

**Resisting medicalised discourses of schizophrenia: Mindfulness and the
construction of a positive self**

A research report submitted in partial fulfilment of the requirements for the degree of MA Research
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Declaration

I, Kasia Venter (Student number: 830881), hereby declare that this research report is my own work. It is being submitted in partial fulfilment of the requirements for the Degree in Master of Research Psychology by Coursework and Research Report at the University of the Witwatersrand, Johannesburg. It has not been submitted for any other degree or examination at this or any other university.

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Resisting medicalised discourses of schizophrenia: Mindfulness and the construction of a positive self

This study has two aims. The first is to explore how individuals who have been diagnosed with schizophrenia, and have used mindfulness-based approaches, resist medicalised discourses of schizophrenia. The second aim is to explore what role the resistance of the medicalised discourses play in the construction of the self.

When the concept of schizophrenia first emerged over a century ago, it was accompanied by little anticipation of recovery (Frese, Knight & Saks, 2009). In contemporary society it is described as a severe “illness” (Bentall, 1993; Rudge & Morse, 2001). Several theories of schizophrenia have been proposed including biological (genetic and biochemical factors, neuropathology and brain metabolism), psychosocial and psychoanalytic theories (Sadock & Sadock, 2007). However, it remains a disputed category (Geekie & Read, 2009; Scheff, 1970). It has been argued that there is little agreement concerning what constitutes the rudimentary characteristics of schizophrenia, and whether a disease entity of it exists (Scheff, 1970).

Diagnosing schizophrenia has become progressively problematic because patients exhibit symptoms that do not neatly fit the conventional diagnostic criteria for schizophrenia and that overlap with other categories (Bentall, 1993). The concept of schizophrenia is used to explain an extensive range of experiences and behaviours. Yet, it is rare that all of these experiences and behaviours are present in a single individual (Bentall, 1993). Due to this, two individuals with a diagnosis of schizophrenia may not resemble each other in any way (Bentall, 1993; Pilgrim, 2007). The diagnosis of schizophrenia has been argued to lack aetiological and treatment specificity (Bentall, Jackson, & Pilgrim, 1988). The causation of schizophrenia is contested and the same

treatment is often used by psychiatrists for individuals with completely different diagnoses (Pilgrim, 2007).

Bentall et al. (1988) stated that it is necessary for a diagnosis to be both reliable and valid. For a diagnosis to be valid it needs to be predictive and should be discernable from other diagnoses. According to Bentall et al. schizophrenia fails to meet these criteria and should therefore be abandoned as valueless. They conclude that “schizophrenia appears to be a disease which has no particular symptoms, which has no particular cause and which responds to no particular treatment” (Bentall et al., 1988, p. 227). Not only has the diagnosis been argued to be invalid, but it has been argued to be harmful as well (Romme & Morris, 2007). Romme and Morris explain that this is because the diagnostic process ignores the reasons for the experiences of the diagnosed individual. They argue that the core experiences of “schizophrenia” do not represent pathology. The abovementioned critiques of the diagnosis of schizophrenia beg the question why in the face of criticism of empirical, logical and sociological grounds, this diagnosis has survived for so long (Pilgrim, 2007).

It is not merely the diagnosis of schizophrenia that is problematic but also the research on it. Mainstream research takes the category for granted and uses the presence or absence of the diagnosis as an independent variable (Bentall, 1993). Such research relies on the assumptions that the symptoms of “schizophrenia” are due to biological dysfunction, and that all individuals diagnosed with “schizophrenia” share common aetiology despite the heterogeneity of their symptoms and experiences. In spite of the abovementioned and several other critiques of the diagnosis for the past 50 years, schizophrenia as a category is used as a discreet diagnosis, and maintains a powerful legitimacy within psychiatry (Pilgrim, 2007).

There are alternative ways of thinking about experiences of “schizophrenia” that do not rely on the diagnostic classification used presently, argued Bentall (1993). Rose (1988) argued that we

need to examine the function history performs in the discipline today. He stated that it is valuable to question and analyse the certainties of the present. In doing so, the apparent certainties presently held by our discipline may begin to fragment. It is therefore, that this study refrains from taking the category schizophrenia for granted, and focuses on how individuals who have received the diagnosis construct the category. By doing this, this study hopes to shed light on the nature of the category and how different discourses are used to construct it.

Research advocates that there are many ways in which the discourses used by individuals, and especially the discourses individuals produce about themselves, are crucial to the outcomes of the individual (Lysaker, Lancaster & Lysaker, 2003; Meehan & MacLachlan, 2008). The discourses that the individual produces play an essential role in the creation of the subjective self (Drapalski et al., 2013; Meehan & MacLachlan, 2008). Yet, there is a lack in research on discourses of schizophrenia (Raballo, Sæbye & Parnas, 2011; Thornhill, Clare & May, 2004). Therefore, this study is interested in investigating the discourses that individuals with a diagnosis of schizophrenia that are using mindfulness-based approaches use.

