophrenia's refractory positioning and thereby sustained its ungraspability.

Kirmayer suggests that there are epistemological grounds which preclude illness' encompassment by theory:

> In sickness we confront the inchoate. Bodily suffering distorts the landscape of thought, rendering our previous constructions incoherent and incomplete. The study of the essential irrationality of sickness is hampered by the fact that the "objective" social sciences adopt many of the same rationalistic values as biomedicine. For medicine the irrational is pathological; for the social sciences the irrational is deviant or exotic... The dominant theories of the social sciences tend to treat the nonrational aspects of existence as defective or in need of rationalization. (Kirmayer 1992: 329-30)

He goes on to suggest that this propensity toward reason, common sense and control is itself a cultural trait which permeates our models of, and uses for, knowledge. Some human phenomenon (such as illness and emotion) elude such biases. Throughout this dissertation I have suggested the social conditions which allow schizophrenia to epitomize that escape from reason and its discourses. Foucault (1967) has addresses the same point from an historical perspective: that madness is the critical rupture which never ceases to interrogate the discourse of knowledge.

Schizophrenia thus highlights a double transgression. It highlights the limits of intersubjectivity — a limit which is, as Schutz (1972: 97ff) has argued, an abiding feature of the human world in general and an everyday problem for sociality as such. It also highlights the limits of theory to accommodate such a possibility. Thus, schizophrenia brings into question the dual premises of Schutz's social phenomenology: that the social world that we (as individual social actors) immediately experience as meaningful is also meaningful for others, and can also be rendered meaningful from the standpoint of the social scientist (Schutz 1972: 10).

Schizophrenia was transgressive in the manner defined by Foucault: a crossing and re-crossing of limits which affirms what is substantial on either side of a border.

> The limit and transgression depend on each other for whatever density of being they possess: a limit could not exist if it were absolutely uncrossable and, reciprocally, transgression would be pointless if it merely crossed a limit composed of illusions and shadows. (Foucault 1977b: 34)

Such crossings are dangerous because they frequently entail punitive responses, either repugnance, disparagement or stigma. Participants lived with these rebuttals every day. They asserted both the reality of their crossings into other realms of experience, and of the punishments which flowed as a consequence. They appreciated both the possibilities which existed 'beyond' social acceptance, and the difficulties that others had in conceding to this transgression of cultural and experiential limits.

Some of the pivotal experiences associated with schizophrenia transgressed common sense boundaries, as, for example, between voice, thought and image. Everyday limits functioned as both a touchstone by which participants measured their experiences, and as a resource on which they drew in order to communicate those experiences to others. They relied on such resources in order to chart their movement both toward and away from what was common. Their attempts to convey that movement drew upon a range of cultural materials which similarly operated by way of transgression — popular music, science fiction (the term itself encapsulating contradiction), drugs, art, video and television — but which were also recognizable and communicative social forms. As the epitome of transgression, schizophrenia was both amenable and intractable to intersubjectivity, and to the (practical and theoretical) representation of this enigma.

It was the dialogues, negotiations and engagements entailed in fieldwork which brought the possibilities and limits of intersubjectivity into focus. It was in such interactions that participants — who asserted that they often felt confined and isolated within their own experiences and understandings — had the opportunity to stand outside of themselves and interpret their experiences. They did this by employing understandings which were constitutive of a wider everyday world and thereby not solely determined by psychiatric categories (cf. Kapferer 1986: 197). This was the significance and value of the tropes outlined in Chapter 1. With them participants sought to communicate their experiences, but they were also the basis of joint interpretation because we each had a cultural repertoire of understandings which construed drugs as disorienting, war as assaulting, death as transfiguring, dreams as anomalous, and so on. Fieldwork in people's homes and everyday settings structured both the standpoint and the context for this convergence toward intersubjectivity. Our talking together and going out together entailed a sharing of time and space, as well as the bodily, subjective, and interactional negotiations which such activities demand. It was this convergence of individual standpoints on a specific task — an intersubjective project (Jackson 1998) to understand schizophrenia — which promised the sharing of experience, just as it, through its own extraordinariness, enabled each of us to reflect on that experience.

Barham (1993: 199ff) has suggested that schizophrenia — as an idea and a clinical phenomenon — is conceptually and physically located on the edge of what is known and shared, that is, 'on the edge of the common'. As the ethnography presented throughout this dissertation has demonstrated, while that edge may be the frontier of community and experience, it is not altogether beyond them.

As a limiting case of human empathy (Jaspers 1974) — and, in some accounts, of what it is to be human at all — schizophrenia is the quintessential 'madness'. It represents a limit which has long been recognized in Western cultures. Roccatagliata (1991), for example, has traced the sources of the concept (variously named but inhabiting 'the same semantic field') from the 7th century BC to the 11th century AD, based on philological analysis. Schizophrenia's distinctive features have thus been described, classified and treated over millennia. The abiding presence of this 'madness' (whether as a counter-image, an erasure, a fear, or a focus of philosophical and medical speculation) is attested to by its continuing re-creation in literature, film and popular representations of 'schizophrenics' and 'mad' people generally. This very historical continuity perpetually focuses the question of what is within and what is beyond the bounds of experience and sociality. The persistence of the question suggests an abiding relationship between an extremity and those social conditions which define it as such. Hence the tradition of looking at how schizophrenia and society reflect each other. The possibility of this reflective relationship, and the perpetual return to the questions it raises, suggests that there are at least some pathways by which this edge is traceable back to the common.

THE LIMITS OF SOCIAL DETERMINISM: INTERPELLATION, SUBJECTION AND SOCIAL POSITIONING

A persistent theme throughout this dissertation has been the relationship between participants and the structures, institutions and forces which were prominent in shaping their lives as people diagnosed with schizophrenia. This relationship loomed large in any sense they had of themselves: both in the freedom they demanded to construct identities for themselves, and in their confrontation with the limits and determinations of agency which were given by their situation. It was a relationship that was implicit in the diagnosis itself, which brought professional psychiatric classifications and clinical practices to bear in the most powerful and penetrating way. It was participants' amenability to having their whole person rendered 'schizophrenic' which highlighted the power of institutions to define them, of the state to determine their material circumstances, and of organizations to co-ordinate and rehabilitate the conduct of their daily lives. In shaping how they might be known, these external determinants were also implicit in participants' relationships with other people — since they shaped anticipations, expectations and inhibitions — and with the 'community' or 'society' more generally. These latter relationships were even the explicit focus of government policies, something which was not the case for many other citizens. Such circumstances raised the question: to what extent did people see the institutions, professions and policies which sought to define them as providing a sufficient means of representing and understanding who they were? This was a question for people diagnosed with schizophrenia, as much as for an analysis of their situation, and thereby provided a further basis for the reflexivity which pervaded the research process at every level.

Throughout this dissertation I have privileged the view which participants themselves had of the various forces of determinism in their lives, and of the strategies which they enacted in response. Here I review some sources for the perspective which I have explored ethnographically.

Participants' identities were not easily accounted for in terms of the processes of subjection and interpellation which are commonly attributed to psychiatric institutions. Participants were not confined to a 'total institution' with the power to restructure their identities to its own ends, nor were their 'careers' inevitably and fatefully tied to a coercive hospital structure, the constraints of which could only be countered by the freedom of 'role distance' or the tactics of an 'underlife'.[1] Partly this was a measure of the social and

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[1] See Goffman (1961: 187ff); see also Estroff (1993: 255) for other critiques of Goffman's thesis on the self-concept of patients in total institutions, especially that of Townsend (1979).

institutional changes which have taken place since Goffman conducted his research mid-century. Local hospitals had literally been 'broken up' and the social conditions which had produced the resistance of freedom-seeking individuals by way of a simple opposition to monolithic institutions were no longer operable, or even possible. Diagnosis, rather than asylum, had emerged as a much more important force in the structure of hospital treatment and the organization of mental health services generally (see Barrett 1996). With its capacity to be embedded deep within the person — or even made synonymous with the person — diagnosis was a highly transportable measure of psychiatric power which did not rely so directly on confinement to a tangible institution.

In this, diagnosis could be seen to interpellate a schizophrenic subject in the manner proposed by Althusser (1971) for ideology. Althusser defines interpellation as a mechanism by which a human subject is constituted by ideology to perform the roles demanded by a particular social formation: '... ideology 'acts' or 'functions' in such a way that it 'recruits' subjects among the individuals (it recruits them all), or 'transforms' the individuals into subjects (it transforms them all) by that very precise operation which I have called *interpellation* or hailing, and which can be imagined along the lines of the most commonplace everyday police ... hailing: 'Hey, you there!' ' (ibid: 162-3). This (allegorical) process results in a 'mutual recognition' (ibid: 162) when the person responds appropriately and thereby accepts the terms by which he or she has been hailed. Identity is constituted by a turning around to face the law; the call itself is "an entrance into the language of self-ascription — "Here I am"" (Butler 1997: 107). The image suggests a model of participants' complicity with psychiatric designations (see Chapter 4), expressed as the ability to recognize themselves (their 'calling') as 'schizophrenics', and to respond appropriately.

Many participants were highly self-conscious of being identified as mentally ill, a process which had often begun with the elaborate and mortifying procedures of psychiatric assessment and diagnosis. They were well versed in being constituted as 'schizophrenics' by psychiatry, by their families, and by service providers in ways which resonate profoundly with Althusser's account. But it was this constitution which they also contested and resisted.

One participant, Brian, used the same archetypal scenario to characterize the problems he had in public places, especially the surveillance of his actions which he believed was undertaken by security guards patrolling the shopping mall where he liked to go. He said that he sometimes heard a voice yelling out, questioning his right to be there, taunting him, or "paying me out for not being macho enough". He would look around, but had never seen anyone addressing him: perhaps they were "hiding it"; perhaps they were "never there" in the first place and it was his own mind "playing tricks" on him. His strategy in such circumstances was to ignore the voice and keep on walking: "If it really did happen then no-one can pin it on you because you're not reacting." Brian's response to all negative ascriptions — from 'voices', from 'doctors', or from unidentified others — was disarmingly simple: "don't react". In this way he resisted the implicit 'hailing' of himself by what he called "negative forces", whether real or imagined.

As I have shown, participants in this study had both a material means (their houses) and an inalienable resource (their extraordinary experiences) with which to counter the authoritative hailing of themselves as nothing more than interpellated subjects (see Chapters 3 and 4, respectively). In part, Althusser's formulation accommodates this possibility by way of the acknowledged 'ambiguity' of the term *subject*. This refers both to 'a centre of initiatives, author of and responsible for its actions', and to a 'subjected being, who submits to a higher authority, and is therefore stripped of all freedom except that of freely accepting his [*sic*] submission' (Althusser 1971: 169). Participants lived with and mediated this ambiguity in the most direct way possible. It was their location both in and outside of institutions — together with the multiple bases for exercising agency and constructing identities which this engendered — that mitigated against a straightforward submission to diagnostic prescription. It was their 'betweenness' which opened up alternate avenues for the subject as a centre of authorship and initiative.

