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ESCAPE, ENLIGHTENMENT AND ENDURANCE

Narratives of recovery from psychosis

This paper reports findings from a study which analysed the narratives of individuals who described themselves as recovered or recovering from psychosis, a term referring to experiences such as hearing voices other people do not hear, seeing or sensing things other people do not see or sense, holding unusual beliefs (delusions) or beliefs about the malevolent intention of others which seem unwarranted (paranoia). A narrative approach was taken since it allows for a focus on the construction of meaning and it is the breakdown of shared meanings which, at least in part, defines psychotic experience. It was also anticipated that the way the individual narrated their experience would offer important clues as to how they (and others) had facilitated the recovery process. This paper reports on the analysis of genre, tone and core narratives. Three distinct genres emerged from the analysis: narratives of escape, enlightenment and endurance. There was a relationship between genre, tone and core narrative. The study raises questions about how psychosis is experienced, understood and treated by the individual, by mental health professionals and by society.

I also think that telling a story is very much part of the recovery process [...] if you consider that the more you tell your story the more you get familiar with it, so the more you understand it for a start and also the more you accept it really.

(Suraya)

The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma.

(Herman 1992/1997, p. 1)

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The story of psychosis, as told by the individual who is experiencing or has experienced it, is one that is barely heard either in our academic journals or in the public domain. Stories of recovery from psychosis are as rare, if not rarer. There are exceptions in prose literature (e.g. Frame 1961; Kavan 1940, 1948; Vonnegut 1975; Waugh 1957/1998) and drama (Kane 2000; Penhall 1996, 2000) as well as more recently in mental health publications (e.g. Anonymous 1983; Baker & Strong 2001; Barker *et al.* 1999; Faulkner & Layzell 2000; Lapsley *et al.* 2002; Leibrich 1999; Lovejoy 1984; May 2000; Read 2001). Nevertheless, there remains a dearth of literature focusing on subjective accounts of psychosis and recovery. This is partly due to the swing in psychiatry and psychology in the twentieth century towards positivism and the use of positivist scientific methods, such as statistical analysis of numerical data. It is increasingly recognized in the twenty-first century that the pendulum has been allowed to swing too far in this direction and that work is needed to redress the balance (Faulkner & Thomas 2002; Roberts 2000). The use of methods which allow for an understanding of the lived experience of individuals, through the study of language and meaning in texts and dialogues, is required in order to influence and deepen our knowledge base.

The focus of this study is narrative, and the importance of language and meaning in influencing and structuring our experiences and life-trajectories. The way we think, feel and act in the world is patterned by language, meaning and interpretation (Polkinghorne 1988; Sarbin 1986). How we think, talk and write about events affects, even at times determines, how these events impact on our lives and those of others (Crossley 2000; Gergen 1992; Lieblich *et al.* 1998; Riessman 1993). In a dialectical relationship with narrative are incoherence and silence. If we run into problems with our personal or professional narratives, if they stop making sense to us or to others, we find that a taken-for-granted coherence has been lost. This can be a feature of experience following trauma (Crossley 2000; Herman 1992/1997). It is also relevant to the experience of psychosis, which by definition refers to experiences that are hard to make sense of, either for the individual concerned or for any observers. Attending to narrative can offer a means of grappling with key aspects of human experience that have to do with meaning or difficulties with making meaning (Crossley 2000; Roberts & Holmes 1999). Stories of suffering can be silenced and this can be a powerful weapon for those who are oppressors or perpetrators, whether at a societal or interpersonal level. It is common in cases of child abuse, or rape, for example, where the victim/survivor may be unwilling or unable to tell their story for fear of reprisal or in the anxiety that their experience will be denied or disbelieved (Herman 1992/1997). The fact that stories of psychosis and recovery are so rarely heard also attests to the 'taboo' nature of these experiences in our society.

Recovery can be defined in various ways, and may hold different meanings for different people. In psychiatric terms, it may be defined primarily as the absence of particular symptoms or diagnostic criteria. From a survivor perspective, it may be seen as regaining an ability to function in society and achieve one's life goals (Coleman 1999). For those who consider hearing voices to be a valuable experience, however, the term recovery may not be appropriate. The concept of recovery is integral to the 'recovery model' of mental health care in the USA, New Zealand, Australia and in some areas in the United Kingdom, which emphasizes empowering

people to take an active role in shaping their own recovery rather than passively complying with professional treatment. Central to the recovery model is the idea of developing a voice and reclaiming ownership of one's experience (e.g. Anthony 1993; Coleman 1999; Dillon & May 2002; O'Hagan 2002; Ridgeway 2001). Narrative has been shown to play a crucial role in constructing, and sometimes transforming, the meanings of experiences as diverse as living with a terminal illness, surviving sexual abuse or political imprisonment, or recovering from mental health problems (Crossley 2000; Frank 1995; Gray 2001; Harvey *et al.* 2000; Kleinman 1989; Langer 1996; Lapsley *et al.* 2002).

