Narratives of Recovery from Serious Psychiatric Disabilities: A Critical Discourse Analysis

Michael A. Mancini
St. Louis University
mancinim@slu.edu

Rebecca Rogers
University of Missouri St. Louis
Rogers3948@aol.com

Abstract

We analyzed separate interviews of two adults about their experiences with psychiatric disability, the mental health treatment system and recovery using critical discourse analysis (CDA). Our goal was to contribute a more detailed portrait of the process of recovery from serious psychiatric disability by exploring the commonalities and departures within the interviews. To foreshadow the conclusions, each participant's representation of self shifted across two domains. Furthermore, these representations shifted reflexively with changes occurring in their environments and social support systems. This research sheds light on the nature of disease-centered subjectivities and the construction of practice and policy contexts that build on the domains where the adults demonstrate the greatest agency and ability. Practical implications for mental health research, policy and practice are shared.

Key Words: mental health; critical discourse analysis; consumer narratives

1. Introduction

Despite historical misconceptions regarding the chronic and hopeless state of people diagnosed with serious psychiatric disabilities (SPD) such as schizophrenia, bipolar disorder and major depression among others, a recovery paradigm has emerged recognizing that people with these disabilities can and do recover to lead independent and meaningful lives (Anthony 1993). Since the emergence of this paradigm, empirical studies have discovered that an individual's subjective conception of self plays a critical role in this process (Davidson and Strauss 1992; Mancini 2005).

We used critical discourse analysis to analyze personal interviews with two adult psychiatric survivors discussing their recoveries from SPD in order to explore how their subjective sense of selves shifted throughout the process of recovery. We explored the similarities and differences in the discourses surrounding their recovery narratives at two points in their recoveries with the purpose of helping service users and professionals to better understand the importance of identity and language in the recovery process.

The research questions that guided this paper were: What are the ways in which psychiatric survivors position themselves in the different phases of their recovery from serious psychiatric disability? How do their subjectivities shift throughout the recovery process in relation to their environmental contexts? In the following sections we provide a review of research on the recovery process. We then describe our methods and outline our findings. We

conclude with a discussion of implications for mental health practice, policy and future research.

1.1 The recovery paradigm

The recovery paradigm that has recently emerged challenges the assumptive world of professions and institutions and especially the 'medicalization' of mental health needs by broadening the traditional conceptualization of psychiatric disability and recovery. This paradigm views recovery as a deeply human experience that involves hope, and an internal sense of well being, independence, and self-worth (Anthony 1993).

Studies examining first-person accounts of people who have experienced recovery have found that the subjective transformation of an illness-dominated sense of self to one that is defined as competent and agentic is an important part of the recovery process (Mancini et al. 2005; Davidson and Strauss 1992, 1995; Estroff 1989). For instance, Davidson and Strauss (1992) conducted semi-structured interviews with 66 current and former consumers and found that rediscovery and reconstruction of a competent sense of self was crucial in recovery. Davidson and Strauss (1992) illustrate that participants described a process where they began to look inward and fight against what they had come to believe about themselves and 'rediscover' those aspects of themselves that they lost due their treatment as psychiatric patients. In the end, participants attributed a large part of achieving and maintaining their recovery to the development of a more functional sense of self.

We rely on a conceptual framework of recovery developed by Ralph (2005). Using a six-phase model, Ralph describes a process whereby an important part of a person's recovery involves a transformation from a sense of despair and anguish over one's illness to a sense of well-being and recovery (Ralph 2005). In this model a person begins in a 'despair and anguish' phase characterized by hopelessness and apathy. The person then experiences an 'awakening' phase. In this phase a person develops a sense of hope that recovery is possible. This phase is often initiated by a critical turning point or experience that suggests that a better life is possible. The awakening phase is followed by a phase in which a person develops 'insight' into their condition. The person then begins to move forward by 'taking action' and 'making a determined commitment to be well'. Ralph points out that movement through the various phases of recovery is not a linear process but rather a reflexive progression toward the final phase of 'well-being' (2005).

We draw on four sets of narratives from two individuals who have experienced psychiatric disability and recovery. The first two narrative segments describe participants' experience of psychiatric disability that can be most closely related to the anguish and despair phases of the recovery model developed by Ralph (2005). We then selected two additional narratives from participants that are most closely aligned with the awakening phase of this model. In doing so we show how the discursive constructions of self shift over time as participants' moved from a phase of anguish and despair to one of awakening where they began their journey toward wellbeing.

1.2 Critical Discourse Analysis and mental health

Models of recovery are important in the development of an understanding of this complex and abstract process. A discursive framework recognizes the intersection of the individual and the social world and assumes that both domination and liberation are socially constructed. As such, recovery is a set of processes that is constructed and represented through talk, material practices, institutional positions, and social networks. A Critical Discourse Analysis (CDA) framework assumes that discourse constructs and represents the social world (Slembrouck 2001).