Likewise, analyses of the subjection which is achieved through institutional regulation — in which the subject is initiated through a primary submission to power (see Foucault 1977a) — do not adequately take into account the range of locations in which participants dwelt, or the variety of resources on which they could draw in this context.[2] The distinctiveness of participants' everyday lives was grounded in an expansive field which provided numerous opportunities for 'absenteeism', and for 'defaulting' from 'prescribed being' (Goffman 1961: 188).

Social positioning was thereby also open to a range of forces and possibilities. That the field of schizophrenia, dominated as it was by psychiatry, intersected with a number of other fields meant that there was no one position which discourses created, offered or determined for the individual. Participants exhibited various means of escaping the 'subject positions' given by the social structure, whether these be kinship roles within the family, work roles within the economy, or patient roles within the mental health system.

Holland and Skinner (1997) note the conflation of 'position' with subjection:

> In the conceptualization of subject position, the individual's creation and understanding of his or her own position, identity, and subjectivity and how these develop in history are *not* the focus. Rather, a subject position is understood as one's *subjection* and placement within particular forms of control and discourse. (Holland & Skinner 1997: 197; original emphasis)

They contrast this subjection with a dialogic focus on identities as 'psychocultural and psychosocial formations that develop as individuals and groups engage in activity in a

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[2] Foucault's own *oeuvre*, however, pivots on this contrast between an early focus on the 'techniques of domination' in hospitals, asylums and prisons, and a later interest in those 'techniques of the self' which permit individuals to effect operations on their bodies, thoughts and conduct so as to transform themselves — see Jackson (1998: 21). See Foucault (1988: 2) on his project to establish the conditions which would facilitate 'an exercise of self upon self ... to transform one's self and to attain a certain mode of being'.

lived world' (ibid). Identities are 'perspectives on the world that are formed in experience and named or symbolized for the self through verbal ... visual ... and other cultural devices' (ibid). Participants in this study similarly insisted on a view of themselves as having been 'formed in experience'. As I have shown in Chapter 4, most participants resisted identifying only with those positions given by the field's most powerful institutions, this resistance pivoting on a claim that their extraordinary experiences allowed them to transcend structurally given roles and propelled them to act in accordance with that extraordinariness. They combined this with a strategic and rhetorical demand to name and interpret those experiences in their own terms.

Participants' biographical 'development' had been the subject of extensive scrutiny: a 'developmental history' was part of all diagnostic procedures and was even repeated in conjunction with each Present State Examination (PSE) conducted for this study. It was hardly surprising, therefore, that historical and biographic frameworks were prominent in how they understood themselves (and equally, in how they wished and expected to be understood by others). All of the assessment procedures that participants had endured highlighted and objectified them as individuals having a specific 'history-in-person' (Holland & Skinner 1997: 198), which was therefore a social construction as much as an existential project, the two developing together as participants continued to learn about and explore who they were from multiple points of view. They sought only a measure of control over that process, so that identity was simultaneously a form of subjectivity and a vehicle for

> ... having an ongoing point of view, an ongoing place that provides a view from somewhere ... Having a lived identity means having a sense of one's interests and feelings related to those interests, and it means having an ongoing sense of what sort of actor one is — who one is or where one stands in the world. (Holland & Skinner 1997: 198)

Their homes — as specific places 'from which to look out on life' and 'contemplate events from somewhere in particular' (Basso 1996: 56; see Chapter 3) — accommodated and substantiated this project which, of necessity, mediated institutional and experiential predications of identity.

ASSESSING THE ANALYTIC TOOLS

The analytic tools derived from Bourdieu have proved valuable for mapping out the broadest structures which delineated participants' everyday worlds. Thus, Chapter 3 employed the concept of 'field' in order to identify those institutions and forces which had the greatest power to predicate the person diagnosed with schizophrenia, ascribe that person with an identity, and prescribe the appropriate courses of action which such a person should follow as a consequence. I have designated this constellation of forces as the field of schizophrenia . It included those substantive institutions (such as the hospital), organizations (Schizophrenia Fellowship, Clubhouse), state instrumentalities (the mental health service) and policies (the *National Mental Health Plan*) which broadly circumscribed the possibilities of, and constraints on, people's lives. Throughout Part II I have shown the relationships which existed between these forces, their interpenetration, and the power of their determinations.

In particular, Chapter 4 surveyed some of the strategies of both collusion and resistance which participants used to act on and through the institutions, services, bureaucracies and policies which were specifically directed toward them. Here, Bourdieu's account of how agents strategize to achieve their aims, even though they act under conditions of unequal power and symbolic violence, was particularly relevant. It was participants' understanding (and conscious use) of this strategizing which equally revealed the limitations of Bourdieu's framework since, as Karp has observed:

> The difficulty with Bourdieu's formulation is that he grants too little knowledge to actors at the same time as he fails to recognize that action itself may be articulated in terms of ontological principles other than those found

> in capitalist social formations. Bourdieu's actors are all small-scale entrepreneurs, struggling to acquire without either much ability or opportunity to reflect on the conditions of their existence or much understanding of their culture. Differences in personhood or ideas of being are missing from Bourdieu's outline. (Karp 1986: 133)

Dreyfus and Rabinow (1993) note similarly that Bourdieu's approach is concerned, above all, with a strategizing over symbolic value, and suggest that this is not a sufficient account of the existential structures and social meaning of human Being within culture. Turner (1982: 46) has also argued for a 'non-transactional order or quality of human relationship' in which 'people do not necessarily initiate action toward one another in the expectation of a reaction that satisfies their interests'. Participants did have knowledge, founded in their situation, which they could deploy as forms of 'capital' in order to achieve certain types of strategic gain. But such a functional outcome was not all there was to say about their lives. Except in the exceptional circumstances of having us researchers turn up, it is doubtful that the 'capital' of their experiences could be proffered in an exchange in which it was valued, or had the potential to be revalued or reinterpreted. Most participants had learnt that their interests were rarely satisfied in interaction with others.

Use of these analytic tools therefore led to their subversion as a means of specifying how a life was lived within such determinant structures. Thus I have shown that the positions attributed to and claimed by participants were equivocal in fulfilling the role which Bourdieu attributes to social positioning in reproducing a field: to some extent participants were able to evade the hegemony of its institutions; sometimes those evasions in themselves contributed to maintaining and recreating the field. Equally, as a form of capital specific to schizophrenia, 'experience' was a resource by which participants could both withdraw from or transcend the 'rules of the game' by which such 'capital' was evaluated and transferred. Identities and forms of agency both confirmed and effected an escape from the field.

In particular, participants evinced an exceptional capacity for reflexivity which defied the taken for grantedness of the *habitus* and its unproblematic articulation with a field or social structure. While much of this reflexivity was directed toward themselves, their bodies and minds, it also embraced their social situation and their engagements with a wider world. There was an imperative attached to this reflexivity. The everyday dispositions of people diagnosed with schizophrenia were subject to all manner of surveillance, intervention and management. In this way they were objectified, both to themselves and for others. In part it was these processes — social and political (cf. Laing 1967: 100) as well as clinical and therapeutic — which rendered people diagnosed with schizophrenia necessarily reflexive.

In part, these dualities and contradictions could be said to reflect the open and emergent qualities of a field itself — an indeterminacy given by its characterization as a 'field of struggles'. Perhaps this was a particularly volatile field. This latter rendering was easy to sustain given local changes to the mental health system, the explicit 'realignment' of institutions, and the progressive agenda (in the dual sense of both on-going and liberalizing) of public policy in respect of deinstitutionalization. But the problem for analysis is not just one of accounting for these substantive issues. It concerns the capacity for the analytic framework to adequately embrace the subject matter to which it has been applied: that is, the lives, experiences and knowledge claims of people diagnosed with schizophrenia.

What status should I attribute the self-representations which such people offered me as a way of accounting for their lives and experiences? What do I make of their strategic and rhetorical claims to represent themselves? How to take account of participants' desire to speak for themselves, and to have their voices accorded epistemological and moral weight? To take the ostensible form of these expositions — strategic, rhetorical, fantastical — as their only significance, and thereby conflate their form with their content, would be to abrogate the task of analysis itself, as well as do immeasurable damage to the relationships and settings from which they emerged. To dismiss participants' desires, representations and actions as merely rhetorical and strategic or, more pointedly, as deluded and 'mad', is only to reapply the psychiatric frame which participants understood themselves to be escaping by talking to us. To render participants' concerns as 'symptoms' in this way would only re-objectify them in the same terms that they said psychiatry had done. If this were the case then there was nothing to say that had not already been said about them, or for them; certainly, there was nothing to be gained by bringing another disciplinary perspective to bear. What and who they were (or could be) had already been determined by the dominant institutions which framed their lives. An analysis which only reproduced participants' encapsulation by psychiatry could say nothing about the divergent expressions which schizophrenia took within individual biographies, or about schizophrenia as a technical, institutional, historical and cultural construct.

As many participants insisted, schizophrenia was not all there was to know about them. As their own biographies showed them, they were not pre-given, natural (if diseased) objects: that is, 'schizophrenics'. Their arrival at this position had been effected by complex processes of construal in terms of a category which was itself the site of enormous historical and institutional contestation — processes of which they were highly conscious and could reflect upon. Participants knew themselves to have been other things before, and could construe themselves as other than schizophrenic in a variety of ways. They had come to the field of schizophrenia via diverse routes, and had other histories. They enacted divergent strategies therein, and had various ways of escaping.

THE HEGEMONY OF COMMON SENSE: *HABITUS* AS HOMOLOGY WITH A FIELD OF DOMINATION

Habitus produces common sense and reasonableness as a correlation between objective social possibilities and agents' subjective aspirations. In being taken for granted, such common sense is 'normally' beyond scrutiny, intention or control (Bourdieu 1984: 466).

Participants in this study, however, evinced an abiding reflexivity — and hence distance from — such a structuring of experience (see Bourdieu 1990a: 60). For them, common sense and reasonableness were what was at stake in the field of schizophrenia. These were capacities which had to demonstrated in order for a person to be afforded 'community placement' in the first instance, and they had to be sustained if psychiatric intervention was to be minimized and the placement maintained. Such capacities were therefore also political tokens. The appropriate display of these capacities could dramatically affect participants' material and social circumstances; it also afforded them diminished scrutiny, privacy, and some freedom to pursue their own projects. To this extent, common sense was a primary medium of complicity with the field (see Chapter 4).

Participants were thus directly confronted with common sense and reasonableness as social forces of the field itself: in their diagnosis and its implications for their person; in the ongoing visits to psychiatrists and clinics which were initiated by this diagnosis; in the assessments which were made (and repeated at intervals) to support receipt of social security benefits; and in the maintenance of a placement in 'the community'. It is hardly surprising, therefore, that common sense was itself the subject of reflection, as participants consciously worked to construct it, assessed it in others, sought to ascertain what it meant to psychiatrists or community nurses, and worried that they were demonstrating it appropriately. In this way, reflecting on common sense was another example of that mode of 'living circumspectly' — maintaining a routine, avoiding stress, taking medication, monitoring thoughts and managing finances — which Walton (1995: 164ff) identified as a distinctive feature of her participants' future orientation: 'To be circumspect is to look around watchfully, to be cautious and prudent' (ibid: 164). The need for common sense to be continually established and reiterated perpetuated this reflexivity. Paradoxically, then, the field sustained a 'hyperreflexivity' — itself a measure of schizophrenia's pathology — through a hegemony of common sense.