Mindfulness offers an alternative discourse to the traditional discourses in constructing schizophrenia. According to the discourse of mindfulness, distress is not an inherent consequence of experience but is the reaction of the individual in response to an experience (Abba, Chadwick & Stevenson, 2008). The discourse of mindfulness argues that it is the attachment to an experience that contributes to feelings of suffering rather than the experience itself (Hirst, 2003). Therefore, the discourse of mindfulness encourages individuals to decentre from their thoughts and experiences (Pepping, O'Donovan, A. & Davis, 2013). No thought or construct is to be evaluated (Braer, 2003; Abba, Chadwick & Stevenson, 2008). In essence, unlike the medicalised discourse, the discourse of mindfulness does not conceptualise “schizophrenia” as an inherently distressing experience and therefore offers unique discursive resources for constructing it.

In the literature review of this report it will further be demonstrated why it is important to study the discourses of individuals diagnosed with schizophrenia and the role they play in the construction of the self. The literature review will discuss how schizophrenia has been constructed over time and will then turn to discuss the contrasting discourses of mindfulness. Thereafter, in the methodology section, a description of and rationale for using social constructionism as a theoretical framework will be provided. Details concerning the sampling, data and method of analysis of this study will be discussed in the methodology section. The analysis of the data will then be presented. The report will conclude by discussing the implications of the findings for the notion that schizophrenia is a disorder that exists independently of social processes, and to comment on the relationship between discourses of schizophrenia and constructions of a self.

Literature Review

In context of this study and its aims, it is necessary to understand that the relationship between schizophrenia and the self is important and the reasons therefore. It is also vital to understand the role of discourse, especially in the construction of the self and the construction of schizophrenia. Discourses are moulded by both the contexts of current interactions and by history. Schizophrenia as a category has been constructed over time. It is therefore essential to be aware of the dominant discourses that constructed schizophrenia since the category was first used, and how those discourses influenced the discourses used today.

Hope and agency have both been argued to be essential for well-being and have both been neglected in research on schizophrenia. The implications of this will be highlighted. Mindfulness, as an approach, differs greatly from traditional medical approaches in ways of dealing with, and thinking of experiences that are categorised as mental illness. It uses discourses that are noticeably

dissimilar from the medicalised discourse. For this study it is important to be familiar with the discourses of mindfulness and how it influences the self.

The literature review of this study therefore discusses five sections: schizophrenia and the self, the power of discourse, discourses of schizophrenia, schizophrenia, hope and agency and the mindfulness approach.

Schizophrenia and the self

Recent literature argues that schizophrenia is a self-disorder (Sass & Parnas, 2003). Often literature that make this argument views the self as something that an individual *is* and that resides within (Schneider, 2003). However, the notions of the self and of identity are complex constructs and have been defined in various ways (Schneider, 2003). This study will adopt a different approach to the approaches prominent in the literature concerning schizophrenia and the self by utilising the social constructionist framework, thereby focusing on the discourses of schizophrenia and the self rather than accepting the “self” and “schizophrenia” as objective, predetermined constructs. Social constructionism argues that the identities of individuals arise from the discussions, relations and interactions individuals have with other individuals (Williams & Collins, 2002). For the purpose of this project the term “self” will therefore refer to a socially constructed identity. Research exploring the relationship between the self and schizophrenia will be mentioned even when a social constructivist view of the self is not used in order to demonstrate the importance of the self when studying the category schizophrenia.

It has been hypothesized that in “schizophrenia” the disagreement between the individual’s sense of self and others’ views of the individual promotes the withdrawal, undermined self-esteem and alienation that characterise the construct schizophrenia (Estroff, 1989). Although this research by Estroff (1989) did not take a critical stance on the nature of the category schizophrenia, the

results questioned whether the chronic characteristic of the construct schizophrenia is influenced by the identity, which is socially constructed and negotiated after receiving a diagnosis, rather than by a “disorder” which exists independent of these social processes (Williams & Collins, 2002).

Another example of the relationship between the diagnostic category schizophrenia, and the self is the discourse of internalised stigma. When adhering to a discursive framework internalised stigma refers to when an individual employs discourses other individuals produce of them. Results obtained by Drapalski et al. (2013) demonstrate that individuals do use the discourses others produce of them when constructing themselves. This has been found to lead to increased negative outcomes. Raballo et al. (2011) state that there is a complete absence of the concept of self and consciousness of self in contemporary views and descriptions of schizophrenia. This current absence in consideration of the self in schizophrenia seems peculiar due to the fact that several historical writers constructed schizophrenia as an abnormality of the sense of self (Berze, 1914 cited in Parnas, 2004; Bleuler & Zinkin, 1950).

Schizophrenia is described as an “I am” disorder (Estroff, 1989). The identity of individuals diagnosed with schizophrenia is often said to be redefined (Estroff, 1989; Lysaker, Ringer, Maxwell, McGuire & Lecomte, 2011). Estroff (1989) argued that schizophrenia is not merely a disorder that one has but is something that the person is, or will become. Therefore, Estroff asserted that individuals do not only receive a diagnosis but a new identity as well. She states that the individual does not merely “suffer from schizophrenia” but “becomes a schizophrenic”. Her argument serves to emphasize how identity is a social process influenced by a diagnosis and being described as belonging to a particular diagnostic category. A diagnosis then adheres to a specific discourse.