Critical Discourse Analysis is a set of frameworks that helps to describe, interpret, and explain the relationships between micro and macro interactions (Gee 1999). It is an underutilized approach in examining the process of recovery from SPD. Few studies have looked closely at the discursive patterns associated with recovery from SPD. Such an analysis presents a more complicated version of recovery and its processes.

Fraser (1991) argues that a theory of discourse can help us (1) understand how people's social identities are fashioned and altered over time; (2) understand, how, under conditions of inequality, social groups are formed and unformed; (3) illuminate how the cultural hegemony of dominant groups is secured and contested; (4) shed light on the prospects for social change and political practice (p. 98).

Positivistic approaches to identity assume universal, progressive stages of development. There has been work in gender and identity formation (Gilligan 1982), in social class and identity (e.g. Steinitz and Solomon 1986) and in race and identity formation (e.g. Gilyard 1991) that questions positivistic views of identity. In this research we use the term subjectivities, cultural models, and storied selves to represent the multiple, fluid, and unstable relationships that comprise who a person is. Furthermore, we draw on current work that uses discursive and narrative analyses to explore how professional and client identities are constructed and reconstructed through interactions with each other and broader care systems (e.g. Hall et al. 2003; Hall and White 2005; Mishler 1981; Rappaport 1993). Subjectivities are then negotiated through overt and covert communication processes and these negotiated positions are impacted by historical influences related to power, status and domination.

Chouilaraki and Fairclough (1999) discuss the discursive construction of subject positions. They argue that subjectivities are not stable. Further, the more heterogeneous the discursive practices that comprise the self, the more likely there will be room for change. On the other hand, the more stable the discourses are, the less likely there will be change. They refer to the construction of subject positions as a set of discourse practices – or what they refer to as 'orders of discourses' that are made up of three, connected functions of utterances (genre, discourse, and style). Every utterance has a way of interacting, a way of representing, and a way of being that is constitutive of the speaking self and the context in which the subject speaks.

2. Methodology

The original study utilized in-depth, semi-structured interviews with 16 established leaders in the consumer provision of mental health services (Mancini 2005). Each participant had experienced SPD, formal mental health treatment and recovery. Participants were asked to identify and reflect upon experiences that either helped or hindered their recovery process, and to offer personal theories as to why and how these experiences were important.

We selected two interviews for critical discourse analysis in order to demonstrate the complexities of the recovery process. The rationale chosen for selection included: (1) commonalities in the demographics and backgrounds of participants; (2) differences associated in the acknowledged pathways to recovery. In order to explore the commonalities and disjunctions in the recovery process, we decided to select two cases that shared commonalities and differences. We then selected narratives from each participant that discussed their experiences at two phases of the recovery process from the model developed by Ralph (2005). The first phase (Anguish and Despair) shows how participants struggled with psychiatric symptoms and oppressive treatment practices. The second phase (Awakening) was during a time when participants' recoveries were just beginning to emerge.

2.1 Data analysis

All of the interviews were audio-taped and transcribed with the permission of the adults. The analysis was conducted in several stages. The transcripts were read and reread and notes were taken on the themes and patterns of each of the interviews. From here, we went through a series of discourse and ethnographically oriented analytic steps. We selected narratives where participants clearly positioned themselves within the anguish/despair and awakening phases of the recovery process and categorized examples within the narratives under these phases, recognizing that there was overlap between the domains. However, before conducting a discourse analysis, we conducted a number of analyses to get baseline description on the data. These analyses included a content analysis for themes in the interviews (Rubin and Rubin 1995), a contrastive, narrative analysis (Bruner 1991; Labov 1973), and finally a critical discourse analysis (Chouilaraki and Fairclough 1999; Gee 1999).

We define CDA as the systematic study of ways of interacting (genre), ways of representing (discourse), and ways of being (style). We chose to use CDA as the methodological tool because CDA can capture the linguistic nuances that are associated with identity as well as the changes in linguistic patterns that occur across various contexts. We conducted the CDA in several stages. We chose sections of the transcript that provided the greatest conceptual leverage; i.e. where there was an obvious mixing of phases and/or the places where we could clearly see each of the phases so that we could code each of the excerpts with orders of discourse to begin to look for patterns within and across the phases.