Bourdieu's conception of domestic space as the locus of a 'natural', 'self-evident' and 'common-sense world' (Bourdieu 1990a: 58), constituted by an internalized *habitus*, has clear resonances with the field of schizophrenia itself as institutionally defined and dominated. The attempt to 'normalize' subjectivities and practices was implicit in the field's focus on community/home as the appropriate setting in which people with schizophrenia should live their daily lives. From the perspective of government policy, what was 'normal' about being 'at home' in 'the community' was that it was a 'natural' and taken-for-granted location (see Chapter 3). Such normalizing practices and locations were also explicit in programmes offered by non-government organizations such as Clubhouse. These sought to teach people 'living skills', including practical exercises in daily routines and household management. When a person was deemed to be deficient in this respect they could draw on 'community support' personnel who came to the home and taught or augmented these skills.

If there was a *habitus* given by the field it was one which was unproblematically assumed by psychiatry and promulgated by a range of mental health services. To be or remain a 'client' or a 'consumer' — rather than a 'patient' — required a display of appropriate self- and household-management. The perceptions, dispositions, schemes of thought, ways of moving, and so on associated with schizophrenia were aberrant in respect of this normalizing ideal. Living in the community presupposed that these 'symptoms' had been removed, or at least sufficiently controlled by medication so as not to impede 'normal' functioning or appearances. Fieldwork in people's homes revealed, however, that many so-called 'symptoms' persisted (see Appendix 1), or were even sought out and elaborated if this could escape psychiatric attention.

Many of the people with whom I worked did not make common sense, because they did not live common lives. In particular , they had experiences which did not conform to socially approved 'rules' and 'recipes' by which such sense is constructed:

> We may say that a man acted sensibly if the motives and the course of his action is understandable to us, his partners or observers. This will be the case if his action is in accordance with a socially approved set of rules and recipes for coming to terms with typical problems by applying typical means for achieving typical ends. (Schutz 1962a: 27)

For Bourdieu, such a facility is given by the *habitus* which precedes interaction and everyday practice, and which provides the unconscious (that is, historical) grounds for what is reasonable and common sensical (Bourdieu 1990a: 56).

To insist that participants should make such sense — or that their lives could only be analyzed in terms of it — risked diagnosing them all over again. It would have meant disattending to what they were actually demonstrating about themselves, and adopting psychiatry's practical stance within the field. Thus, Kirmayer and Corin (1998: 212) characterize the process of diagnosis in North America as a 'private colloquy' in which the meaning of symptoms is assimilated to a 'clinician's diagnostic grid rather than reflecting a dialogical understanding of the patient's lifeworld'. From a study of therapeutic interactions they concluded:

> As the diagnosis did not build on current understanding of patient and family, it was likely to remain external to the person and of little use in organizing the structure and meaning of everyday life. In this Western context, communicating the diagnosis and leading the patient to accept it is a sort of pedagogical enterprise. The patient's task is to accept the authoritative diagnosis and he or she has little freedom or encouragement to rework it in a personal and creative way. (Kirmayer & Corin 1998: 212)

Such acceptance (and its demonstration through 'insight') is predicated on an acquiescence to the 'naturalistic perspective' of the dominant psychiatric paradigm (ibid: 213).[3] In this context, privileging the *habitus* given by (or presumed) by the field would only confirm the latter's domination by psychiatry and fail to reflect the actuality of participants' everyday and embodied worlds.

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[3] Kirmayer and Corin (1998: 214) note further that this also implies acceptance of a culturally distinctive construction of the person which emphasizes privacy, individualism, autonomy and self-control. See also Fabrega Jr. (1982: 56-7) and Gaines (1992).

RETURN TO EXPERIENCE

To attend only to the analytic framework of 'field' would be as limited and impoverished as attending only to the diagnostic framework of psychiatry. Both disguise how any particular 'lifeworld' escapes its theoretical determination. Jackson characterizes the lifeworld as,

> ... that domain of everyday, immediate social existence and practical activity, with all its habituality, its crises, its vernacular and idiomatic character, its biographical particularities, its decisive events and indecisive strategies, which theoretical knowledge addresses but does not determine, from which conceptual understanding arises but on which it does not primarily depend. (Jackson 1996: 7-8)

The phenomenological insistence that the lived immediacy of experience perpetually escapes the confines of theoretical elaboration and conceptual systematizing (Jackson 1996: 2-3) echoes participants' accounts of their extraordinary experiences, as well as their evasiveness in respect of psychiatric predications of their identity and their installation as 'clients' of (or 'stakeholders' in) the mental health service. It is in this way, also, that the 'radical empiricism' of phenomenology is an apt analogy for the ethnographic encounter as a practical, personal and participatory experience (see Jackson 1989: 3).

It was schizophrenia's perpetual escape from specificity — and participants' evasion of determinism — which has informed the broadly phenomenological style of this dissertation. Schizophrenia was difficult to grasp: there were no obvious physical stigmata and its lineaments were unclear to me, as well as to those who were diagnosed with it. It could only be revealed by each person making available relevant aspects of their life in its everyday settings, thereby bringing the ordinary and the extraordinary into mutual definition. I was unfamiliar with much of what was revealed in this way, especially the unusual perceptual phenomena, the traumatic backgrounds, and the on-going poverty. This was a new type of everyday world for me, much as some participants said it was for them as a consequence of the transformations which schizophrenia had occasioned in their own lives. This made attending to 'things themselves' a particular imperative (Jackson 1996; Crotty 1998: 78ff). Those 'things' were the phenomena — experiences, social positionings, material circumstances — which presented themselves to participants as integrally tied to their diagnosis, and which they presented to me as a means of understanding their situation. I was equally inclined by my background and training (including, importantly, the *absence* of any clinical or psychiatric training) to lay aside prevailing understandings of those phenomena and to attend to my immediate experience of them:

> Phenomenology asks us not to take our received notions for granted but … to call into question our whole culture, our manner of seeing the world and being in the world in the way we have learned it growing up. (Wolff 1984: 192)

This stance — more of an orientation than a methodology — was largely in accordance with participants' own concerns and orientations. They lived the imperative to rethink or abandon presuppositions, conceptual schemes and prior habits of thought. For them, schizophrenia represented a break with any familiar acceptance of the world as previously known from experience or socialization. They were compelled by the 'intentionality' associated with classical phenomenology, having a heightened appreciation of the relationship between subjects and objects (and of themselves as both). If consciousness is always a consciousness of something (that is, intentional in Husserl's sense) then participants exemplified the restless consciousness of consciousness itself. They were 'hyperaware', not just of their own subjective states (Sass 1992a: 228), but of being the object of psychiatry because of being this sort of conscious object to themselves. All of the psychiatric attention and treatments they had received highlighted the way in which their subjectivities were not just their own, as an object for themselves, but were also an object for others. Existential phenomenologists have extrapolated this (inter)relationship between a conscious subject and its objects to a consideration of the relationship between human beings and their world as an irreducible being-in-the-world. Schizophrenia is seen, by some, not just to problematize this relationship but to embody its transgression (see Binswanger 1963).

Participants' experiences and social situation combined to exacerbate the questioning of this relationship between themselves and their everyday world, as well as a range of other less obvious 'worlds' — 'the community', 'society', the 'psychic world', the 'otherworld'— which they saw themselves as inhabiting. It was this which led many of them to espouse a seemingly 'naive' existentialism, while some pursued it more actively and rigorously through reading and debate. It is this correspondence between their concerns, their circumstances, and certain philosophical principles which renders phenomenology such a seemingly apt vehicle for the analysis of schizophrenia (see Laing 1967; Sass 1992b; Walton 1995). Throughout this dissertation I have explored some of the social circumstances which gave this correspondence force.

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Through an ethnography broadly informed by phenomenology's dual aims of empiricism and critique (see Crotty 1998: 82-5), I have suggested ways in which it is possible to reinterpret schizophrenia, allowing it to reveal new and fuller meanings as a human phenomenon. Indeed, the 'first critique' (ibid: 85) embodied by this dissertation is that people diagnosed with schizophrenia did in fact have everyday lives, even if uncommon ones — lives which were not just 'schizophrenia', in the same way as they insisted that they were not just 'schizophrenics'. The 'reinterpretation' facilitated by this approach also suggests that schizophrenia may be a vehicle for reflecting on social theory itself, bringing forth new and fuller analytic tools.

As I noted in Chapter 1, schizophrenia exemplifies those extraordinary experiences which Shokeid (1992) seeks to reclaim as a neglected category of everyday life. The very distinctiveness of schizophrenia throws into relief the everyday processes which may go undetected in a variety of social domains. In particular, as I have demonstrated in Chapter 5, schizophrenia challenges and serves to highlight those processes by which the everyday is taken for granted, its hierarchies are maintained, and its struggles for legitimate representation and classification are disguised. Schizophrenia, I suggest, is a cogent vehicle for bringing to light and reflecting on those social categories 'which delimit what is thinkable, which predetermine thought, and which evoke [a] whole world of assumptions and presuppositions' (Duncan 1990: 182). Participants themselves recognized this as both its power and its threat. Moreover, schizophrenia's condensation of experiential, social, political, ethical and cultural elements makes for a particularly fertile analytic ground. At least in the 'community' setting with which this dissertation is concerned, schizophrenia fulfils all of the criteria of uncertainty, idiosyncrasy and privacy which Shokeid suggests (1992: 241) are the 'hidden scripts' which most tellingly reveal a culture and its constraints. Far from being an aberration of human life — marginal and of no social account — schizophrenia has the potential to be a major vehicle by which to revisit some of the most persistent questions of social theory. My ethnography has explored some of these, including questions of agency and identity, the relationship between structure and experience, and the construction of personhood. Questions of consciousness, intentionality, emotion, memory, objectivity versus subjectivity, the structured production of social action, and the capacity of action to modify social structures might just as fruitfully be informed and reinterpreted using schizophrenia as a lens.