The power of discourse

Discourses can be defined as systems of representation and the construction of knowledge through language (Wetherell, Taylor & Yate, 2001). Discourse in this sense is concerned with language and practice as it emphasizes the construction of realities through language. Research shows that the way individuals talk and write about events affects the impact of the events on the lives of the individuals in question (Crossley, 2000). Social constructionists argue that the self is not fixed. It is not something that we are but rather something we create, especially through language (Schneider, 2003). Individuals create a self by resisting or embracing larger cultural discourses.

Individuals play an active role in the construction of the experiences of living with a diagnosis of mental illness (Crossley, 2000; Gray, 2001). A multitude of discourses are available for individual to employ, therefore individuals may employ several subject positions at particular points in time. This is due to the fact that discourses are shaped by numerous experiences and individuals that come into contact with the individual concerned (Meehan & MacLachlan, 2008). Thornhill, Clare and May (2004) state that the construction and meaning of the experience of the individual may vary depending on the type of narrative the individual produces. The construction of experience also emphasizes the social construction of diagnostic categories themselves and in turn urges that the contemporary views of this practise be reconsidered in order to acknowledge a nature of schizophrenia that exceeds medicalised discourse (Thornhill, Clare & May, 2004).

Potter and Wetherell (1987) stated that it is virtually impossible to separate the nature of the self and language. Individuals are taken to be members of social categories and as such virtues and characteristics associated with the category apply to the individuals belonging to that category (Potter & Wetherell, 1987). People and selves constructed in terms of categories (Potter & Wetherell, 1987; Schneider, 2003). Categories do not exist independent of their use during social

interaction (Schneider, 2003). Certain meanings are, therefore, only associated with certain categories due to the way they are used in social interactions. The categorisation that occurs during discourse is, consequently, described as active (Schneider, 2003). Categories are articulated in various ways during talk and writings in order to achieve certain goals, such as to justify or to blame (Potter & Wetherell, 1987; Schneider, 2003). Categories need to be maintained, negotiated and are open to be contested (Schneider, 2003).

Discourses of schizophrenia

Discourses that are employed in the present have a history (Parker, 1992). The history of the psychological sciences in particular is an authoritative history (Rose, 1988). Psychology and psychiatry have had the responsibility of providing devices that could transform human capacities and mental processes into information about which calculations could be made (Rose, 1988).

Rose (1988) argued that the functioning of the psychological sciences, and their relationships with more general social, political, and ethical transformations, should be understood as techniques for disciplining of human difference. Their role is to individualise humans by classifying them, to calculate their capacities and behaviours, to record their characteristics and deficiencies, and then to manage and utilise their individuality and variability (Rose, 1988). Through these techniques, the discipline of psychological sciences “creates” individuals (Foucault, 1979). Therefore, psychology does not construct individuals as active agents in the construction of their world; it constructs them as passive objects.

The first notions of the construct schizophrenia were that it is a disease involving grave deterioration of the diagnosed individual (Kraepelin, 1919; Bleuler & Zinkin, 1950; Frese, Knight & Saks, 2009). The dominant theoretical model for conceptualising the construct schizophrenia is the medical model (Pilgrim, 2007; Larsson, Loewenthal & Brooks, 2012). This discourse

originates from the notion that a diagnosis such as schizophrenia is a medical term used to describe a naturally occurring phenomenon (Pilgrim, 2007). It emphasises neurological aetiology and often deems individuals with a diagnosis as lacking some cognitive capacity about their actions. Pilgrim's descriptions of the commonly used medicalised discourse of schizophrenia are reflected by several other authors.

Rudge and Morse (2001) performed a Foucauldian review of literature and found that the frameworks according to which the most literature concerning schizophrenia positioned itself were biological, clinical or statistical frameworks. The research was concerned with classifying, diagnosing and objectifying. As such, the literature described the construct schizophrenia primarily from positivist frameworks. What was discussed in the literature was therefore largely founded on neuro-scientific explanations and the “known” pharmaceutical characteristics of treatments. Individuals with a diagnosis of schizophrenia were referred to as “schizophrenics”, and as sufferers and victims of schizophrenia (Rudge & Morse, 2001; Larsson, Loewenthal & Brooks, 2012). Often it was found that the literature implied that the “victims” passively received care and passively related to their symptoms. Frequently the literature attempted to find a “pathway to recovery”. This pathway was often assumed to be influenced by an accurate diagnosis and effective treatment (Rudge & Morse, 2001). Details concerning recovery were often lacking. The overall tone of the literature was found to be overly authoritarian, delegitimizing and de-personalizing. The medical model of “schizophrenia” is reinforced and justified through the use of medicalised discourse in everyday interactions (Larsson et al., 2012).

Research has found that participants' constructions of schizophrenia resemble the representations of schizophrenia as constructed by the medicalised discourse. McCann and Clark (2004) conducted a study to investigate how individuals find meaning in schizophrenia. Their findings resemble the common discourse of schizophrenia as something devastating (Rudge &

Morse, 2001). They reported finding that individuals with a diagnosis of schizophrenia experience feelings of guilt and embarrassment. The self-confidence of all of the participants were said to be adversely affected due to the “fear of embarrassment upon themselves” (McCann & Clark, 2004, p.788). Schizophrenia was constructed as a devastating experience and one that caused individuals to see no future beyond their illness. Participants that have claimed to have recovered demonstrated a fear that “ill health” could return at any moment (McCann & Clark, 2004). Therefore, discourses of recovery constructed recovery as being temporary. The construct schizophrenia was associated with a sense of despair and hopelessness. McCann and Clark (2004) conclude their study by saying that schizophrenia was constructed as a “shattering experience” (p. 793). Studies indicate that discourses of schizophrenia associate it with a loss of hope (Bassman, 2000; Lysaker & Lysaker, 2001; Kylmä et al., 2006) and “grief for the normal life that is lost, and future plans than will never materialise” (McCann & Clark, 2004, p. 785).