Working from Chouliaraki and Fairclough's (1999) definitions we coded each of the interviews for *genre, discourse, and style*. We defined genre as 'ways of

interacting' or a description of the organizational properties of interactions. Aspects of 'genre' included ways of interacting such as the thematic structure of the text, cohesion devices (parallel structure, repetition), wording, metaphors (signifying), politeness conventions, turn taking structures, revoicing, narrative sequencing and call and response. Discourses are 'ways of representing' and include the chain of production, consumption, and distribution of texts and talk. Discourses, in this definition, necessarily embody tensions. Styles are 'ways of being' and include an analysis of active/passive voice, modality (e.g. tense and affinity), transitivity (e.g. action, affective, state, ability, cognitive statements), and pronoun use (Fairclough 1992). We coded each of the transcripts at the level of the clause or what Gee (1999) calls 'idealized lines'. Within any one line there may be overlapping nodes of genre, discourse, and style or multiple occurrences of any of the orders of discourse. After coding each of the interviews, we contextualized the micro analysis within the larger context of the interviews.

Overall, we read through the data four times with different levels of abstraction in mind each time we read the data. As we analyzed the data we kept analytic memos on each of the participants that eventually were constructed into vignettes based on their interviews. We consulted the literature in recovery when relevant themes came up in the interviews. Since we will be discussing only relatively small parts of long interviews and doing so in a discontinuous manner that cannot present the material in a chronological manner, we will first summarize parts of their case studies.

2.2 Participant case summaries

Kelly

Kelly is a white woman in her 50's who provides peer-based advocacy services for a northern U.S. state. In her work she advocates for recovery-oriented policies and services. She describes being diagnosed with 'rapid cycling' bipolar disorder while in graduate school for nursing. Kelly is an accomplished artist with numerous published poems and is a classical pianist among other artistic pursuits. Kelly stated that following her diagnosis she was hospitalized at least 4-6 times. During this time, she was forced to drop out of graduate school and stated that she experienced progressively severe symptoms. She stated that she lost many friends due to her frequent hospitalizations and the stigma associated with this disorder. Her relations with her family were also strained. Kelly eventually became an activist using her experiences of psychiatric disability, stigmatization and recovery to help build hope in others. She reports that she still experiences psychiatric symptoms and manages them without medication, choosing instead to use alternative therapies including yoga, tai chi and African drumming among others.

Nancy

Nancy is also a white woman in her 50's who provides peer-based advocacy services for a northern U.S. state. Nancy is a leading activist for consumer

rights and for recovery oriented treatments and policies. She reports struggling with bipolar disorder for several years and reports numerous hospitalizations. Nancy attributes her recovery largely to finding the right medication to control her symptoms. Nancy uses her experiences with psychiatric disabilities, recovery and the mental health treatment system to help others. While a staunch ally to other consumers and very critical of the coercive and paternalistic aspects of the mental health treatment system, she also acknowledges the importance of psychiatric treatment including medication.

3. Interpretations

Differences between the two cases exist. One participant, Kelly, attributed her recovery to developing a sense of meaning through advocacy and helping others, establishing a support network and engaging in alternative, non-medical treatments to deal with her psychiatric symptoms. Nancy attributed her recovery in large part to finding the right psychiatric medication. Using this point of departure as a reference point, we applied critical discourse analysis in order to analyze and understand more deeply the discursive construction of their identities through the recovery process and present a more complicated understanding of the recovery process to mental health practitioners and researchers.

3.1 Despair and anguish phase of recovery

Excerpts 1 and 2 demonstrate Kelly and Nancy's experience of despair and anguish regarding their psychiatric conditions and current experiences with the service system. This phase of the recovery process is marked by a sense of hopelessness and helplessness where the person feels dominated by their condition and sees little hope for recovery.

Excerpt 1 – Kelly – discourses of patienthood

Discourses of patienthood represent Kelly's experiences with an internalized sense of brokenness and despair. These discourses co-occur exclusively with styles of passive voice and negative affect. Contextually, these discourses and styles coincide with narrative storylines and segments that are marked by negativity, powerlessness, oppression and hopelessness. For instance she says:

> I think it was after my sixth hospitalization, I had a long term stay at Eastern County Medical Center and then they transferred me because I went from the mania and then I went through the profound depression. I went back to the mania, and they felt that I needed a long-term stay so they transferred me to the Barrymore Psychiatric Center, and that was when I felt all hope just [swoosh sound]. So I was at Eastern County Medical Center for about three months, and at that point, I was with, you know, a lot of the staff that I had been hospitalized with before and they had always, they always seemed to sustain hope. You know they would always ask, gee, prior to discharge, if I was

feeling well enough, and they were jotting off poetry. 'Oh gee, that's really brave. Will you bring me books?' You know, just encouraging me to go back to school and recognizing my talents.

Kelly utilized discourses of despair, patient and prisoner with passive construction and negative affect and ability. She also talked about herself in the third person, while also using distancing language for both herself and the professional staff of the hospital.

Kelly also uses passive construction when discussing her long term stay at Eastern Medical Center indicating that she had little control over this placement. She also uses passive construction when discussing her transfer indicating how medical staff (i.e. 'they') transferred her. She indicates that her transfer was the result of the severity of her symptoms and the opinion of medical staff who 'felt' she needed to be transferred to a long-term facility. At no point in this segment does Kelly use active construction or voice any sense of agency. She represents herself as a passive patient/prisoner to both her symptoms and to the medical staff in the facility. She claims that these actions had a profound effect on her wellbeing and in a loss of personal hope.