CROSS-CULTURAL REFLECTIONS

Anthropologists have argued for the centrality of reflexivity in a range of cultural settings. Thus, Kapferer (1991) has highlighted the role of reflexivity in the rituals of Sinhalese exorcism: 'Major demon ceremonies … are performed under conditions where the ordinary and routine practices and characterizations of everyday life are created as problematic, and where many dimensions of a "prereflective", taken-for-granted world, are thrown open to examination' (ibid: 2-3). He argues that ritual comedy, in particular , is ‘internally reflexive’ in that the work of ritual specialists is ‘opened up’ and presented for cultural interpretation (ibid: 286). Such ritual also effects a ‘subjective distancing’ in which actors present ‘objectifications, constructs and typifications of the reality in which they participate and as they appear to view it’ (ibid). Both the performing characters and their audience are enjoined to adopt perspectives outside of their own particular subjective standpoint, and thereby to reflect on those standpoints (Kapferer 1986: 200). This is an intersubjective process because it highlights ‘the different and changing standpoints of the actors upon their own action and the actions of others’ (Kapferer 1991: 286). Kapferer argues further that ritual reveals culture itself as reflexive: ‘It is in performance that ritual gains its efficacy, and … reveals itself as essentially the “hermeneutic” of culture — a method whereby culture analyzes itself’ (ibid: 244). Many participants viewed schizophrenia, and attempted to use their experiences of it, in the same way.

If, as Kapferer argues, Sinhalese exorcisms cure by way of reintegrating the patient — psychologically, socially and cosmologically — with his or her everyday world then they offer a striking contrast to the isolation and dis-integration which participants in this study said were the consequences of their experiences, and of psychiatric diagnosis and treatment. Kirmayer and Corin (1998) similarly emphasize the gulf which exists between everyday and professional understandings of psychotic experience. In a North American setting they noted,

> … the fragmented, solitary, and uncertain character of explanations for illness offered by patients and their families. No encompassing framework was available to them through which they could explore and integrate the meaning of the illness. (Kirmayer & Corin 1998: 212)

The contrast is all the more striking given that some participants in the present study articulated sources of distress in their own lives which were similar to Kapferer’s Sinhalese patients, *viz.*: ‘Demons introduce an abnormal ordering of the world, confounding reality as it should … be comprehended and experienced’ (Kapferer 1991: 1). Like those patients, many participants in this study saw themselves as propelled into ‘an existential state of solitude in the world’, where everything was individuated and separated them from others (Kapferer 1986: 195). In Sinhalese demonic attack, suffering, misfortune, disease and illness find their own ordering — their own meaning and experience — in being structured by malign forces (Kapferer 1991: 1). This too was many participants' representation of schizophrenia. If the efficacy of exorcism is due to the central role played by reflexivity and intersubjectivity in its rites (as argued by Kapferer), then the absence of these processes from psychiatric treatment marks a particular point of contrast which is worthy of further analysis.

In being pronounced 'chronic', people with schizophrenia felt that they were rendered unable to reflect on or critique the very processes by which they were constructed as such; to do so risked a charge of 'lacking insight' and having the diagnosis reinforced. It was in this endless circle that their own voices had been de-legitimated by illness and its institutional sequelae. Thus Zöe complained:

> "[Psychiatrists] have a different view — that it [schizophrenia] is purely a disease, and that all I have said about it is the manifestation of the disease. It is not the truth at all. That's why I am called a liar... That's why I'm called mad."

Constituted through such repetitions, conceptual redundancies and double-binds, schizophrenia itself (as both a diagnostic category and a vehicle for psychiatric practice) was perceived by participants to rob them of a capacity to reflect on their lives, to speak of and through their experiences, and to have those experiences count as personally, socially and culturally significant. It was this attributed exclusion from the capacity to speak and reflect — and participants' reflexive awareness of the power of this exclusion — which marked their estrangement from self and others.

Like Kapferer, Parish (1996) argues for the centrality of reflexivity to culture, and especially for the human capacity to reflect on culture itself. He illustrates this by way of an ethnographic exploration of the agency and 'moral imagination' which emerges when Nepalese untouchables confront the 'violent strangeness' of their own caste system. He asks: 'If people's relationship to tradition is in some sense hermeneutic, and existential, what choice do they have but to interpret?' (ibid: 60). Like participants in the present study, Parish's informants were moved to interpret culture and self on the basis of personal experience, or personal reflections about the meaning of experience (ibid). They too were moved to do so by anxiety, doubt and the nature of their life-situations. Thus, while echoing Kapferer's (and Dumont's) observations on the way society must 'think itself', Parish relocates this reflexivity in individuals who must also 'rethink society' as human subjects in dialogue with their culture:

> Persons capture culture not in an entirely unmediated way, as if self and culture always form an identity, but rather grasp particular meanings in terms of other meanings, relate experience to experience, all in ways that reflect the fashion [in which] an actor actively engages a life that is always socially situated. (Parish 1996: 60)

This echoed the strategies, mediums and tropic devices which participants in the present study used to apprehend and convey not just their experiences but their overall 'situation' as people diagnosed with schizophrenia. This required a double presentation of themselves in terms of what others (especially psychiatry) said they were and how they understood themselves to be (cf. Rabinow 1977: 119). This was an inherently reflexive project, the imperative for which was greater for them than it was for me: they self-consciously lived with, and had to mediate, powerful ascriptions of who they were; I did not. It was also an intersubjective project:

> The self exists within subjective horizons that are not identical with a given ideology. The actor — as interpretive agent — grasps ideology through other meanings and experience, through a translation "into" consciousness, and a translation "out of consciousness": an active interpretive process both ways. (Parish 1996: 60)

To paraphrase Parish, one could say that participants had, of necessity, to translate diagnosis 'into' their consciousness and daily lives, and equally sought to translate their lives 'outward' from their own consciousnesses to whatever intersubjective and dialogic spaces they could achieve for themselves.

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APPENDIX 1

QUANTITATIVE DATA: DESCRIPTION OF THE SAMPLE

Appendix 1

DESCRIPTION OF THE SAMPLE

1.1 RECRUITMENT OF PARTICIPANTS

Contact points for the recruitment of participants are set out in table 1.

Table 1.
Source of participants

psychiatrists in private practice	9
self-referral	6
referred by another participant	3
general hospital outpatient department	4
psychiatric hospital outpatient department	13
community social worker	3
community nurse	8
community psychiatric facility	1
Schizophrenia Fellowship*/Clubhouse Inc.**	3
Total	50

* A non-government organization providing education, counselling and recreational support to people with schizophrenia, and their families.
** A non-government organization which runs a work-based rehabilitation programme for people with a range of mental illnesses.

The project began by requesting access to the case loads of both private psychiatrists and those working in the public health sector. These clinicians were told about the project, and requested to pass on information about it to any of their current patients who they thought would be able to participate. Potential participants were provided with written information about the project and invited to contact the research team if they were interested. The project was also promoted in a widely distributed newsletter produced by the state mental health service. Seven participants were recruited from a psychiatric outpatients facility where they were attending a Clozapine clinic for regular blood testing — all had been commenced on this recently introduced antipsychotic medication during the year prior to the study. As the project developed there was a diversification in the points of contact including liaison with nurses and social workers within community mental health teams, self-referral from people who had heard about the project and wanted to be involved, contact with people known to earlier participants, audiences at presentations for the Schizophrenia Fellowship, and meetings at other events which brought people with schizophrenia together. Diversifying the initial point of contact in this way was an attempt to recruit participants who were representative of the wide range of people with schizophrenia who live in the community.

It was made clear to potential recruits, whether they were introduced to the study by their treating clinician, community nurse, social worker or one of the researchers, that they were under no pressure to participate. It was anticipated the people with paranoid ideas would not wish to be involved because of suspicion and mistrust. However this was not the case and a number of people who were diagnosed with severe paranoid ideation or who had developed complex and long-standing delusional systems were eager to talk about their experiences. Instead there was a subgroup of people who did not wish to talk about psychotic illness, who actively avoided thinking about it, and who had previously suffered from symptoms which were both distressing and embarrassing. These observations are in keeping with the work of other investigators who suggest that acute psychosis in itself may lead to a form of post-traumatic stress disorder, accompanied by an active avoidance of all thinking or talking about previous experiences.[1]

At times it was necessary to decline offers or requests from several people to be part of the study, either because they did not fit the research profile, they held unrealistic expectations of the project's outcome (e.g. that it offered a 'cure' for schizophrenia), or they were unable to fully understand (and therefore consent to) the research programme.

The project also sought to meet with family members, spouses and/or friends who could provide additional perspectives on the participant and his or her illness. Overall we met with 63 people who were designated by participants as being in some way significant in their lives. For most participants we met with one additional person (range 0 - 5). For 12 participants we unable to meet with either a relative or a friend; it was notable that 5 of these participants stated explicitly that they did not want to discuss their experiences of schizophrenia with anyone else, or have others discuss it with us.

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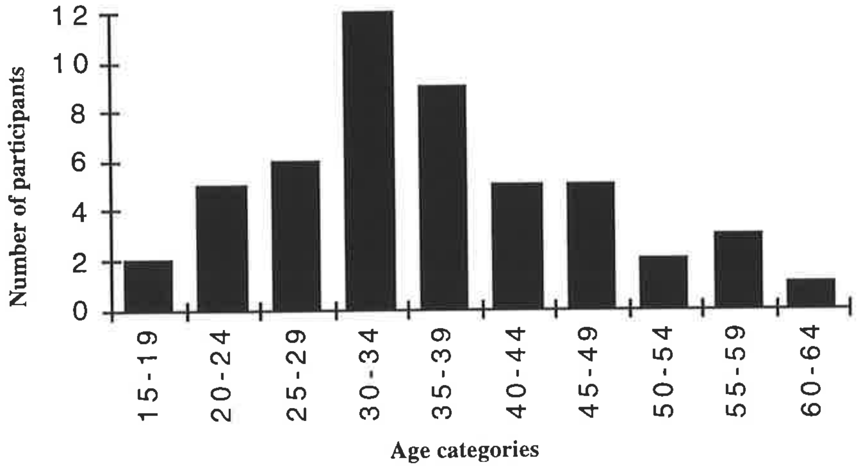
[1] See K. Shaw, *The Impact of Psychosis and Hospitalization in Psychiatric In-Patients*, RANZCP Research Dissertation, 1993.

Participants were met with formally on an average of 4 times (range 2-10 times). In addition, there were numerous casual encounters, chance meetings and telephone conversations which it was not practical to enumerate. The length of more formal sessions varied from 1 to 5 hours, depending on the interest and stamina of the people involved. For most participants this process was completed over the course of a month, but in some cases contact was maintained for much longer than this, the longest period of ongoing contact being 24 months.

1.2 BASIC DESCRIPTIVE DATA

Age: The mean age of the sample was 36 (range 18-63). The age distribution is set out in figure 1.

Figure 1. Age distribution of sample



Sex: There were 30 male participants and 20 female participants. This may reflect the well-established predominance of males with long-standing schizophrenic illnesses. The female participants were on average slightly older (mean age 37, range 18-59) than the male participants (mean age 36, range 19-63).