Different types of narrative may achieve, or attempt to achieve, the construction of meaning in various ways. Studies of illness/recovery narratives have demonstrated this by identifying various types of narrative genre. Hawkins (1990) suggests that the illness/recovery narrative is a modern version of the conversion/growth story within religious tradition. However, Frank (1993) and Crossley (2000) note that not all narratives may 'succeed' in this way. Frank (1993) describes three types of illness narrative, characterized by 'chaos', 'quest', and 'restitution', with the latter, where the speaker anticipates some kind of repair or redress, being most favoured in our present culture. The concept of 'quest' is echoed in the few studies of narratives of recovery from psychosis (Hyden 1995; Ridgeway 2001), and Ridgeway (2001) identifies a process of change and enrichment over time that emerges in the core narratives within survivors' accounts. In 'chaotic' or 'frozen' illness narratives, on the other hand (Crossley 2000; Stern *et al.* 1999), the illness remains a series of random, incomprehensible events, and the task of reconstructing a sense of meaning has not been achieved. This raises the question of what facilitates or hinders the construction of a narrative that helps the person to make sense of an experience and move on, and how wider social and cultural meta-narratives may impact on this process. A few studies to date have examined aspects of the language of psychiatric treatment (Harper 1999) and survival (Crossley & Crossley 2001). Understanding more about this in relation to narratives of recovery from psychosis would serve a number of purposes. Most significantly, it would offer further understanding as to how people experiencing psychosis might move towards recovery rather than a 'chronic patient' role, and how helpers and supporters might facilitate this.

The present study, therefore, aimed to explore the narrative accounts of individuals who had experienced psychosis and who viewed themselves as recovered or recovering. The narratives were explored with respect to genre, tone and core narratives.

Method

Participants

The participants, nine women and six men aged between 30 and 70, were recruited as a purposive sample through advertisements and word-of-mouth. All of those interviewed identified themselves as recovered, or recovering, from one or more psychotic episodes, and all but one had had at least one hospital admission that they understood to result directly from their experience of psychosis. The participant who

had not been in hospital had been given a diagnosis of schizophrenia as an outpatient. Participants were not recruited according to particular diagnoses, partly due to the controversy surrounding the validity of these (Boyle 1990, 2002; Charlton 2000), and also since taking a 'symptom-based' rather than a 'diagnosis-based' approach is currently recommended in psychological research into psychosis (BPS 2000). Nevertheless, seven of the individuals had received a diagnosis of schizophrenia, two had been diagnosed with schizo-affective disorder, four with bipolar disorder or mania, two with a psychotic episode and two with depressive psychosis. Some had received different diagnoses at different times, hence 17 diagnoses are mentioned above although there were 15 participants. Most were of white European origin; two were of Asian origin. Individuals defined their own recovery. For some, an absence of symptoms was important, along with being able to work, and not taking medication. For others, being able to live a meaningful life, regardless of the presence or absence of symptoms or medication, defined their recovery.

Researchers

One of the researchers (HT) was a trainee clinical psychologist and as such undertook clinical and academic work in the field of psychosis. One (LC) was an academic with a clinical psychology training who had worked as a clinician within the mental health system with people who had experienced psychosis. One (RM) was working as a clinical psychologist in the community and in a hospital in a deprived inner city borough of London, much of this work being with individuals diagnosed with psychosis. In addition, we as researchers had some experience of the mental health system outside of our professional lives, either through personal experience or through having witnessed the experiences and treatment of friends or family members who had become emotionally and mentally distressed. This dual perspective was valuable for this research and it allowed us a way to overcome the professional 'failure of imagination' (Kirmayer 2002) which can lead to a profound lack of understanding, even suspicion and mistrust, between professionals and those assigned to be assessed or helped by them.

Among the assumptions and expectations that we ourselves brought to the work, the most prominent was the belief that the mental health system is in need of change and improvement. This was accompanied by the expectation that individual narratives of engagement with the system would include negative as well as positive experiences, while narratives of recovery would emphasize what the individual had done to promote his or her own recovery, rather than necessarily what the mental health system had offered.