When asked to discuss the low point in her recovery process, Kelly recognized the development of an illness dominated sense of despair and hopelessness that resulted from her social environment. In the following excerpt Kelly discuses reactions of staff and how they influenced her sense of self.

> And then, when I was, you know, once I was there like three or four months, it was almost like you felt this gradual or [swoosh sound] withdraw of energy. They thought, you know, gee, you don't...in fact, I even overheard some of the conversations. You know, it was kind of like, you know, 'gee, it's so sad; she has so many talents and she's never really ever going to be able to do anything with them'. 'She's never really going to go anywhere'. 'She's never going to really be able to accomplish anything'. I actually heard a couple of those conversations. At that point then, you know, it was like, you know, just increase the meds. And it was, like, I remember that hospitalization; you just felt the people just withdrawing their energy from you and focusing on people that maybe were admitted for the first or second time and they felt maybe they had a better chance. I felt devastated.

Again using passive construction and the genres of re-collection and comparison, Kelly recognizes that professional staff had supported her at first, but reports that due to the length of time in the hospital she could sense the withdrawing of staff energy and hopefulness. Kelly, through her passive construction and use of self in the third person distances herself from staff as the 'other.' She positions herself as a passive recipient of either hopefulness or hopelessness from staff. In both time periods, Kelly claims that her interactions with staff had a profound effect on her well-being. She does not mention anything about her symptoms, but focuses directly on her interactions with staff. She also does not mention anyone outside of the institution as well which may reflect her lack of contact with outside world.

In the following excerpt, Kelly uses multiple genres. She uses recollection of past conversations she overheard from staff as well as comparison of how she perceived staff views of her prior to her long term status. She acknowledges here that her status within the institution changed from a temporary patient

with hope for recovery to a 'chronic patient' with no hope and that when she introduces this new view of herself, she reports a coinciding change in staff behavior towards her.

> And then it became kind of like, you know, when I would talk about, you know, when I would feel...have a good day and talk about maybe kind of, you know, taking small steps towards claiming those dreams again. It was kind of like, no, Kelly, that would be too stressful. You need to kind of back off. You need to just ...that was the word I couldn't stand 'maintain.' if you attempted to go back to school, take a course, or attempted to do volunteer work, attempted to work a little bit part time, would just destabilize you even more. You know, and you would end up back in the hospital. So it was kind of like you began to feel like you were this fragile egg thing. You know, you had to be almost like the bubble boy, maintained in a bubble the rest of your life and exposed to no stress. Just kind of, I don't know, you just felt like you were too fragile. And I began to believe that when I had enough people tell me that, I started kind of like that state dependent thing, where you go to self-help.

Kelly depicts staff as paternalistic as well. Using a revoicing genre, she illustrates how staff encouraged her to abandon her goals. When Kelly started making plans to move forward, she claimed that staff would discourage her because of a fear that she would have a relapse in symptoms. She reports that staff wanted her to 'maintain' her current status as a dependent patient – a status she views with almost a sense of disgust. Plans to move forward such as work, volunteering or school, plans that are normal activities open to all people, were withheld from Kelly marking her status as different from 'normal' people due to the fact that she was a psychiatric patient.

Through discourses of patienthood, Kelly discusses how her interactions with staff began to influence how she viewed herself. Due to overt and covert paternal attitudes of staff, Kelly began to view herself as a 'fragile egg thing,' a 'bubble boy' and a 'state dependent thing' and she outwardly states that she began to believe this because people told her this was so.

In the following excerpt, Kelly describes how she also began to view herself as 'one of the chronics'. Here we observe that although recovery is a social process, so is the despair and hopelessness that can be its precursor.

> I started identifying with the horror stories. Instead of identifying with the people that were making it, I started identifying with the people who were despondent, who were suicidal, who felt there was no meaning to life, you know. So I began to view myself as one of the chronics, not one of the people that were optimistic about, which usually in the past I did, but once the providers, you know, started and then I started seeing myself more, you know. That only lasted for about a year though.

Kelly describes how she eventually developed a subjective conception of self as a 'chronic.' She continues to use the discourse of patient, but she also differentiates between two different types of patient. She states that through her interactions with staff, she began to identify with people who were 'despondent,' 'suicidal,' 'felt that there was no meaning to life' and as one of the 'chronics.' In this way she uses the genre of comparison when she compares two different types of patient – one to be hopeful about and one that will not recover. She also views herself through the lens of professionals.

Kelly reports in the end of this section that she too finally succumbed to this evaluation.