Discourses provide subject positions which in turn constrain and constitute the construction of the self (Meehan & MacLachlan, 2008; Willig, 2000). Positions that construct the individual as being sick, for example, are in part promoted by the medical discourses that are present in the talk of the individual and in the talk of other people, including professionals, about the individual (Meehan & MacLachlan, 2008). Williams and Collins (2002) argue that the general public and health professionals have low expectations for individuals with a diagnosis of schizophrenia. Even interventions aimed at helping the individual often communicate low expectations and reiterate stigma (Estroff, Lachichotte, Illingworth, & Johnston, 1992). Results of a study by Howe, Tickle and Brown (2014) also found that individuals with a diagnosis of schizophrenia experienced being treated as “subnormal” and as unintelligent by professionals. In a study by Hayne (2003) participants claimed that the medical discourse undermined their sense of being and hindered their

progress. These social factors may contribute to negative outcomes for the individuals with such a diagnosis (Williams & Collins, 2002).

Potter and Wetherell (1987) explained that certain terms are readily evaluated. These terms inherently attribute values to acts of individuals implicated by the term. Schizophrenia is such a term loaded with assumptions and that is tied to an institutionalised discourse. It is an exceptionally powerful diagnosis to receive (Deegan, 1987 as cited in Howe, Tickle & Brown, 2014). There are numerous ways according to which groups of people and sets of beliefs can be characterised and there will always be alternative descriptions and categorisations available to use (Potter & Wetherell, 1987). The use of a description, therefore, involves a number of decisions to be made. The discourses employed by individuals have specific consequences for the constructions of themselves. This is because of their diagnoses and the way in which schizophrenia can be constructed according to different discourses (Potter & Wetherell, 1987).

Individuals diagnosed with schizophrenia do not necessarily have to use the category schizophrenia in their construction of themselves. Research by Schneider (2003) found that individuals diagnosed with schizophrenia do not simply adopt the traditional discourse of schizophrenia that constructs them in a negative light. The life circumstances and cultural knowledge of individuals can be used as resources for the construction of the self (Schneider, 2003). In doing so, these individuals change the cultural knowledge of schizophrenia. Schneider (2003) argues that the strategies used to manage the type of self constructed by individuals with a diagnosis of schizophrenia are not merely embedded within certain social situations; they are also consequences of the stigmatising public discourse of schizophrenia. Individuals with a diagnosis can reject the label “schizophrenia” and can account for the behaviours that are argued to be indicative of schizophrenia by invoking a range of biographical, social or spiritual accounts (Rogers, Pilgrim & Lacey, 1993; Romme & Escher, 1993).

Research by Austin and Fitzgerald (2007) demonstrate that individuals can resist a category by creating an alternative category to use. They can also resist categories by reconstructing the actions associated with those categories. Actions can be reconstructed as being normal and reasonable (Austin & Fitzgerald, 2007). Consequently, the category itself may be reconstructed as normal and reasonable. Individuals can resist any category with which they have come to be associated with through interactions.

What is considered to be a symptom of mental illness is determined by covertly comparing the beliefs or ideas of the patient, those of the observer and the society in which they live. The concept of mental illness is, therefore, intimately associated with the social and ethical contexts in which it is created (Szasz, 1960). It is Szasz's (1960) opinion that by explaining problems of living, as he calls it, as neurological defects one focuses on those beliefs as mere symptoms. The problem with this is that the beliefs themselves are not examined. This is the case with schizophrenia. Practitioners disregard experiences as mere symptoms to be treated with medication.

It is therefore that Scheff (1970) resisted the conventional medical conceptualisation of schizophrenia as a disorder. He argued that the concept of schizophrenia is an ideology embedded within the history and culture of Western civilisation. Schizophrenia as a disorder then is not to be considered as something that is value-free or neutral. Scheff (1970) further explained that the concept of schizophrenia is associated with certain discourses which legitimise the very concept. More so, as some of the characteristics said to be demonstrative of schizophrenia as a disorder have been argued to have been produced by social processes rather than be a product of the disorder itself, the nature of the disorder can be contested (Estroff et al., 1992).

Parker (1992) argued that discourses and power relations should be discussed simultaneously because often discourses serve to reproduce power relations. He claimed that the

increase in the institutionalisation of psychology increases its power over both those inside and outside of it. Medicalised discourses are historically situated practices that play a role in cultural production and reproduction (Wilce, 2009). The diagnostic label has been said to create a power inequality between the professional that diagnoses and the individual that is diagnosed (MacDonald 2002; Hayne, 2003).

White (1990, p. 14) states that “ways of speaking and acting make it possible for mental health professionals to construct people as the objects of psychiatric knowledge, to contribute to a sense of identity which has ‘otherness’ as its central feature.” These pathologising discourses declare that those that support them possess the rights to declare their truth about the individuals with whom they interact. Such a positioning allows those that adhere to the discourse to distance themselves from the consequences of such truth claims.