Procedure

Each participant was interviewed once. Most interviews were conducted in a room in a university department, although two participants were visited at home. Interviews were tape-recorded and lasted between 40 and 90 minutes, with most taking about an hour. The interview began in each case with the following open question:

As you know, the conversation we are about to have is part of a study to try to help understand what enables people to recover from – or perhaps live

meaningfully with – psychotic experiences. Perhaps, to begin with, you could tell me something about yourself and what has brought you to the point of sitting here talking to me about recovery.

This question was designed to elicit a narrative account. The interviews were led by the participants' accounts and the interviewer's reflections on what they said. Where necessary, the interviewer prompted with questions or suggestions relating to the following pre-identified topic areas:

- What does 'recovery' mean to you?
- What is it you feel you have recovered from?
- What helped, or did not help, at different stages in your recovery?
- Were there any particular turning points?

Following the interviews, the accounts were transcribed, and each interviewee received a copy of his or her own transcript. Pseudonyms were used so that the identity of each interviewee was known only to the interviewer.

Analysis

Riessman (1993) suggests that the narratives themselves should invite thought as to the most useful way of bringing out key elements. Our approach to narrative analysis developed over the course of the study and involved interrogating the texts with a number of questions, which in turn provided insights as to how to approach the texts in order to elicit answers to further questions. Rather than selecting discrete sections of text that met criteria for being 'storied', as some linguists have done (e.g. Labov 1972), we opted to take the accounts as a whole to represent narratives in a wider sense (as discussed by Fludernik 1999). Whole transcripts were therefore read and re-read, initially simply in order to become familiar with the stories, and then with particular questions in mind.

Narrative genre

The first aspect of the narrative analysis was the analysis of narrative genre ('holistic-form' analysis, according to Lieblich *et al.* 1998). This has been used quite extensively in narrative research, particularly in examining so-called 'illness narratives' (e.g. Crossley 1999; Frank 1995), narratives about coming to terms with a disability (Gray 2001), 'sexual stories' (Plummer 1995) and narratives about 'mental illness' (Hyden 1995; Stern *et al.* 1999).

Our approach was informed by work on narrative analysis and narrative genre (e.g. Gergen & Gergen 1983; Lacey 2000; Mishler 1986; Todorow 1990). The key question asked of the transcripts was 'What kind of a story is this?' In addressing this question, we considered aspects such as plot development, structure and language use. Each text was examined in this way and thus types of story began to emerge. These were categorized according to recognized genres which were named using concepts or language found in the texts.

Core narratives

Core narratives were identified using the approach described by Mishler (1986). The identification of a core narrative, in a similar way to the analysis of genre, has been used to characterize key aspects of narratives as a whole, either individually or collectively. For example, Mishler (1986) identifies the core narrative in his interview with a middle-aged man about his life as 'Yet we always *did* what we had to do, *somehow* we did it'. In our analysis, we did not attempt to develop a core narrative which would fit all the accounts. Rather, like Mishler (1986), we attempted to summarize each story in a few words (e.g. 'fighting for survival'; 'an ongoing journey').

Tone

Crossley (2000) and McAdams (1993) also suggest that an early part of a narrative analysis should be concerned with trying to characterize something about the narratives as wholes. They suggest focusing on narrative tone. This is achieved by reading and re-reading the texts and identifying the dominant tone of the narrative. As with the identification of a core narrative it may be possible to identify more than one tone; therefore the researcher's subjective response to the story plays a key role in the analysis as well as the participant's manner of telling. In our analysis we drew out more than one dominant tone in some narratives. However, we restricted ourselves to identifying no more than two dominant tones in each narrative, for the purposes of this analysis.

Credibility and trustworthiness

The key aim of a qualitative research study such as this is to produce a credible, trustworthy account that resonates with participants and readers. A number of strategies can be followed in an attempt to enhance credibility and trustworthiness (e.g. Elliot *et al.* 1999; Yardley 2000). Good practice in this respect was attempted through independent analysis of aspects of the accounts by the researchers, followed by discussion of similarities and differences in viewpoints aimed at reaching a consensus. The researchers also made use of peer supervision, contact with other mental health researchers, and advice from experts in the field of narrative analysis. One important element in the present study was participant involvement. All the participants were invited to contribute comments on the developing analyses of their accounts. Several did so, with three sending detailed comments that further elaborated on the issues identified, and their views were taken into account in refining our understanding of the findings. For example, Mary wrote:

I would agree that my story could be characterized as a 'narrative of escape'. I feel like I've had a very lucky escape. I could easily have lost my independence – job, job prospects, home, even child – and become a long-term service user.