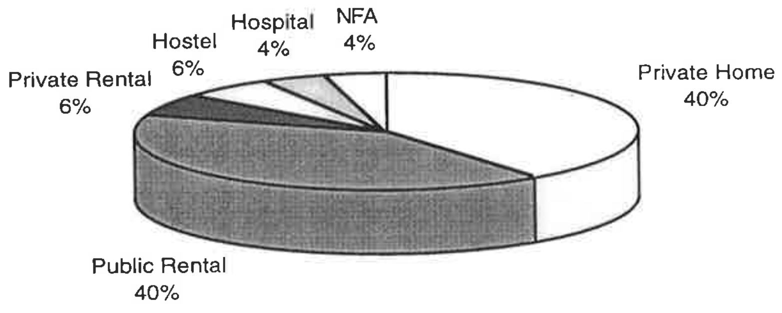
Marital status: The majority of the participants were not married. Thirty one (31) were single, 8 were divorced and 3 were separated from their spouses. Of the 8 participants who were married or living in a common law (defacto) relationship, it is of note that 6 were women.

Occupational status: No participants were involved in full-time employment over the time in which the research was conducted. Five were involved in part-time work, 6 in domestic work (home duties) and 5 were actively engaged in voluntary work as a significant component of their daily or weekly schedule.

Major source of income: The overwhelming majority of participants (44 of the 50) received a disability support allowance. Three (3) received superannuation pensions. One received sickness benefits. The two participants who did not receive any form of financial support were both married women who fulfilled domestic duties at home.

Residence: Figure 2.1 illustrates the types of accommodation in which participants resided when we began working with them. Forty three (43 or 86%) of the participants lived in a private home, either their own, their parent's, or a rental property. Three (3) lived in boarding houses or hostels. Two (2) resided in a hospital as part of 'transition' programmes. A further 2 participants were of no fixed address (NFA).

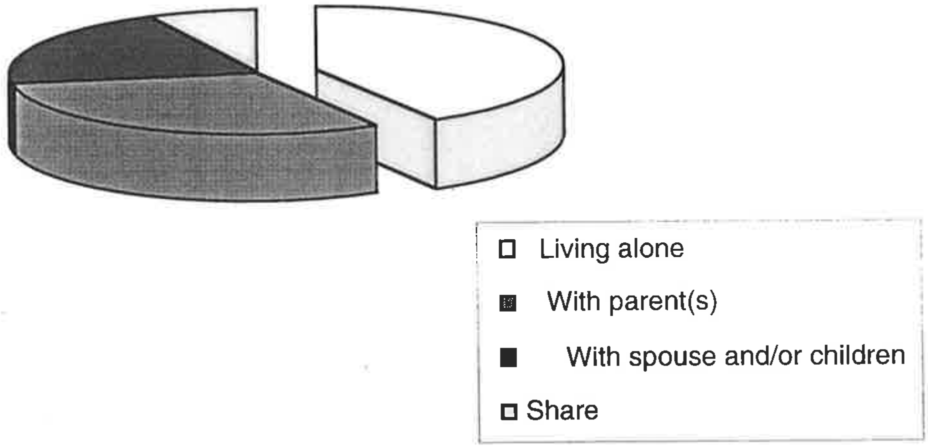
Figure 2.1. Residential type



Of those 43 participants living outside of hospital or supported care, 18 (42%) lived alone, 13 of these in public housing and 5 in privately owned accommodation — see figure 2.2. Thirteen (13 or 30%) of these participants lived with a parent or parents. Four (4) participants lived with a spouse/partner and children; 3 resided with a spouse/partner only; and 2 had only their own children living with them.

Over half of all participants (27 or 54% of the sample) were not living with a family member or a spouse.

Figure 2.2. Residential living arrangements

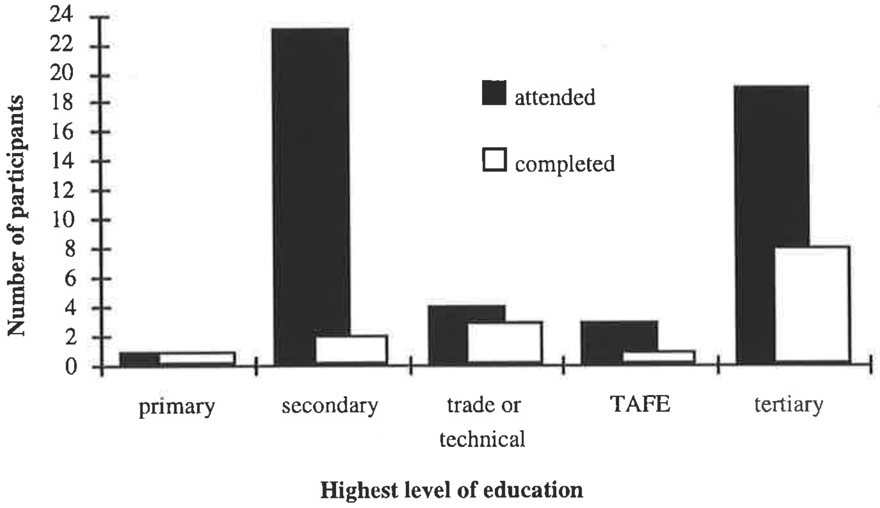


Of those participants living alone, 17 received community support in the form of nursing services, care worker visits, or social work support. Such services were often the focus of regular structured activities such as shopping, assistance with house work, or going to the cinema.

<u>Educational status:</u> One (1) participant was educated only at a primary level, 23 at a secondary level, and 4 had undertaken trade or technical training. A further twenty-two (22) had in the past pursued some level of tertiary education, and of these, 9 had attained a qualification. This was sometimes achieved over an extended number of years interspersed with illness or hospitalization. Seven (7) participants were involved in further tertiary education (either Adult Education, Technical and Further Education [TAFE], theological studies or university courses) during the period of

research (1994 - 96). Figure 3 sets out the educational achievement of the 50 participants, showing the highest level attempted and the corresponding completions.

Figure 3. Educational achievement



The sample included a relatively high number of people who were or had been involved in tertiary education. They had been referred from a range of sources including private psychiatrists (5), a general hospital outpatient service (3) and psychiatric outpatient and community services (7). It is notable that of the 8 participants who referred themselves, 7 had been involved in tertiary education.

1.3 PSYCHIATRIC ASSESSMENT

Structured psychiatric assessments were conducted with all participants. Psychiatric research data were generated by use of the Present State Examination (PSE), the WHO Disability Assessment Schedule (DAS), the Schedule for the Assessment of Positive Symptoms (SAPS), the Schedule for the Assessment of Negative Symptoms (SANS), and the Behavioural Observation Schedule (BOS). All assessments were conducted by a psychiatrist (R. J. Barrett) trained in the use of the PSE.

Because the methodology of the project (which privileged participants' own understandings of their experiences) demanded that a largely unstructured and undirected narrative be elicited first, formal psychiatric assessments were positioned as one of the last formal meetings with participants, rather than at initial contact. This had the following advantages:

- Participants' accounts were not preempted by structuring them into a standardized psychiatric format which would tend to focus on standard symptomatology such as auditory hallucinations and delusions, or the chronological elaboration of symptoms and disability.
- Firm working relationships had already been established when the psychiatric assessments were conducted. This meant that participants were more willing to expand on their experiences during structured interviews.
- By this time, the researchers had a greater store of knowledge by which to interpret responses to the interview schedules.
- Having prior knowledge from the ethnographic data collection meant that we are also able to compare accounts within two differing contexts — the informal, open ended dialogue and the formal psychiatric interview.

As a result of this psychiatric assessment the diagnosis in each case was established according to DSM III-R[2] and ICD 10[3] criteria.

1.3.1 Illness characteristics

Age of onset: The mean age of onset was 24 years (SD 8). The earliest age of onset was 12 years and the latest was at 55 years.

Length of illness: Illness duration varied widely. The average length of illness was 12 years (SD 8). The shortest duration was 2 years and the longest was 40 years.

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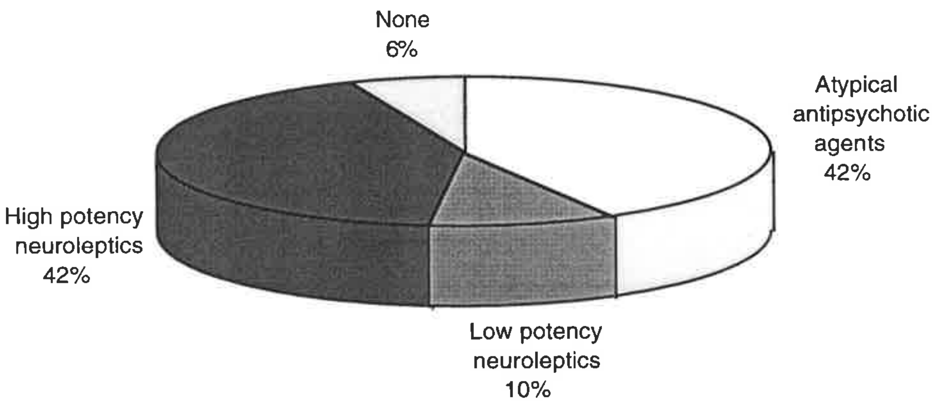
[2] Third (revised) edition of the *Diagnostic And Statistical Manual of Mental Disorders* (1987), the official classification of mental illnesses published by the American Psychiatric Association.

[3] Tenth edition of the *International Classification of Disease* (1992), the official list of disease categories issued by the World Health Organization (WHO); subscribed to by all member nations, who may assign their own terms to each ICD category.

Medication: Three (3) of the 50 participants were not taking antipsychotic medication during the period of research. Twenty one (21) were receiving the newer, so-called 'atypical antipsychotics': clozapine (15) and risperidone (6). All of these participants had previously been prescribed 'conventional' antipsychotic medication.

Current medication use across the sample is set out in figure 4.