It is important to remember that The Diagnostic and Statistical Manual (DSM) is both a scientific document and a revisable political manifesto (Pilgrim, 2007). “Disorders” are subject to debate and may cease to exist as disorders. An example of this is the revocation of the diagnosis of homosexuality as a disorder. This notion supports Scheff’s argument that “disorders” are influenced by the culture and politics of greater society.

There are authors that claim that due to an “expanded knowledge of schizophrenia” individuals with a diagnosis are no longer viewed as being ill (Noiseux & Ricard, 2008). These authors claim that a more positive view of individuals with the diagnosis is embraced by professionals nowadays, and that individuals are considered to play an active role in their progress (Noiseux & Ricard, 2008). However, the study by Noiseux and Ricard (2008) contradicts numerous studies that found the opposite (Estroff et al., 1992; Rudge & Morse, 2001; Hayne, 2003; Frese, Knight & Saks, 2009). In spite of these arguments, what matters most is not what research found

the nature of the prominent discourses of schizophrenia to be, but whether individuals with a diagnosis of schizophrenia construct the dominant discourses of schizophrenia to be helpful or not.

Schizophrenia, hope and agency.

The use of discourses of agency and hope are important regardless of the psychological state of an individual (Noh, Choe & Yang, 2008; Libman-Sokołowska & Nasierowski, 2013). Discourses of hope serves as a source of strength during existential challenges (Libman-Sokołowska & Nasierowski, 2013), and the construction of an enduring sense of the self as an active and responsible agent is crucial for improvement (Davidson & Strauss, 1992; Deegan, 1993). Lysaker, Buck, Hammoud, Taylor and Roe (2006) studied the relationship between the personal narratives of people with schizophrenia, their hope level and recovery. They found that the change in how participants reconstruct themselves as individuals taking part in life in a significant way is imperative to improvement (Lysaker et al., 2006). For professionals to foster this they will need to allow for, and encourage a more active role for those they aim to help. They will also need to critically examine whether their discourses encourage and empower those they claim to want to help.

The construct hope is not always deemed to be an important component of an individual's psychological state (Libman-Sokołowska & Nasierowski, 2013). Recent literature on hope in individuals with a diagnosis of schizophrenia reveal that this component of the individual's functioning is neglected by and surpasses the interests of most psychiatrists and psychologists (Kylmä, Juvakka, Nikkonen, Korhonen & Isohanni, 2006; Lieberman, Stroup & Perkins, 2006; Noh, Choe & Yang, 2008; Libman-Sokołowska & Nasierowski, 2013). This changed somewhat with the emergence of positive psychology (Libman-Sokołowska & Nasierowski, 2013). This negligence of hope seems peculiar because the relationship between the construction of one's life as hopeful and well-being is well established (Libman-Sokołowska & Nasierowski, 2013). Discourses

of hope construct life as meaningful, and in expectance of a better tomorrow (Fitzgerald, 1979; Roe, Chopra & Rudnick, 2004). For individuals with a diagnosis it is described as the discourse that there is life beyond the discourse of mental illness (Fitzgerald, 1979).

The mindfulness approach

Mindfulness is an approach that contrasts the traditional approaches significantly. Discourses of mindfulness emphasise consciousness and promotes psychological well-being and hope (Brown & Ryan, 2003). Mindfulness is inspired by 2,600 year Buddhist traditions and emphasizes the value of being aware of the present and the self in the present (Brown & Ryan, 2003; Shapiro & Carlson, 2009). The process of mindfulness is constructed as the existence of awareness. The outcome of mindfulness or mindful practice is constructed as the deliberate practice of attention in a manner that is discriminating and open (Shapiro & Carlson, 2009). It is therefore comprised of both heightened attention and awareness. Awareness is constructed as the process of monitoring the environment (Brown & Ryan, 2003). Attention refers to the increased sensitivity of an event or experience due to the focussing of conscious awareness. Receptive attention to present psychological states is crucial according to the mindfulness discourse. In other words, the discourse constructs that if an individual is mindful, the emotions experienced by the individual would be clearly acknowledged and will not occur outside of the awareness of the individual (Brown & Ryan, 2003). The discourse of mindfulness is also characterised by encouraging interest in new experiences and curiosity (Marchand, 2012).

According to the discourse of mindfulness, distress is not an inherent consequence of experience but is the reaction of the individual in response to an experience (Abba, Chadwick & Stevenson, 2008). Mindfulness, communicates that human unhappiness is not due to particular experiences but due to the formation of attachment to those experiences (Brown & Ryan, 2003;

Hirst, 2003; Abba, Chadwick & Stevenson, 2008; Shapiro & Carlson, 2009). Mindfulness claims that forming attachments to phenomena in consciousness gives them significance (Hirst, 2003). It argues that forming an attachment causes phenomena to become objects in and of consciousness. Suffering is constructed to originate because attachment to phenomena, conceptualisation or objectification, lead to a process of misunderstanding the phenomena as well as reality (Hirst, 2003).