Mary's comments offer some legitimacy for identifying her narrative as a narrative of escape. In his feedback, Simon wrote:

TABLE 1 Results of analysis of core narrative, tone and narrative genre

<i>participant</i>	<i>core narrative</i>	<i>tone</i>	<i>genre</i>
Peter	'battling a corrupt system'	educating, protesting	enlightenment
George	'getting shot of schiz'	educating, protesting	escape
Mary	'fighting for survival'	protesting, angry	escape
Martha	'getting the healing'	educating, thoughtful	enlightenment
Patricia	'an ongoing journey'	educating, resigned	endurance
Kate	'going it alone'	angry, resigned	endurance
Suraya	'getting control of my story'	educating, protesting	enlightenment
Simon	'seeing my way in the world and exploring new places'	educating, thoughtful	enlightenment
Hugh	'getting on with my life'	educating, monotone	endurance
Richard	'looking for an identity'	disenfranchised, resigned	endurance
Donald	'living a recovered life'	educating, protesting	enlightenment
Indra	'achieving integration'	angry, educating	enlightenment
Cathy	'coming full circle'	disbelieving, shocked	endurance
Miriam	'making a narrow escape'	thoughtful, protesting	escape
Meera	'finding my identity and fitting into two cultures'	thoughtful	enlightenment

about the idea of 'enlightenment' (which I first used to describe certain things I went through, and you took up in your analysis) [There is a] [...] danger, I suppose, of this description presenting a too romantic and simplistic version of (for me) a very complex reality.

Incorporating Simon's comments, we have tried in our analysis of the results not to oversimplify individuals' experiences and, with respect to the genre identified as 'enlightenment', to discuss the complexity of the experiences this encompasses.

Results

An exploration of narrative genre suggested that the narratives fell into three overarching groups, narratives of escape, enlightenment, and endurance (see table 1). Tone and core narrative were closely related to narrative genre.

Narratives of escape

The broad genre of 'escape' narrative includes stories of avoiding natural disaster or breaking free from imprisonment, for example. The narratives classified here as 'escape' narratives had all the drama associated with this genre. Key elements

included figuring out the enemy's goals and building up a picture of the methods adopted to achieve these, learning to dissemble, finding points of least resistance, perhaps in the form of a sympathetic individual who offers a way out, and the contribution of luck or chance. The backdrop for this kind of narrative is the use of imagery about imprisonment or torture to describe the experience of treatment within the mental health system. Mary talked about 'being convicted of' five psychotic episodes. She experienced hospital as 'a prison' in which there was a continual danger of attack. As a voluntary patient, Mary wished to exercise her right to leave, but was threatened with compulsory medication:

And I walked to the door. You know, goon squad jump on me ... they actually showed me the needle ... they held it in front of my eyes ... said, 'Here it is. This is what you'll get if you don't take your tablets'.

George describes his treatment in an 'old, walled ... enormous, walled hospital' in the 1950s and 1960s, saying that he 'kept going into the padded cell there'. He describes the fear of being 'beaten up' when he would refuse medication:

two male nurses can't cope ... you can say, 'No, I don't want an injection' [...] three nurses is the worst. I call it 'a gathering of three'. Each one would hold an arm and the other would slap and punch you until you agreed to be injected.

George explains that his escape from what he familiarly terms 'schiz' and from hospital admissions took place when a fellow patient shared a technique with him for dealing with his voices. He also identifies as crucial the agreement of his psychiatrist to let him leave hospital without taking medication, since he had previously found the side-effects had made it difficult for him to pursue his career.

In addition to physically escaping from hospital and unwanted treatments, these narratives describe escaping from the imposition of a certain kind of belief system and from the identity of a chronic psychiatric patient. Miriam contrasts her own experience with that of her father who had a breakdown in his youth, 'took medication for the rest of his life', and 'was never really free of the role of the psychiatric patient'. She identifies one important element of her escape as being her own certainty that there was more than one way of understanding her psychosis and rejecting the medical/biological model which she felt was being imposed on her and which carried with it a sense of determinism and hopelessness. She contrasts her perception of the staff view that 'You are now schizophrenic and we treat you with medication' with her own view: 'I had a very passionate feeling that I needed help with a great many human problems'. On her second admission she was admitted onto a therapeutic ward, run along psychodynamic lines. Here she was offered the opportunity to talk and be listened to. In addition, her family was invited and her father's difficulties were talked about openly for the first time. She felt that being listened to and taken seriously was a 'life and death issue' because it meant the difference between being given the chance to develop as a person or being classed as the same as her father which meant for her 'the end of my life'. Thus for Miriam escaping from the hopeless prognosis of professionals and from the identity of a

chronic psychiatric patient was as important as being able to leave hospital and possibly more important for her than getting over the experience of psychosis itself.