Figure 4. Medication

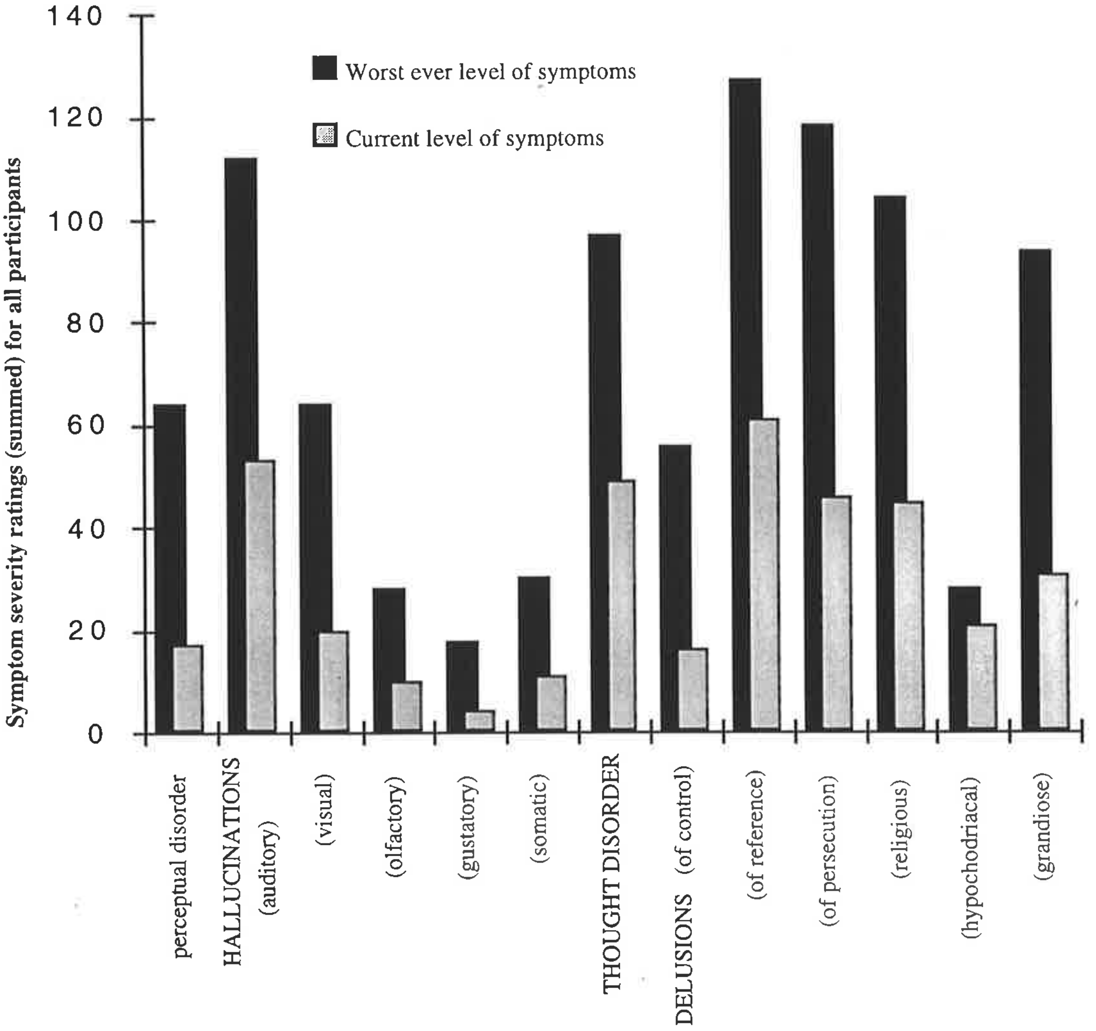


The low potency neuroleptics taken by participants in this study were chlorpromazine, thioridazine and pericyazine. High potency neuroleptics included fluphenazine, haloperidol, trifluoperazine, pimozide, thiothixene and flupenthixole.

1.3.2 Symptom Profile

Figure 5 sets out the symptom profile of the sample. It is based on ratings derived from the Present State Examination (PSE). This figure compares 'worst ever' with the level of symptoms at the time of assessment.

Figure 5. Level of symptoms (rated on the Present State Examination)

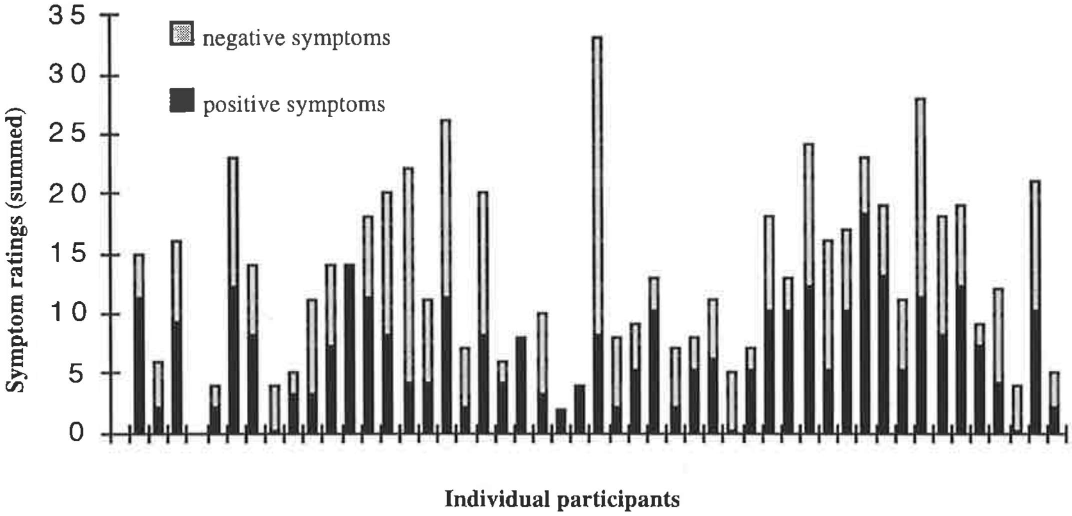


Auditory hallucinations, thought disorder and delusions were prominent. It is of note that delusions of reference were a particular problem for this group of people, and that many participants were still encountering difficulties in relation to this symptom during the period of research. Figure 5 also demonstrates that this was a group of people who were living with active, ongoing symptoms.

Figure 6 demonstrates the same finding by means of different instruments: the Scale for Assessment of Positive Symptoms (SAPS) and the Scale for the Assessment of

Negative Symptoms (SANS). It displays the total symptom level for each participant, showing the relative proportion of positive and negative symptoms. Of the 50 participants, only 2 were symptom free at the time of assessment.

Figure 6. Positive and negative symptoms



Positive symptoms of schizophrenia (as rated by the SAPS) include:

- auditory, somatic or tactile, olfactory and visual hallucinations;
- persecutory delusions, delusion of jealousy, guilt, reference or control, religious delusions and grandiose delusions of special powers and abilities;
- thought broadcast, thought insertion and thought withdrawal;
- bizarre behaviour such as conspicuously unusual clothing or appearance, inappropriate social or sexual behaviour, aggressive or agitated behaviour, and repetitive or stereotyped behaviour (in which actions or rituals must be performed over and over); and
- formal thought disorder: derailment, tangentiality, incoherence, illogicality, circumstantiality, pressure of speech (where speech is rapid and difficult to interpret), distractible speech (where speech is interrupted by nearby stimuli), and clanging (in which sounds rather than meaningful relationships govern word choice).

Negative symptoms of schizophrenia (as rated by the SANS) include:

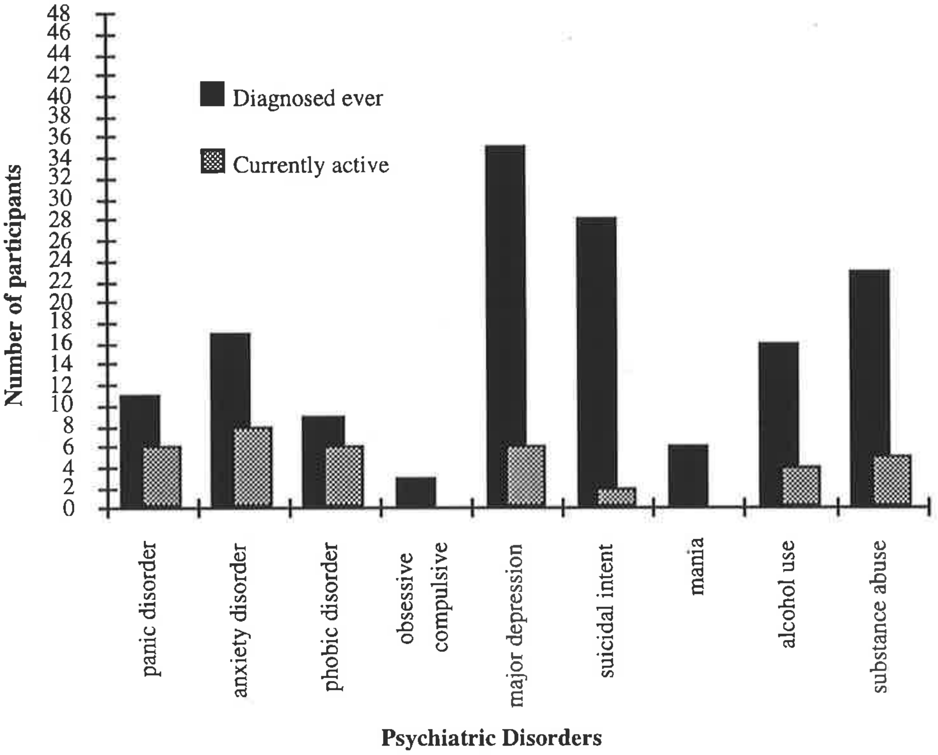
- affective flattening or blunting demonstrated by an unchanging facial expression, decreased spontaneous movements, a paucity of expressive gestures, poor eye contact, a failure to laugh or smile, inappropriate or incongruous affect, and a lack of vocal inflections;
- alogia, including poverty of speech, blocking or interruption of the train of thought, and increased latency of response (taking a long time to reply to questions);
- apathy in the areas of grooming and hygiene, impersistence at work or school, and anergia (being physically inert);
- asociality, including few recreational interests and activities, decreased sexual interest and activity, inability to form close or intimate relationships, and isolation (having few or no friends); and
- attention deficiencies, including social inattentiveness (appearing uninvolved or disengaged), and being inattentive during psychological testing (such a subtractions and spelling).

1.3.3 Co-morbidity

There was a high level of co-morbidity in the group, with 47 of the 50 participants having satisfied diagnostic criteria for other psychiatric disorders at some stage during the course of their schizophrenic illness. In 20 cases two other psychiatric disorders had previously been diagnosed.

At the time that assessments were conducted, other psychiatric disorders continued to be a problem for many participants. Twenty (20) of the participants were experiencing symptoms associated with the anxiety-related group of disorders (panic disorder, anxiety disorder, phobic disorder and obsessive compulsive disorder). Six (6) were experiencing active symptoms related to major depression, and 2 were suicidal at the time of assessment.

Figure 7. Co-morbidity

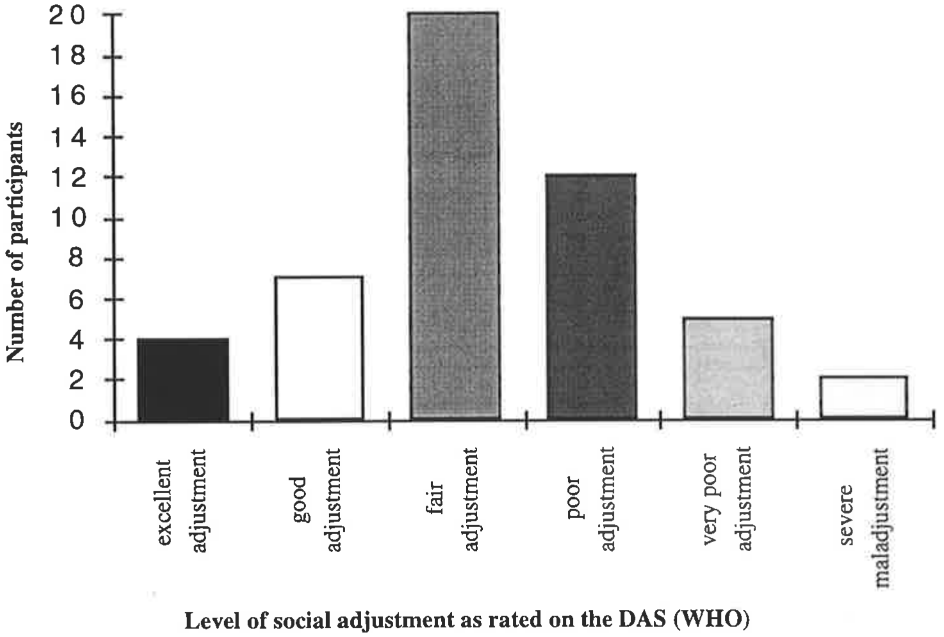


It can be seen from figure 7 that the most commonly related disorder was major depression associated with suicidal ideation. Thirty five (35) of the 50 participants had experienced an episode of major depression at some time in the course of their illness. Suicidal ideas and behaviour were also a problem. Twenty eight (28) of the 50 participants had attempted suicide at some time in their history and a further 8 had seriously considered doing so. It had been common in the past for nearly half of the participants to use substances (chiefly marijuana, and to a lesser extent, alcohol) to a debilitating extent.