Hirst (2003) explains that during attachment the object in the awareness of the individual is constructed as having an inherent existence outside of the consciousness of the individual who conceived it. In every day mental health practices the attachment to feelings and experiences are common, as practitioners and individuals laboriously try to rid individuals from their “symptoms” (Hirst, 2003). The Dalai Lama (2002, p. 145) claims that these conceptualisations, phenomena and objectifications “do not exist in their own right, but only have an existence dependent upon many factors, including a consciousness that conceptualises them”. According to the discourse of mindfulness, letting go of phenomena helps to relieve the person from developing or reinforcing unhelpful or harmful habitual cognitive, emotional or behavioural patterns (Hirst, 2003).

The discourse of mindfulness constructs that it is essential for individuals to view sensations as they are. Therefore, no judgement is to be made of the sensation and the individual is not to try and analyse the nature of the sensation, where it originated from, or why it has occurred (Braer, 2003; Abba, Chadwick & Stevenson, 2008). It is described as both an outcome and a process (Shapiro, 2009).

The use of discourses of mindfulness has been found to be associated with higher levels of self-esteem (Brown & Ryan, 2003; Pepping, O'Donovan & Davis, 2013). Pepping et al. (2013) explain that this could be due to the fact that mindfulness is characterised by discourses encouraging individuals to decentre from their thoughts. They argue that it is because of this that

individuals who use discourses of mindfulness are less likely to spend time engaging in critical and judgemental thoughts and emotions that characterise low self-esteem. Individuals adhering to discourses of mindfulness are also less likely to express experiencing thoughts that are self-critical (Pepping, O'Donovan & Davis, 2013). Individuals with low self-esteem frequently construct themselves negatively (Brown, Ryan & Creswell, 2007). It remains unclear which of the elements of mindfulness contributes to the increased positive views of the self but due to the nature of discourses it is plausible that mindfulness as a discourse plays a role in not only the construction of the self but in the self-esteem of the individual.

It has been identified that discourses of mindfulness practice are beneficial in addressing self-identity (Johnston, 2012). In particular it offers discursive resources and subject positions that could contribute to the construction of different selves than provided for by medical discourses. Because a diagnosis of schizophrenia may influence how individual constructs themselves, due to the medicalised discourses and stigma accompanying a diagnosis, mindfulness might be particularly relevant as a discursive resource in constructing a different self than those constructed through more common medicalised approaches.

Research Questions

This study has two research questions:

1. What discursive practices are used by individuals that have been diagnosed with schizophrenia and are using mindfulness-based approaches to resist the medicalised discourse of schizophrenia?
2. What role do these discourses play in the construction of the self?

Theoretical framework

The theoretical framework used in this study is social constructionism. Social constructionism argues that reality is socially constructed (Alvesson & Sköldberg, 2009). Social constructionism is rooted in phenomenology but has more recently been linked to postmodernism (Alvesson & Sköldberg, 2009). Research that is in accordance with this paradigm aims to examine how social constructions come to be and what functions they possess. This study wanted to examine how the category schizophrenia is constructed and resisted. It examined what function resistance played in the construction of the self. It is therefore that social constructionism functioned as the framework of this research.

According to social constructionism, individuals live in several realities, some of which individuals share with others (Alvesson & Sköldberg, 2009). Social constructionism theorises that reality is shaped through language and that nothing is real unless people agree that it is (Gergen, 2001; Gergen & Gergen 2004). It is therefore plausible that while the reality for one individual might be that schizophrenia exists, to another participant the reality might be that it does not exist. The reality of schizophrenia is essentially dependant of how people construct it. Social constructionism argues that it is not something that exists independently of social processes but is a product of it.

According to Berger and Luckmann (1966), the pioneers of social constructionism, individuals “typify” other individuals in many different ways. For example, individuals typify others as English, as man or woman, grown-up, child, teacher or nurse etc. The everyday life contains “objectivations”. In other words, everyday life is comprised of an order of objects that have been designated as objects before the individual’s appearance on the scene. An example of an objectivation is language. Language also plays the role of generating “a social stock of knowledge”

(Berger & Luckmann, 1966, p. 56). It postulates the order within which the objectifications of everyday life make sense and hold meaning to the individual. Attention is drawn to the idea that the experiences of individuals are mediated by history, language and culture (Willig, 2008). The ways through which individuals construct their realities are examined as well as the effect those constructions have on the experiences of individuals.

It is important to note that according to social constructionism knowledge is not only constructed, it is deconstructed and reconstructed through ideological discourses (Hook, Kiguwa & Mkhize, 2004). Hook, Kiguwa and Mkhize (2004) state that individuals are therefore not restricted to certain roles. They argue that the core of social constructionism is twofold. Firstly, social constructionism argues that because the realities and identities of individuals are constructed, they can be deconstructed. In other words, it is possible to investigate and analyse social realities. Hook et al. (2004) state that the second core component of social constructionism is the fact that it possesses an epistemological agenda. Social constructionism aims to determine how we come to know things. It claims that if knowledge is constructed through language and re-presentation there cannot be an absolute technique for knowledge claims. Social constructionism then promises that it can expose knowledges which define themselves as being indisputable, self-evident truths (Hook, Kiguwa & Mkhize, 2004). An example of such a knowledge could be that schizophrenia as a disorder exists and is independent of social processes.