The tone of these escape narratives is thus predominantly one of anger and protest at attitudes and treatment which are perceived as damaging rather than helpful. In addition, individuals talk about escaping from the experience of psychosis itself, for example finding ways of dealing with the experience of hearing persecutory voices. The core narratives reflect these themes: 'getting shot of schiz', 'fighting for survival', 'making a narrow escape'. These narratives have much in common with narratives of survivors of imprisonment (e.g. Langer 1996). This raises important questions about how treatment within our mental health system can be experienced.

Narratives of enlightenment

The genre of the enlightenment narrative, also called the quest, conversion or growth narrative, is common to religious texts, especially conversion stories and medieval tales, as well as to stories framed within a positivist scientific discourse. A key element in this genre is the sudden or gradual dawning of understanding, bringing a new perspective. In the narratives which we characterized as 'enlightenment' narratives, 'enlightenment' was evident in coming to a gradual understanding of the self and the experience of psychosis, for some accompanied by a notion of spiritual insight, for others understanding focused on the personal or political realm. Sometimes this led to conflict where the surrounding system did not share the same view, and there was a sense of 'battling' with the system. Thus, some enlightenment narratives convey a protesting tone. However, the predominant tone is thoughtful and educative, with an emphasis on 'getting control of my story' (Suraya) and developing important insights that can be shared with others.

Following a series of difficult experiences, use of LSD, and involvement in a 'New Age' style weekend, which he says drove him 'completely mad', Simon was admitted to hospital. He chose not to take medication and despite behaving in a difficult way he was neither compulsorily detained nor treated. He regards these as important aspects of his recovery. After a time something 'dawned' on him and he decided to 'let go ... of being that mad'. This was a special moment:

It was like serendipity ... it was like a moment of, you know ... religious language would be kind of 'grace' or something, you know. It would be like ... something changed. And I was aware that something changed and I let go of something.

Gradually Simon began to piece his life back together, moving in with his girlfriend, signing on, and doing some menial work. Later he began to explore what therapy had to offer as well as other approaches to mental and physical well-being. Eventually he trained as a therapist and worked in various capacities in mental health.

Enlightenment narratives also sometimes reflect a different experience of psychosis to that described in some escape narratives. That is, the experience of psychosis itself is viewed as having positive as well as negative aspects, and sometimes as revealing feelings and experiences that had been hidden or not talked about:

Well, I suppose what it was, was in my psychotic episodes the really ... the one theme was about my own child abuse when I was younger ... and in my psychosis I always went back like a [...] detective ... trying to work out the riddles, the clues as to what happened.

(Suraya)

Suraya identifies the psychosis as positive in that it forced her to confront issues she had previously avoided:

I feel like I've got the control back. And possibly the psychosis helped me to get that control back. [...] I think it was the psychosis that really sort of made me look at things [...] And having looked at them I feel a lot more ... calmer about myself.

Coming to understand the psychosis as a response to previously experienced psychological or physical trauma such as childhood sexual abuse is a recurring theme in some of these enlightenment narratives:

I was experiencing being raped and being sexually abused [...] but there wasn't anybody there to say ... They just said, 'paranoid schizophrenia' which means, I was imagining it. But there wasn't anybody there who said to me 'Well, have you in your childhood ever experienced these things?'

(Indra)

Donald describes a crucial step on his journey of recovery was realizing that his voices were meaningful within his life experience, for example, that he heard the voice of the catholic priest who sexually abused him as a boy, of his dead father, and of his girlfriend who committed suicide. He was then able to grapple with the issues they raised (such as comments about how he was guilty or to blame for the abuse) and thus demystify and disempower the voices.

'Enlightenment' is described in many forms in the narratives. Peter, who has medical training, discusses his discovery that he suffered from a thyroid deficiency which he identified as contributing to his psychotic experiences when it went untreated. He also describes exploring other areas in his search for answers to his experiences, such as therapy and different medications. These narratives suggest that individuals often hold several different narrative threads together and are able to weave these into an account that makes most sense to them, according to their beliefs and experiences.