1.4 OUTCOME

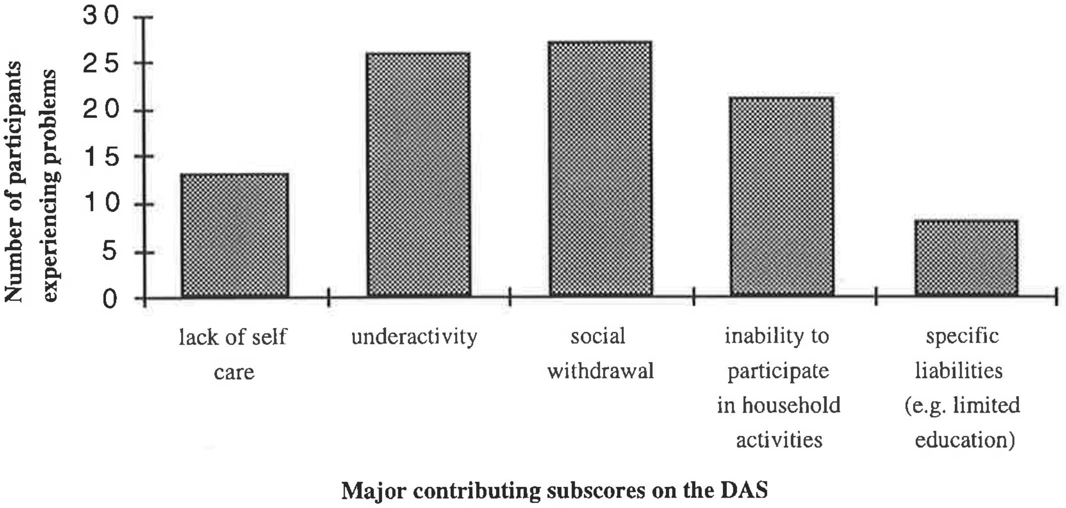
Several measures of outcome were used in the project. Symptomatic outcome was measured using the Present State Examination (PSE), the Scale for Assessment of Positive Symptoms (SAPS), and the Scale for the Assessment of Negative Symptoms (SANS). Social functioning was measured using the World Health Organization Disability Assessment Schedule (DAS). The social functioning profile of the sample is set out in figure 8, based on global ratings from the DAS.

Figure 8. Level of social adjustment



The major subscores on the DAS which contributed to an impairment in social functioning were underactivity and social withdrawal (and to a lesser extent, difficulties in contributing to ordinary household activities). Figure 9 shows the number of participants that were experiencing problems in each of these respective areas.

Figure 9. Most common problems identified by the DAS



APPENDIX 2

‘VOICES’

Appendix 2

'VOICES'

The following are a selection of participants' accounts of 'voices', either in their own words or drawn from my notes (the latter being rendered in full italics). This listing does not include all of the numerous accounts and comments which were elicited during the course of research. It is, however, broadly representative of such accounts.

The headings under which they are grouped here are not exhaustive of all the possible ways in which participants talked about their 'voices'. Some accounts could not be categorized in this way at all. However, the headings do identify the most prominent recurring motifs which emerged from comparing the accounts of fifty participants.

Nor are the headings mutually exclusive (as is indicated by the appearance of the same participants under different headings). Many accounts of 'voices' were predicated on a process of change and transformation (see Chapter 7) which rendered them inimitable to definitive classification.

1. **SPEECH**	**a)** Roland They sound like every day voices. The ones that I actually hear, that I've got no control over, sound like everyday voices.
	b) Michele They come from outside ... It's like being on a telephone sometimes. We all hear 'voices'. [When they are] at a constant pitch or level you are just normal, but the 'voices' become troublesome when they become nasty and that's when you get disturbed and all the stuff starts and you might start hallucinating.
	c) Adam I'm a real heavy telephone abuser, because it's just like the 'voices'.

	d) Kate It's just like people talking, but I can hear them coming through the radio. The music's still there, but the 'voices' are there as well, usually in the background, but sometimes it's really full on and really close.
	e) Shaun It has to do with neural transmitters. There is a voice centre in the middle of the brain. It controls inner voices and speech. It is the language centre for the brain. Schizophrenia is the cost of mankind becoming communicative. This centre misfires on a neural level so you get fissures in the inner voices. Your identity fizzes out and you get ghost voicing. The medication bridges the neurotransmitters to get the correct firing — to get the brain cells to fire correctly.
2. WHISPERINGS	**a)** Shaun *Do they sound like real voices?* They don't have middle tones. They are more like extremely faint whispers — micro-whispers. They don't have anything like the middle tones of speech.
	b) Michele ... it sounds like whispers coming in at you. I can't make out the tone, can't make out if it is male or female.
	c) Paul [*His 'voices' were 'whispers' coming from a distance which he estimated to be 50 metres or more away.*] They are just this slight whisper that you have to concentrate on. *Asked how he could hear a whisper over such a distance he replied:* I don't know. There is a lack of clarity, so I have to work hard on what the words might be ... Words sound the same sometimes ... you're making assumptions about whether it's that word, or it could be some other word in a different context ... I just think in my head and a little 'voice' [comes] — sometimes a whisper, and I can't understand it. It's always whispered, it's very hard to hear ... It's like my thought processes are audible in a whisper outside my head to my hearing, but in a female's voice.

	d) Roland … it was more than a feeling, it was almost like someone was whispering in my ear saying, 'Don't go there, go here'.
	e) David They were just like — it was just like small whispering voices — [that] sort of thing, you know. *And where did you appear to hear them from?* In the other rooms, I suppose you could say. Yes … The next room. *Could you ever make out what they would say?* No, never, no. … *Did they sound like real voices?* No, just like, 'pss, pss, pss'. Like whispering, like that, sort of … Just making that sound all the time.
	f) Oscar Keith Richards spoke to me in mum's bedroom — [*he imitates:*] 'pss, pss, pss'. *How did you know it was him?* Because I am a Stones fan and you listen to his voice on LPs … you can pick up the nuance. He sort of whispered in a certain sort of way which indicated that it was him. [It went on for] 5 minutes, then cut out.
	g) Tony The aliens speak in extremely subtle voices. I call them a whisper.
	h) Aiden The 'voices' are a lot clearer if they're spirit guides … I mean, I can actually hear them, like I can hear you. They're very audible. Whereas the schizophrenia 'voices' are more whisperings, murmurings, that sort of thing.
3 THOUGHTS	**a)** Christopher It's like hearing your thoughts. You've got this inner sound — [an] inner voice. It's within you and you repeat it to yourself — and it's like hearing that inner voice … That didn't last too long — it came outside the head, it turned from inside the head to outside the head.

b) Lawrence
I have obsessive thoughts where I think about things repeatedly during the day. I don't know whether those thoughts are — because they are so repetitive — whether or not they're classified as 'voices'. There's not very much I can do about them, they just seem to be there.

c) Peter
I remember when I heard my first 'voice'. That was a friend of mine's mother — I was walking past her house and it was the first 'voice' I heard. And it went on from there ... I don't know if she was there or not... [I] can't remember what the words were. It was hostile ... I got a bit of a shock ... I thought she must have been looking through the window at me, as I was walking by on the street ... It was just her thoughts, I guess ... They were her thoughts towards me in [the form of] a 'voice' ... She didn't say it out loud ...
I started hearing 'voices' after that, from everywhere. They weren't — not enemies, not frightening voices, not threatening or anything. [They] just wanted conversation or something ... I can't remember [what they said], just everything you could imagine. [They came] one at a time ... I think everyone hears 'voices', if you listen. [Most people are] too busy to listen.

d) Jeff
... but they're not actually voices, they're thoughts in your mind. I still get them, I had them today and I had them yesterday. They say things about me and Raelene [*his wife*] , they try and make you feel guilty.
Are they your thoughts or someone else's?
It's hard to tell. Sometimes you think that it's telepathy. I can be watching TV and start to lose interest in the TV because of the thoughts in my mind — that's when I go out and paint. Sometimes they come on so strong it doesn't matter what medication you're on. They come into your mind so strong and so fast — 'tell her to go and get stuffed'. I'm shocked and I try to ignore it.

I didn't know what 'voices' are. When you go to hospital and ... when you get admitted they ask you, 'How are your 'voices'?' I used to say, 'I'm not having 'voices', I'm just having thoughts'. The thoughts were in my mind.

4. VISIONS	**a)** Michele The ['voices'] appeared everywhere — the monks, the doctor who chairs committees — and then they all started. I could see them — they were over-exposing, making their presence felt and they were just appearing.
	b) Roland [*The 'voices' appear sometimes.*] I just see them … Sometimes I see them very clearly, other times — if you've seen a camera lens and you put a milky [screen] on it — sort of like that. So it's sort of like seeing people through a hazy mirror. You don't see them totally clearly, but you see them.
5. A COMBINATION OF MODALITIES	**a)** Jack Have you ever heard of schizophrenics having 'voices'? I get one voice which is my own voice. *Is it just like the thinking voice in your head?* Yeah, but when you've got schizophrenia it's a bit different. I say to myself 'that's a load of bullshit' to half the things I hear. They say I should have a go at my father. I don't know if it's a 'voice', it's a feeling I have. I don't know if they are thoughts. I see pictures in my mind. Pictures and 'voices' mixed together.
	b) Christopher [*Recalling a transformation of the 'voice' from 'thought' to an internal 'mantra' which he himself did not produce, to external speech. The designations 'inside' and 'outside' remained perplexing.*] Initially it was my own [thinking] voice, and then the next thing that happened it was a mantra going on inside of me, and then it changed to a 'voice' outside of me. The mantra inside, and a 'voice' outside … From what I gather this 'voice' is some way related to my inner voice, except that it is out there.
6. DISTORTED FORMS OF LANGUAGE	**a)** Michele [The 'voices'] call it 'high velocity' — [it's like] hearing voices in a high pitch.

b) Christopher
I hear the voice out there and I know that it can't [be].
And what does that voice sound like?
That's another part of the problem because it sounds like a little girl, or a little woman, something like that … From what I gather this voice is some way related to my inner voice, except that it is out there. And it is childish too.

c) James
Why [do you call the 'voice'] 'young baby'?
You know when a kid … starts to learn how to speak — that's the way it speaks … in-between — when they start off talking — it's just like that.