To conclude, this study uses the social constructionist framework it assumes that the sense of self and experiences of individuals are constructed through language. This study theorises that mindfulness-based approaches are comprised of their own discourses and that these discourses may be used by individuals in constructing schizophrenia and the self. In accordance with social constructionism this study then also assumes that it is possible to study these constructions of the self and thus aimed to do so by examining the language of the individuals involved. By doing so,

this study aimed to explore how participants using mindfulness resist the nature of schizophrenia according to the medicalised discourse and also what function this resistance has.

Methodology

Research design

This research uses qualitative methodology and adheres to a social constructionist framework. This research was interested in the role of language in the construction of the self and how participants resist the medicalised discourses of schizophrenia. It aimed to refrain from taking the category schizophrenia for granted and as such wanted to avoid using predetermined questions and prompts in order to collect data.

Sampling and data

The sample consisted of the discussion forums and blogs participated in by individuals who identified as being diagnosed with schizophrenia and as either currently using mindfulness-based approaches or having used them in the past. Purposive sampling was used due to the fact that the discussion forums and blogs of individuals were required to have been written by individuals that possess the abovementioned characteristics. Two blogs were used as well as eight different discussion threads on four different websites. Keywords used in internet search engines included: “schizophrenia and mindfulness”, “mindfulness”, “schizophrenia blogs mindfulness” and “discussion forum schizophrenia and mindfulness”. Bookmarks were saved of each relevant forum or blog. The data was also saved as screenshots. Only blogs and discussion forums that were written in English were used. This is because analysis could only be conducted in languages understood by the researcher.

The chosen data collection method focused on naturally occurring text. There are several notions of what constitutes naturally occurring data (Potter & Wetherell, 1995). It has been argued

that naturally occurring data is not merely a particular type of data to be collected, but is a product of analytic standpoint (Potter & Wetherell, 1995). The data of this study is naturally occurring because the researcher played no role in the production of the data. That is, even in the absence of the researcher and this project, the interactions analysed would have occurred.

Potter and Wetherell (1995) stated that experimental methods, surveys and studies with vignettes are used on the basis of the argument that the world is extremely complex and that it should be controlled and reduced in order to produce reliable conclusions. They argued that it is precisely this level of control and involvement of the researcher that makes it difficult to understand how interactions work when there is no researcher. It is therefore, that the use of naturally occurring data in this study is so beneficial; we are able to see how interactions take place in the everyday lives of the participants.

While this study does not question the genuineness of interactions which occur during say, an interview, it acknowledges that such interactions are constructed in the setting in which they take place and should be studied as such. Such an interaction may certainly be argued to also be naturally occurring, but would be naturally occurring interactions in an interview. Therefore, discourses produced during the interview should be studied as discourses produced in an interview. This study examines how participants resist and produce discourses in their everyday interactions with other individuals on an online domain. It was the participants that chose the topics to be discussed, and they were able to respond to whoever and whatever post they chose. The data collection method chosen provided the individuals the opportunity to not only respond in their own words but also did not limit the content that was discussed. The responses of the individuals were not directed by the type of questions asked or by the discourses of the interviewer.

An advantage of using data that allows the opportunity for inter-participant interaction is that participants can respond to, elaborate on or challenge each other's positions in a way that reveals more than when a researcher conducts an interview or survey (Potter & Wetherell, 1987). This made it possible to clearly see how participants orient to, defend and resist certain discourses and positions. This is valuable because much information is provided by the orientations participants demonstrate during talk and the repair procedures they engage in (Schegloff, 1992).

Participants in this study operated in online domains. A sense of self is conveyed in a different manner over the telephone, in person or during online interactions (Postman, 1985). Scholars of cyber-culture consider online domains such as chat rooms as places where individuals play with aspects of their selves that might be fixed in other domains of life. By looking at online domains it is possible to see what is possible in terms of constructing particular kinds of selves precisely because of this. Due to the fact that users of these sites might be more comfortable to play with the way they construct and represent themselves online than at other times it might be useful to see whether these findings hold in interviews, focus groups as well as in other natural settings (Marwick, 2005).

Data analysis

Discourse analysis was used to analyse the data. Discourse analysis emphasizes the role of language in the construction of the lives of individuals (Willig, 2008). It is interested in interpersonal communication and the relationship between discourses. This study was interested in how participants resist medicalised discourses. It was also interested in seeing what role the medicalised discourse, as well as discourses of mindfulness, played in the construction of the self.

In accordance to what was said by Meehan and MacLachlan (2008), this study agrees that discourse analysis is useful because the subjective positions the participants held were explored in

relation to the discourses they were producing. Subject positions are defined as “locations” within a conversation (Edley, 2001). They are identities that are made relevant by specific ways of talking. The identities of the speakers often change depending on the different discourses and interpretative repertoires the speakers employ (Edley, 2001). Discourse analysis examines the consequences of taking up various subject positions (Willig, 2008). The main consequence this research is interested in is investigating how the subject positions provided by different discourses influences the constructions of the self.