Narratives of endurance

In this study, a third group of narratives was characterized as reflecting 'endurance'. A key theme in endurance narratives is an acceptance of life as a struggle, and although some aspects may be positive, an acknowledgement of the need to contend with ongoing difficulties. For Patricia, recovery is 'a process [...] rather than an "end thing"'. In these narratives, the experience of psychosis is often regarded as akin to a disability or a chronic health condition such as diabetes, which must be continually

monitored and which constitutes a potential obstacle to progress. These endurance narratives have much in common with a medical narrative of 'schizophrenia', which emphasizes management of an ongoing condition. Indeed, in all these narratives the medical approach holds an important place. A stance of endurance, and even acceptance of a diagnosis of 'schizophrenia', did not necessarily preclude a definition of oneself as recovered, however.

Cathy, recently retired from the armed forces, describes her experience of psychosis as '[thinking] MI5, MI6 was after me'. When new neighbours moved in, she thought they had been sent to spy on her and so she 'went round there to tell them to leave me alone and to stop watching me'. The next thing she knew, 'great big, burly policemen [...] knock my front door down [and throw] me in the back of a meat wagon' and she says that 'in the prison cell they stripped me naked and just left me there'. For her, the experience of psychosis as well as how she was treated by the police and in hospital and subsequently by her neighbours and potential employers are awful experiences she has had to endure, with no redeeming features. She describes a daily process of fighting to retain self-belief and determination.

The core narrative in her story was identified as 'coming full circle' and this reflects her wish to return to how she was before she experienced psychosis, 'which was a full-time job, happy, fulfilled every day'. For her, there was nothing good about the experience of psychosis (which for her was classified as paranoid schizophrenia) and she does not feel she has derived any useful understandings from the experience. Rather, it has represented loss – in terms of finances and status, as well as emotional and psychological security. She describes fighting the idea that: 'It seems that if you have experienced psychosis that your life should end and you end up this vegetable that just sits in drop-ins and you don't do anything'. She describes battling each day to look for work, though she is aware of the stigmatization she faces. She views her partner as crucial in her recovery and identifies the need for

support all the way round ... money, partners [...] health professionals ... You need positive people in your profession. You don't need people who say, 'She'll never recover. She's for the scrapheap, she'll never work again, she's on medication for the rest of her life'.

Hugh accepts his diagnosis of paranoid schizophrenia which he was given when he began to hear voices in his 20s at a time when he went bankrupt and was homeless. His narrative of endurance reflects illness narratives in which the illness is viewed as an obstacle, but not an insuperable one, to progress. He identifies setting realistic goals as key to recovery and 'self-management [...] taking control for yourself'. He describes how he enters into dialogue with his GP or psychiatrist about the dose of medication he should be on, depending on how he is coping.

Although these endurance narratives are closest to the concept of managing symptoms and living with long-term illness typically presented to patients, resignation and stoicism is accompanied by a strong strand of angry protest. This emphasizes a wish to be treated differently by professionals and by society in general, and not be subjected to stigmatization and exclusion.

Discussion

The first contribution of this study to the field was to provide a forum for the telling of a number of seldom heard narratives of recovery from psychosis. The second aspect of the study was the reading of the narratives with a view to analysing genre, tone and core narrative. While it was evident that certain dominant themes overlapped in a number of narratives, it was possible, by analysing closely the narratives' themes, language, plot development and structure, to characterize the stories broadly as stories of escape, enlightenment and endurance.

Tone was related to narrative genre in that an angry or protesting tone was often found in narratives of escape, an educating tone in narratives of enlightenment, and a resigned tone in narratives of endurance. However, an angry or protesting tone sometimes cut across narrative genre and could be found also in narratives of enlightenment and endurance, while an educating tone was evident in some narratives of escape and endurance as well as enlightenment. A thoughtful tone was also found in two narratives of enlightenment and one of escape (see table 1), perhaps suggesting the ongoing creation of the narrative in dialogue. One endurance narrative (Cathy's) was identified as having a disbelieving/shocked tone which may be a reflection of the recency of her experiences of psychosis and treatment, and the fact that the research interview was one of the first times she had talked about these in detail. Thus narrative tone appeared to be related to how individuals understood their experiences and how far they had been able to distance themselves from and reflect on these experiences. The core narratives also reflected narrative genre and tone, for example, Mary's core narrative was identified as 'fighting for survival', the tone was protesting/angry and the genre 'escape'. Simon's core narrative was identified as 'seeing my way in the world and exploring new places', the tone was 'educating/thoughtful' and the genre 'enlightenment'. For Hugh, the core narrative was termed 'getting on with my life', the tone was educating/monotone and the genre 'endurance'.