Excerpt 2 - Nancy – discourses of madness and disease

In the following section, Nancy describes her experiences prior to recovery. Nancy positions herself has being a victim of her disability, rather than the mental health system.

> [It was] 12 or 14 years altogether, where it was, you know, I was a raging lunatic. I can't say that they (family) were exactly part of my recovery and caused some turning point or something. But I just think that it was so crucial and unusual, frankly, from what I've heard, that they... it was like they never gave up. For one thing, they never stopped dealing with the messes that I created. I mean each manic episode was a holocaust. There were messes all over the place with employers and friends and acquaintances and landlords and, you know, an entire world of life. My life was blown to pieces, and I was not capable of mending it....I would have like two weeks of sanity to deal with things that would take, you know, a lot to deal with. And they always did that. I mean they didn't like it and they became very exhausted and weary of it, but they felt that they couldn't not try to repair some of these things and leave landlords, you know, being owed $400, and leave apartments trashed, and leave people, I don't know, millions of things. So they like handled that kind of stuff, all the messes. And they tried to clean them up over and over and over again...

In the above segment, Nancy describes her experiences with bipolar disorder and the impact this disorder had on her life and that of her family. She uses a style of passive voice and past tense to indicate that this part of her life is over. She also relies on the genre of metaphor and repetition coupled with a discourse of madness when describing the sheer destructiveness of her episodes. By describing herself as a 'raging lunatic' she illustrates the intensity of her behavior and experience, but her choice of metaphor (raging lunatic) also signifies a discourse of madness. The historical significance of lunatic is telling. The term was a term used to describe individuals housed in madhouses in the 18th century. The term combined with the adjective raging indicates a person not in control or aware of their destructive behavior. She continues to utilize the genre of metaphor when she describes her manic episodes as a 'holocaust' emphasizing the destructive quality of her episodes. She again repeats this point when she describes the 'messes' she created with people important in her life. She uses the term 'entire world of life' to indicate the global and comprehensive nature of the destruction she caused and then uses the metaphor 'life blown to pieces' to again describe the destructive nature of her episodes.

Nancy represents her problems prior to her recovery as emanating solely from her medical condition. Through the genre of repetition (i.e. 'over and over and over again') she indicates the cyclical nature of her condition. Nancy also alternates between discourses of madness through her use of terms such as 'sanity,' 'lunatic,' 'nuts' and 'crazy' and discourses of disease though the use of clinical terms such as 'manias,' 'grandiosity,' 'delusional.' 'hypomanias' and 'depression' to describe her condition. Unlike Kelly, Nancy clearly positions

the source of her troubles within the context of her bipolar symptoms. Furthermore, her style of passive voice indicates that she viewed herself as largely powerless over her symptoms.

In the next segment, Nancy also uses the genre of comparison to juxtapose her life before and after experiencing bipolar disorder. Nancy uses the age of thirty to describe how she viewed herself before and after she developed bipolar disorder.

> I was completely functional and thriving until then. Now in retrospect, people close to me think things might have been brewing starting when I was around 30. Nobody questions the fact that there is nothing troublesome going on from birth to age 30….Well, it's oversimplifying but not a great oversimplification to say that my manias, you have to understand, were extremely severe and every once in a great while, psychotic, but always achieving unbelievable delusional state and, you know, dangerous behavior. All the classic symptoms of you know, of incredible grandiosity, all these things.

Nancy describes herself as 'functional and thriving' until developing her bipolar symptoms. She also uses the genre of collateral perspective by stating that people close to her did not, 'question the fact that nothing was troublesome going on from birth to age 30.' Nancy demonstrates through a discourse of normalcy how she viewed herself as a positive and functional being. She then juxtaposes this description with one of illness and dysfunction through the use of discourses of disease. Through the use of the descriptors such as 'extremely severe,' 'unbelievable delusional state' and 'incredible grandiosity' she attempts to paint a particularly dire picture of her life after she developed bipolar disorder. Throughout she uses passive voice indicating her powerlessness over these episodes.

Nancy further indicates her powerlessness over her condition when she indicates that she was 'oblivious' to her behavior.

> But also they were all, every single episode, was what I call a happy manic. These were the greatest trips I have ever taken in my life. I had the greatest time in the world while I was actually going around, you know, wrecking the whole world and all the people important to me, all the situations. But I was basically oblivious to it. I mean, not basically, just completely oblivious to the fact that I was doing any damage, and to the contrary I felt that I was one of the most brilliant creative, attractive, intelligent people in the world….And it was often I traveled around so much in various places, you know, on the street, and in bars, you know, I met a lot of people. And in the earlier phases—I mean I had some, you know, bad hypomanic states, as it was transitioning into this severe mania, and when I was just high I kind of was all those things. I mean I became all those things in a way so that, you know, the people that I met who didn't know me responded. I had a lot of people respond that, you know…And not think or show anything about any indication that I thought that they thought that there was something wrong with me. And then within two days when I became crazy, I was pretty much oblivious to peoples' reactions. But clearly they knew I was nuts. So I'm saying all this because the transition from being so called 'normal,' and having this sudden onset, you know, night and day difference. I was mostly oblivious to this and unable to really experience