… it sounds a bit like [*his niece, who died as a baby*]. My niece never talked too much … but it sounds like her if she did talk [*i.e. if she could have talked*] … If she could talk … she would talk like that.

d) Lawrence
[*Listening to the 'voices' is like a child listening to adult conversation — not everything is comprehensible.*]
When you are a child you hear voices and you might not understand what they are saying. Your intellect or whatever hasn't developed and you don't really understand the vocabulary — maybe that's a bit similar [to the 'voices'] … I couldn't understand what they were saying. But it sounded like a memory or something — of my parents [talking].

e) Peter
… I do hear 'voices' through the birds. There's a woman up in Alice Springs called Patsy, she's an elderly Aboriginal woman and she talks to me through the birds. She says, 'come here'.
How does it work that she talks through the birds?
I don't know. She must be a very powerful woman. She must be very clever. The birds talk to me and say what she's saying. A possum talked to me once through her, yeah. The possum said, 'come here sweetheart' [*he laughs*]. I went to Alice Springs and saw her then.
Is it any particular type of bird?
Parakeets. Sometimes she says bad things. If I decide to eat something she might say that it's bad or whatever I'm doing. I think it's impossible to say 'good' through the birds, 'bad' is easy to say. They just seem to be able to manage that word easily.

	f) Zöe I always hear my mother as a owl, calling out: ‘I love you’, ‘I love you’, ‘I love you’ … [*loudly, repeated several more times, with a distinctive cadence*]. That’s my mum — she’s an owl. It pisses me off ’cause it’s worrying me — I don’t want her to worry so much. *What is the owl-like quality — it’s repetitiveness?* Repetitiveness — there are 3 or 4 variations, and it’s always in the morning and whenever I am distressed and if I am doing something naughty [like] having some alcohol or something [*laughs*]. She picks up my nervousness and translates it back to me with, ‘I love you’, ‘I’ll help you’, ‘I do it for you’. When I told her, ‘hey mum, stop sending your owls over my place’, she says that there are birds everywhere. She’s a witch … It’s her, translated into an owl, because of her age — the crones … those classic fairy tale sort of images … It’s a reality.
7. ANOTHER CONSCIOUSNESS, AGENT OR BEING	**a)** Michele A ‘voice’ did say to me once, ‘I am God, you are talking to God’. I know that I’m talking to people, though. My reverend says that God talks to us all. [*‘Voices’ are ‘real’ people instructing her about her life, especially how to improve herself. She is not sure how they do this, but proposes ‘telepathy’ as the most likely mechanism.*] All the time I hear ‘voices’ … they would be saying ‘we’re trying to make you clever’. They would say incredible things — it’s called ‘conversant’ when we talk like this — and they told me little strategies and little plans — how to do things — but I can’t practice any of them because I’m too hopeless, because I can’t do my work plus listen to the ‘voices’ and try and be clever. They were helping me, but I couldn’t do it because I just haven’t got the brain capacity, thinking so slowly on the medication. The ‘voices’ got very cross and disappointed with me because I didn’t recognize them. Many times I was asked to go out and meet the ‘voices’, but I won’t go because it’s too dangerous. They say ‘come out and meet some decent people’. They have not told me [where to meet them] — they have kept it very secret and I don’t blame them at all. Somebody’s been trying to find me a husband. That’s another big problem — the ‘voices’ are trying to pair me off and get me married me off.

b) Oscar
It was in my best interests to listen ... to the comments because, if they're aliens and they can communicate with me and they've come here, they've got superior technology, so it's in my best interests to learn from them. Not only that, over the years I've found it's in my best interests as a non-schizophrenic and as a schizophrenic to listen to anything anybody's got to say — one, to learn from it; two, to consider it; three to acquire more skills in the living as a human being on this planet ...

c) Zöe
The nasty things I hear are usually internal, and that's because the people who have swapped with me have left themselves inside of me and it goes straight into my left heart, or my centre heart. And I might feel painful, hurt, and not understand why, and then I suddenly realize — someone's started saying something nasty to me through the inside of me.

They emanate from inside my body.
Do they tell you to do things?
Yeah — steal. I knew this girl ... she's a kleptomaniac. She off-loaded her fat self on to me ... I feel porous about any sort of negativity. She said something to me one day and it rubbed me up the wrong way ... then I was a bit of her and she was a bit of me. Of course, she walked off with the best parts of me and I walked off with the rotten parts of her, so ... she has left a little bit of that kleptomania in me.

d) Shaun
During the time of 'spiritual happiness' which precedes an 'attack' of 'psychosis' [his term] he begins to hear 'voices', which he believes are other people who have the power to communicate directly with the deepest and most interior of his thought processes. The problem comes when he starts responding to these thoughts/'voices' That's when he gets into real problems and slips into psychosis, which is a state of being controlled or 'driven' by other consciousnesses. He thinks these 'voices' represent people who are more powerful than him, but who are also malicious.

	e) Adam I now have friends in my mind after listening to 'voices' for years. I have fun with them and they have fun with me. It is a brutal but cheerful world. In that world everything you hear affects your emotions. There is no distress and it is a very lively inner persuasion. [The 'voices'] discuss everything I experience and are not living like human beings. They are attuned to me and study my development. They tell me stories and treat me like a child. All I have to do is be on their side. I know that I have climbed a mental mountain and looked into the horizon from there. I have friends and we discuss immortality and living forever or religion and the mystery of creation. The 'voices' like that … Life for the pen is busy and the 'voices' say they read and copy what I write and read it to themselves.
	f) James *How do you explain these 'voices'?* What's happening in my head?. It's two people, from a family, and they're all bitching with each other, fighting with each other. One's saying, 'do this, do that', and my inner self is saying, 'If you do this you'll be put into jail' … two 'voices' and myself … The inner self is my voice — my own voice — and the two people are the 'old man' and the 'young baby'.
8. FROM ANOTHER PLACE	Roland They sound like they're in other places. To me it sounds like — it's as if I was some sort of telepath that didn't have any control, you know, and some being somewhere else, from England, was talking to me, you know, or something ridiculous like that. [*Asked if he thought that the 'voices' could come from somebody in the same room he replied:*] It's more like it's something distant, you know? Gee, that'd be terrible if I heard it like I was listening to you in the room all the time. I couldn't cope with something like that … I mean, they might come from another spiritual plane, but they might be hanging around in the next room or something.

9. FROM ANOTHER TIME	**a)** Oscar I might hear a voice from a little boy that I knew, and he'd grown up ... They'd grown up [*but they said things which indicated their identity from Oscar's childhood*].
	b) Lawrence When I was unwell I might have heard 'voices', but they sounded unreal. They might have been actual phenomenon that was in the world, but to me it seemed unreal. They sounded distant and very, very peculiar... *How were they 'peculiar?* Disturbing. I don't know — they sounded almost like voices that I heard as a child. Yeah, that's what they sounded like ... Like, I heard voices in the house, the voices of [my] family, and it sounded like it was coming from a long time ago.
10. DURING SLEEP, BUT DISTINGUISHED FROM DREAMS	Gerald [*'Voices' are a group of presences who 'tap' into his sleep.*] I don't know how all this came about, that I could remember, but when I woke up of a morning, I just reflected and thoughts started to go through my mind ... I thought I was remembering conversations from the night before, and I thought then I was being, as it were, tapped in my sleep ... I thought Adelaide's high society taps me in my sleep. I don't know how, but I still believe it happened. *What do they do to you? They tap you?* Tap me — speak to me in my sleep. They give me some medication, in the ear somehow, that I'm put to sleep, but they can talk to me and I can talk back. I don't know how they do it. I mentioned it to my psychiatrist, and he said he didn't know of any drugs that could do that, so he said ... I was probably wrong. As far as I'm concerned, they have done it, and as far as I know, they still do it.

	… a woman's voice — I assume it was Mrs Smith [*a 'socialite' whose photograph he had seen in the local newspaper*] — said, 'You're Jewish', and I said 'Am I?' Then I said: 'Is Jacqueline Bissett?'. I'm Jewish, I wanted to marry Jacqueline Bissett … so I said, 'Is Jacqueline Bissett?' and, next thing I know [*laughs*], they got on to her on the phone [*laughs*] and she was talking to me, and the word she said was: 'Hello handsome'. I didn't say anything, so Mrs Smith said, 'sing'. I sang in my sleep then, and it was with a beautiful bass voice … So I sang the song 'Pretty Flamingo' to Jacqueline Bissett, and as far as I can tell, she fell in love with me then … She was trying to hide it a little, not give herself away, but I believe she had been struck by me, maybe not to the extent that I thought, but I thought to myself, 'I've got you babe', so I sang that song too … So I sang that to her, and some of the people over in where Jacqueline Bissett was started to sing a couple of the words too. And Bob Hope was there. I was being tapped in my sleep as far as I understand. And the people of high society, from where they were doing it, rang up America and others came through that way.
11. NOISES, OBJECTS, BACKGROUND EFFECTS	**a)** Billy *In 1964 he was following people in the street, getting messages from their feet. He would focus on the movement — left, right, left right [he demonstrates a marching movement with his hands] — and follow in step. They were 'marking time', and voices came in time to the marching feet. If he stopped the 'voices' would stop; if he kept walking the 'voices' came back. These 'voices' said 'good things'—they were part of the key to the whole situation.* *As a consequence of following people around, Billy was picked up by the police and detained in gaol. The next day a doctor came to see him. During the interview, as the doctor made notes, the pencil talked to him.*

	b) Christopher First of all I wouldn't hear that mantra, but I would go to say something, repeat it, and that voice would say that mantra in its funny way — in a funny way — funny unusual. There was a time when I heard the mantra going on inside of me … I tapped into this sound going through my eardrums, and the mantra was in the sound … It was going on inside of me and I just tapped into it, and I'd hear it and I'd get high on it. At the moment what happens is that I tap into the sound, but there's no mantra there … I tap into this unstruck sound — I call it an 'unstruck' sound because it's not caused by anything. That's how I understand it, it's not caused by anything, it's just there in the eardrums.
	c) Oscar There might be a clicking sound, putting on the kettle. The sound of boiling water — that would resonate. It had a harmony to it. 'Cause I like music. It seemed to have a harmony. Or say, turning on a radio would have a definite click — so noises were sensitized to the extent that they were very, very definite … There was some significance in the sense that they made very definite sounds that were usually precursors to a form of conversation between me and the 'voice'. *How long would that last before the 'voice' came along?* Oh, well, the 'voice' didn't always come on, but, oh, ten seconds. They are an attention-grabber, too. It's as if there is going to be a jazzy song coming through live, or perhaps a 'voice'.