The genre of 'escape' narrative has not been identified in previous studies of health and illness. Perhaps because the focus in other studies has not been on recovery, the notion of 'escaping' from a serious or life-threatening condition has not come to the fore. In addition, however, we must consider whether the experience of psychosis and treatment in the mental health system may be fundamentally different from how other forms of 'illness' and treatment are experienced. In some ways, it clearly is very different. For example, the notion of 'consent to treatment', which a patient is legally able to give or withhold in other realms of health care, is different in mental health care where legally patients can be treated without their consent in a number of circumstances (Mental Health Act 1983). Many of the narratives include accounts of being forcibly treated with medication in hospital.

It remains a routine part of clinical practice on acute psychiatric wards to detain individuals against their will on admission and to physically restrain and medicate them with an injection of neuroleptics in the backside. Refusal to take medication orally or via injection during admission can also result in these measures. This is not only the case for individuals who seemingly pose a risk to others, but for any patient identifiable as having a 'treatable mental illness', who refuses medication. The prevalent belief that medication is required to alleviate mental health problems,

regardless of how it is administered, enables staff to ignore the possible psychological effects of forced treatment. Thus 'escaping' from unwanted treatments may for some individuals become a key part their recovery story. There has been little attempt in the psychological and psychiatric literature to examine the use of these measures and the psychological effects of these on individuals. So far, they have only be hinted at in studies which suggest that individuals can have experiences diagnosable as post-traumatic stress disorder, following their first admission to psychiatric hospital (McGorry 2000).

The structure of these stories and their use of the language and metaphors of imprisonment and torture aligned these narratives more with accounts of survival of imprisonment than illness narratives (e.g. Davies 1990; Langer 1991, 1996; Young 1988). This may in part be a reflection of the aspect of mental health care which functions as social control and which there is pressure to increase in recent government proposals (Department of Health 2002). However these stories highlight the importance raised in previous studies (Baker & Strong 2001; Faulkner & Layzell 2000; Jacobson 2001; Lapsley *et al.* 2002; Martyn 2002; Read 2001; Smith 2000; Young & Ensing 1999) of genuine collaboration between mental health professionals and their clients, where information and power are shared, where each party is treated with respect and dignity and where differences of opinion and belief systems can co-exist.

A second aspect of the narratives of escape is that of escaping from the identity of the chronic psychiatric patient. To an extent, this aspect of recovery resonates with theories of the effects of stigma (Goffman 1965/1986) and labelling (Scheff 1966/1999). Scheff (1966/1999) in the latest edition of *Being Mentally Ill: A Sociological Theory* revises his earlier theory that 'mental illness' is nothing other than the violation of residual rules in society. He remains sceptical about the validity of the disease model of 'mental illness' but recognizes that the effects of labelling are one aspect of experiencing 'mental illness' and offer only a partial explanation of the cause and effect of these experiences. In particular he highlights the importance of the emotional/relational world and he urges researchers and theorists to broaden their perspectives.

In some of the narratives of escape the concept of 'mental illness' is questioned, as when Miriam comments, 'I had a strong feeling I needed help with a great many human problems I had never, ever received any help with'. The notion that what is defined as 'mental illness' is no more or less than a type of human problem reflects the thinking of writers such as Szasz (e.g. 1961, 1973, 1976). Szasz, with a training both in psychiatry and psychoanalysis, has famously rejected these 'expert positions' and offers as an alternative to the terminology 'psychiatric symptoms', the term 'problems in living', which has been adopted by narrative therapists such as Michael White (1987, 1995, 1996). Thus the tellers of some escape narratives would contend that they had to escape form a false and limiting notion of 'mental illness' in order to recover meaningful lives. Interestingly, all of those who told escape narratives had been diagnosed with either schizophrenia or schizo-affective disorder, arguably the most stigmatizing of diagnoses, and escaping from the identity this commonly represents was a crucial part of all these narratives.

The tellers of 'enlightenment' narratives also question a narrow definition of 'mental illness' and protest against a system which can be totalitarian in its insistence

that individuals subscribe to a biological view of their problems, or risk compulsory detainment and treatment. The genre of 'enlightenment' narrative has much in common with specific types of illness or trauma narrative identified in previous research, such as the 'conversion/growth' genre (Crossley 1999) and 'quest narrative' (Frank 1993). They share the emphasis on an ongoing journey involving a search for meaning (Crossley 2000; Kleinman 1989). Similarly, they share key aspects of 'restitution' narratives (Frank 1993), since the recovery journey often involves taking on the role of activist to attempt to address or repair, for others if not for the self, some aspects of what was experienced as unjust or damaging. In their emphasis on making sense of difficult or confusing experiences, enlightenment narratives have much in common with narratives of recovery from trauma or abuse (Davies 1995; Harvey *et al.* 2000) and for some individuals their narratives are of recovery from *both* trauma and psychosis which are understood to be profoundly related.