Specifically, she describes her manic states as 'happy manic' indicating that while she was experiencing so-called manic episodes that she was in a sense enjoying these experiences while unaware of the negative impact her behavior was having on her life and the lives of others. Nancy also suggests that her experience of manic symptoms was largely out of her control. She says, 'So I'm saying all this because the transition from being so called 'normal,' and having this sudden onset, you know, night and day difference.' She characterizes herself as 'normal' and then suffering the 'sudden onset' of symptoms and that these symptoms were largely out of her control.

3.2 The critical turning point in the recovery process: The Awakening phase of recovery

Excerpts 3 and 4 from Kelly and Nancy demonstrate their experiences within the awakening phase of recovery. In this phase participants experience the development of a sense of hope that recovery is possible. This delicate phase is marked by the development of hopefulness for the future and a sense of empowerment whereby a person begins to recognize that they have some control over their fate (Ralph 2005).

Excerpt 3 Kelly – discourses of transformation

In the segment below, Kelly uses the discourse of transformation and the genre's of revoicing and repetition to describe how she experienced a turning point in her recovery from despair to one of insight (Ralph 2005).

> I felt despondent for about two weeks, and I said to myself—and then it was just kind of like there is a fire in me—I said to myself, I can't allow this to happen to me. I mean these are walking dead. You know, it's like, you know, they've given up all hope. I mean most of the people...just again, and that was back when. you know, everybody was over drugged. It was this soulless stare look. You couldn't even see a spark of life in a lot of the folks' eyes. They just walked around the deadened state. I just said to myself it was kind of like a kick start. It was a kind of 'get yourself together, Kell.' You know, you've kind of really worked to not end up this way. And I started helping. And I said, 'Oh my God, these poor kids, you know, their hope has got to be kept alive'. So I started hanging out with a lot of the younger kids, you know, when I had privileges and just kind of offering hope to them, you know. You know, kind of nurturing a lot of the young kids that came from catastrophic backgrounds. That just kind of got really ignited, you know, not only terms of myself, but when I saw people's lives around me and knew they were capable of so much more and knew, you know. That's one thing I do have, is passion, and people usually feel my passion, and I thought if I could jumpstart a little bit of spark, you know, like Claire (former psychiatrist) jumpstarted in me.

Kelly reports that this turning point was self-initiated resulting from a resistance to the treatment she received in the hospital described as her 'fire.' She also states that she was motivated by the injustices she saw others enduring at the hospital.

Through the genre of comparison she says that other patients in the hospital 'walked in a deadened state' due to overmedication and understimulation. Another genre used by Kelly was one of 'self-talk' where she describes how she motivated herself by stating that she 'worked hard not to end up this way,' that is, like the other patients in her ward. Through the use of activist and helper discourses she describes how she transformed her sense of self from one of passive patient (patienthood) to one of active role model and advocate to others on the ward. Throughout she uses an active style through first-person pronoun use and in describing how she helped others on the ward. At the end of this segment she describes herself positively as 'passionate' and how she used her passion to help others. In this segment, Kelly's sense of self is in the process of transformation from a passive, dependent patient to one of active, empowered activist. At the end of the segment Kelly compares herself to a former psychiatrist (Claire) who was instrumental in helping her in the past. In both transcripts Kelly's attributes her lack of recovery to the development of illness dominated identities resulting from the oppression of others, while attributing her recovery to internal motivation and action.

Excerpt 4 – Nancy – discourse of remission

In following segment, Nancy explains how her recovery began. As a stark point of departure from Kelly, Nancy attributes her recovery to finding the right medication after years of searching.

> My recovery, in a nutshell, to me was, in the dictionary sense, recovering from extremely beyond anything dysfunctional and what I call crazy phase that lasted, that would not respond to any medication. From the beginning,, a medical approach was always taken, and one that I accepted. I definitely accepted the chemical imbalance theory without question. At the time, I mean I got my first episode way back in 1975, and for 12 or 13 years it was unremitting, because, as I say, I was what they call a non-responder to everything, starting with lithium and going through everything in the pharmacopoeia. And I had, I think, 14 hospitalizations in 12 years. It was somewhat of a pattern of three months up and to be mania and three months down in bad clinical depressions. I would say the manias were more extreme than the depressions, but the depressions were not pleasant. So very briefly, all recovery means to me is not the kind of journey and, you know, back and forth, one step forward, two steps kind of experience that so many people I know describe and that I know, and that I have seen and that I know very well. And, to me, I have had a little bit of that nonlinear stuff back and forth, forward steps and back steps, definitely, but overall my feeling about my recovery is that it was simply a matter of going from being severely dysfunctional and severely ill and severely crazy and because the proper medication was found after 12 years of searching and experimenting and finally arriving as a research patient at the National Institute of Mental Health, which is the kind of—they don't take anybody. They have like eight or ten people who are patients there, who they accept as patients. And they don't take anybody who isn't at the end of the road, who hasn't been through everything. And my experience there, to make a long story short, I would say due to that experience, that a cocktail finally got developed that worked for the first time in 12 or 13 years.

While Nancy acknowledges her understanding of the dynamic, process-oriented theory of recovery, she states that her recovery did not follow that path. She uses the genre of recollection to describe her past experiences in struggling to find the right medication. She directly states that she believes that her condition is due to a 'chemical imbalance' and that she embraces the medical approach to treatment. Throughout, Nancy uses discourses of disease and remission to describe her recovery. She uses the genre of repetition to make the point that she searched for a long time before finding the right 'cocktail' of medication to control her symptoms. Furthermore, she repeatedly makes the point that her symptoms were severe enough to warrant being a research patient at a national research laboratory for experimental medications.

In the next segment, Nancy further explains how she was helped by her medication, while at the same time positioning herself as an activist and advocate.

> And I'm very much a part of the political mental patients' rights movement and have been involved with in it in a fairly militant way for many years, so it's [inaudible –laughing and talking over each other] I'm sorry, but that's what I think my recovery is simply from. Not a long journey, not being helped by services I received, not being helped by anybody I ever had, you know, any mental health worker from psychiatrists to, you know, a janitor. When I say not helped, I mean not significantly—you know, I certainly met helpful and nice people along the way. I went from crazy to pretty much remission. And due to medication; clearly if I didn't take it I went crazy, if I did take it I was fine. It was that experiment to kind of make sure and that assured me anyway. So to be redundant, unlike a lot of people, especially unlike my colleagues in the movement, as we call it, I feel very strongly that there is a simple answer to my recovery, which I finally found some medication that controls my craziness and that's what I consider it a recovery, qualified by the fact that I believe in never saying never and I always know you know, there can be relapses. But I consider myself definitely in recovery. So that's the ending.

Nancy, almost apologetically, states that her recovery was due to medication and not influenced in any way by professionals. Using a contrasting genre she states that although she has been active in the antipsychiatry and consumer movement 'in a fairly militant way,' a movement often opposed to reliance on medication, she reports that in her case, her recovery was the result of those same medications. The reliance of medication and the belief in medical theory of illness and recovery is a key tension point in Nancy's narrative as she attempts to reconcile this reality with the activist-oriented aspects of her sense of self.

At the end of the segment, Nancy uses discourses of remission to describe that she uses medication to relieve symptoms, but acknowledges that she is forced to be 'vigilant' regarding the possible return of her symptoms. Throughout her narrative Nancy mixes discourses of madness with clinical discourses of disease and remission to describe her experiences as she attempts to negotiate her multiple subjectivities of patient and activist.

Nancy's style of representation switches from active to passive voice. One the one hand, Nancy continues to view herself at the mercy of her symptoms and condition, having to rely on medications to stay well. However, she also uses active voice to describe how she struggled to find the right medications and now uses these medications to maintain her wellness. She describes her medication use as an active choice that she makes in order to fight off her symptoms, while still acknowledging that she has little control over whether they return.

4. Conclusions and implications

Our use of critical discourse analysis demonstrated that the subjectivities of both participants shifted across two distinct phases of recovery. During the time of participants' recoveries most closely characterized as the despair and anguish phase participants discursively constructed subjectivities marked by passivity, negativity and powerlessness. However, the narratives that emerged within the awakening phase were marked by a more active and hopeful affect, active voice and empowered discourses. Differences in the narratives exist. For instance, Nancy was more likely to attribute her problems in the anguish stage to her 'disease,' and the solution to finding the correct medicine. She switched back and forth between madness and disease oriented discourses to characterize her experiences. These clinical discourses are carried over in the awakening phase when she utilized clinical discourses of remission to characterize her recovery after finding the right medicine.

However, Kelly was much more likely to attribute her negative discourses (Patienthood, Prisoner) to oppression by others and demonstrated this through the genre of negative revoicing of professionals that in her view paternalized and infantilized her. She made little mention of her symptoms, but rather attributed her powerlessness and hopelessness to her interactions with hospital staff. Kelly was also more likely to attribute her recovery in the awakening phases to recognizing the development of these negative subjectivities and resisting them through activism and helping others.