However, some of the narratives differ from illness and trauma narratives in that the psychosis itself may be experienced as a kind of enlightenment, bringing to the fore elements of the self that were previously neglected or outside of conscious awareness. This reflects theories of psychosis within existential (e.g. Laing 1960/1991, 1961/1971, 1967/1983) and psychodynamic (e.g. Alanen 1997; Jackson 2002; Jackson & Williams 1994) frameworks. Thus, in these narratives the psychosis itself can herald the start of a journey of self-discovery, aided perhaps by therapy. Psychotic thought processes, rather than being dismissed as empty signifiers of a biological illness, are seen as offering valuable clues to important psychological and emotional issues. Enlightenment, in general, is presented as a process of developing understanding that may take place over many years. As Simon commented on the categorization of his narrative, it is important not to view the term enlightenment as simplistic or romantic but as complex with periods of difficulty as well as development.

The narratives of endurance also map onto previously identified types of narrative genre such as the 'normalizing story' (Crossley 1999) and narratives of 'acceptance' (Frank 1993). They represent a stance that in many ways is akin to the model of symptom management favoured by the medical approach, but nevertheless are able to incorporate the notion of recovery and successfully achieving desired life goals. In addition these narratives retain a strand of protest about wanting to be treated differently by professionals and by society. The narratives include petitions that individuals be given more choices about which type of treatments they are offered, as has been found in previous studies (Faulkner & Layzell 2000; Martyn 2002). There are also pleas for action to be taken so that society develops a more informed understanding of those who carry a mental illness diagnosis, and for legislation to prevent the wholesale discrimination by employers of those who have been diagnosed with conditions such as 'schizophrenia'. This reflects themes in other studies of 'barriers to recovery' (Baker & Strong 2001; Jacobson 2001). Even where narratives have been characterized as stories of 'endurance' and where their tone has been heard as one of resignation or disenfranchisement, it could be argued that the very act of telling the story in the research context moves these narratives beyond acceptance, and represents an act of defiance or of 'restitution' by the tellers.

The participants in this study represented 'key informants who have a profound and central grasping of a particular cultural world' (Plummer 1983, p. 104). They

were mostly highly motivated, educated, articulate individuals, with well-developed ideas about mental health. As such, they may have been able to give an account of experiences shared by others who are less vocal. Most were involved in user groups which often take a critical stance on psychiatric treatment, although additional recruiting at conferences helped to ensure a range of views. It is also important to note that it was difficult to recruit participants from minority ethnic groups.

Developments in narrative therapy centrally address the question of how individuals talk about their experiences, how they cast themselves and others in their narratives, and how far they are enabled or disabled by their stories (White 1995, 1996). One aspect of facilitating recovery may involve hearing the stories people have to tell and accepting their own words and terminology, thus creating a space for dialogue and exploration that can further understanding (Dillon & May 2002). This can occur in any context in which people are in dialogue, and is not limited to the narrow confines of 'therapy'. It is particularly crucial if the mental health system is to offer a service that is genuinely healing (Roberts & Holmes 1999).

It is said that we live in a post-modern age in which modernist notions, such as an unshakeable belief in the progress of science, or the conviction that there is 'one true answer' to every question, have been cast into doubt if not rejected outright. If practice in mental health is to catch up with academic theorizing, then multiple voices and multiple realities must be heard and allowed existence. This does not mean that 'anything goes', it is not to deny differences in the way individuals perceive reality, and it does not mean that experiences can never be defined as 'psychotic', or that a belief someone (professional or lay) holds about an experience cannot be refuted. However, it does mean that there may be more than one way of understanding or talking about experiences, and these should be allowed to co-exist and explored, rather than one interlocuter insisting that their opinions or belief systems are the only ones which have any legitimacy or credibility. Certainly, on the evidence of this study, recovery from psychosis would seem to be compatible with a wide range of understandings and beliefs about the experience. Indeed, it may be that the process of making sense of the experience in ways that are personally meaningful to the individual is one of the keys to recovery.

Acknowledgements

This research was undertaken as part of a doctorate in clinical psychology at University College London. We wish to acknowledge the contribution of the participants, without whose courage, generosity and thoughtfulness this study would not have been possible. They should more properly be termed co-researchers since their thinking about their own experiences forms the basis of the research. We would also like to acknowledge John Rhodes, Corinne Squire, Dave Harper, Carla Willig and Anne Cooke for their consultations at crucial stages of the research process. We owe further thanks to three anonymous reviewers who offered very helpful comments on an earlier draft of this paper.

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