This exploratory study demonstrates the complex ways that people experience recovery and construct subjectivities through interactions with their own symptoms as well as professionals and service systems. This work merges with others that demonstrate the importance of recognizing and understanding how people discursively construct their realities through these interactions (see Goffman 1967; Hall et al. 2003; Hall and White 2005; Mishler 1981; Rappaport 1993). Socializing our attention to not only what people say but how they say it has important implications for policy, research, and practice in mental health. Such an analysis has encouraged us to think more carefully about the relationships between micro and macro level processes when people talk about their process of recovery. This understanding complicates recovery and forces professionals to broaden their understanding of the recovery process beyond medical notions of illness and disability and to recognize that multiple pathways to recovery exist. It also positions them as active co-participants in this process.

The analysis we have provided in this article encourages other researchers to problematize taken for granted language practices in their research and practice. In turn, contesting dominant construction of health and wellness and describing the places where people are positioning themselves in agentic ways opens up possibilities for action and policy interventions. Researchers might, for example, question the taken for granted assumption underlying notions of the chronicity of 'mental illness'. CDA is well suited for advocacy based research because it has the potential to illustrate practices of resistance as we have demonstrated here. More work needs to be done linking the discursive and material practices of recovery.

References

Anthony, W.A. (1993) Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal* 16: 11-23.

Bruner, J. (1991)The Narrative Construction of Reality. *Critical Inquiry* 18(1): 1-21.

Chouliaraki, L. and Fairclough, N. (1999) *Discourse in Late Modernity: Rethinking Critical Discourse Analysis*. Edinburgh: Edinburgh University Press.

Davidson, L. and Strauss, J.S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology* 65: 131-45.

Davidson, L. and Strauss, J.S (1995). Beyond the psychosocial model: Integrating disorder, health and recovery. *Psychiatry* 58: 44-55.

Estroff, S.E. (1989) Self, identity and subjective experiences of schizophrenia: In search of the subject. *Schizophrenia Bulletin 15*: 189-196.

Fraser, N. (1991) The uses and abuses of French Discourse theories for feminist politics. In P. Wexler (ed.), *Critical Theory Now*. London: Falmer Press. pp.98-117.

Fairclough, N. (1992) *Discourse and Social Change*. Cambridge: Polity Press.

Gee, J.P. (1999) *An Introduction to Critical Discourse Analysis: Theory and Method*. London: Routeledge.

Gilligan, C. (1982) *In A Different Voice: Psychological Theory and Women's Development*. Cambridge, MA: Harvard University Press.

Gilyard, K. (1991) *Voices of the Self: A Study of Language Competence*. Detroit: Wayne State University Press.

Goffman, E. (1967) Mental symptons and public order. In E. Goffman (ed.), *Interaction Ritual: Essays on Face-to-Face Behaviour*. New York: Pantheon Books. p.137-148.

Hall, C. and White, S. (2005) Looking inside professional practice: Discourse, narrative and ethnographic approaches to social work and counseling. *Qualitative Social Work* 4: 379-390.

Hall C., Kirsi, J., Parton, N. and Tarja, P. (eds.) (2003) *Constructing Clienthood in Social Work and Human Services: Interaction, Identities and Practices*. London: Jessica Kingsley Publishers.

Labov, W. (1973) The boundaries of words and their meanings. In C.J. Baily and R. Shuy, (eds.), *New Ways of Analyzing Variation in English*. Washington D.C: Georgetown University Press. pp.340-373.

Mancini, M.A. (2005) An evaluation of a peer-operated case management program: Lessons learned. Technical report presented to the Executive Director, St. Louis Empowerment Center.

Mancini, M.A., Hardiman, E.R., and Lawson, H.A. (2005) Making sense of it all: Consumer providers' theories about factors facilitating and impeding recovery from psychiatric disabilities. *Psychiatric Rehabilitation Journal* 29(1): 48-55.

Mishler, E. (1981) Social contexts of health, illness, and patient care. In E. Mishler (ed.), *Social Contexts of Health, Illness, and Patient Care.* Cambridge: Cambridge University Press.

Ralph, R. (2005) Verbal definitions and visual models of recovery: Focus on the model. In R. Ralph and P. Corrigan (eds.). *Recovery in Mental Illness: Broadening our Understanding of Wellness.* Washington, D.CL American Psychological Association. pp. 131-145.

Rappaport, J. (1993) Narrative studies, personal stories, and identity transformation in the mutual help context. *Journal of Applied Behavioral Science 29*: 239-256.

Rubin, H. and Rubin, I. (1995) *Qualitative Interviewing: The Art of Hearing Data.* Thousand Oaks, CA: Sage Publications.

Slembrouck, S. (2001) Explanation, intepretation and critique in the analysis of discourse. *Critique of Anthropology 21(1)*: 33-57.

Steinitz, V.A. and Solomon, E.R. (1986) *Starting Out: Class and Community in the Lives of Working-Class Youth.* Philadelphia: Temple University Press.