The stage of analysis focused on identifying patterns, and more importantly on analysing the function and consequence of what is written. The function of language can be specific or more global (Potter & Wetherell, 1987). A specific function would be to request or complain. A global function would be to construct oneself in a certain way. While this study examined both, it emphasised the latter. The principle theory of discourse is that function involves constructions of versions of the world. The function of language is often revealed by variations of language (Potter & Wetherell, 1987). The way in which subjectivity and selfhood are constructed through discourses is a primary aim of discourse analysis (Willig, 2008). It is therefore that discourse analysis is a suitable method of analysis for this study. Discourse analysis is not merely concerned with discourse; it is concerned with gaining a better understanding of social interaction by studying social texts (Potter & Wetherell, 1987).

Schegloff (1997) argued that it is important to remember that when researching human behaviour we are dealing with people that have the ability to orient themselves to their context, to reflect on their own behaviour and that of others. They can orient themselves to one identity and later to another. Because of this, Schegloff (1997) argued that research should privilege what participants do. Therefore, the characterisation and meaning of behaviour should be decided by participants, not the researcher. Schegloff (1977) argued that discourse is too often grounded in the

interpretation of the researcher rather than the contexts made relevant by participants. He stated that ordinary talk-in-interaction presents as solution to this. This is because such interactions display the products of the interpretations and orientations made by the speakers during the interaction (Schegloff, 1977). It is therefore, that this study uses discourse analysis in a way that acknowledges the orientation of the participants.

Ethical Considerations

The University of Witwatersrand did not require this study to obtain ethical clearance. The participants in this study were inaccessible as the texts were found online and contact details were not provided in any of the instances. Due to this it was not possible to gain consent. However, as the individuals made the decision to publicly distribute their ideas consent is implied. It was also not always possible to determine the gender of participants. In cases that the gender was unknown, one was provided. This was done only to simplify the reference to participants and therefore the presentation of the analysis.

It was not possible to make use of pseudonyms in all cases due to the fact that it was necessary to include some of the content of the online texts in this report. In some cases the profile names of participants were revealed during their interactions with others. Therefore, pseudonyms were only provided in the cases where the name of the participant did not appear in the extracts used for analysis. However, this should not pose a problem as the online content is available for public consumption.

For the purposes of this study no deception was required. All participants were treated with fairness and respect. The essence of this study was to explore discourses employed by the individuals concerned. Therefore, this study assumes that the individuals were empowered in a way. Their voices were heard and their texts served to contribute to the understanding of the role

mindfulness-based approaches play in providing discursive resources to resist the medicalised constructions of schizophrenia.

Analysis

The overarching role that the discursive practices produced in the analysed discussion forums and blogs played, was to resist the dominant medicalised discourses of schizophrenia. Individuals resisted this traditional discourse of schizophrenia in four ways. They resisted it by utilising the online platforms on which these discussions took place, by avoiding the use of the label “schizophrenia”, by creating alternative non-pathologised discourses using mindfulness as a resource for doing so and lastly, by employing professional discourses. Whilst resisting the medicalised discourse of schizophrenia individuals constantly constructed themselves as having agency over their experiences and as being more than “a disease”.

1. The use of the online platform

Individuals participating on online platforms may choose a profile name for themselves. This profile name need not be the true or full name of the individual. Most websites also provide the opportunity for users to include quotes, state their mood and post links, videos and photos to their profiles. All of these features can be used as tools to construct the self.

The profile name of Shrink resistant appears on every post of his (Extract 1). Shrink resistant chose a profile name that identifies him as someone who resists psychiatry. The word “Shrink” is a colloquial term for a psychologist or psychiatrist. The constructs “psychiatrist” and “psychologist” directly refer to the medicalised discourse. By calling himself “Shrink resistant” he is constructing himself as someone that is resistant to, or unaffected by, those professionals and perhaps the profession itself. This construction of the self as someone that opposes psychiatry is a

resistance of the medicalised discourse which constructs individuals with a diagnosis of schizophrenia as in need of professional help.

Extract 1

□ by **Shrink resistant** » Sat May 07, 2005 3:02 am

Shrink resistant

Lucitania,

I've also started a thread in the anti psych forum called "The reasons you should not be taking psychiatric drugs".

Not only does Shrink resistant choose to be identified as someone that opposes traditional psychiatry through his profile name, but he also created a thread dedicated to defending his resistance (Extract 1). Shrink resistant refers another individual on the forum, Lucitania, to his thread "The reasons you should not be taking psychiatric drugs". The title of this thread reveals that he can provide reasons as to why he resists the use of medication. Therefore, the mention of this thread serves to strengthen his argument that medication should not be used, by making the argument seem reasonable and substantiated.

Shrink resistant states that this other thread is placed on an "anti psych forum". The word "psych" is a shortening of either the word "psychiatry" or "psychology". Therefore, by stating that it is an "anti psych forum" he again makes it evident that he is resisting psychiatry and the medicalised discourse that medication for schizophrenia is necessary. In this way the online discussion forum platform is used to share his conviction, to persuade other individuals to abandon the use of traditional ways of dealing with their experiences and to convey himself as someone who resists discourses of psychiatrist and psychology.

Another participant, Fishsandwich, also uses the online platform to construct himself as someone who resists the medicalised discourse of psychiatry or psychology. At the end of each entry made by Fishsandwich, the post is signed with the following:

Extract 2

Psychiatric Survivor
"And just when I've lost my way, and I've got too many choices . . . I hear voices!"
http://www.youtube.com/watch?v=oLCfb54e_kM

The word “survivor” implies that something has been overcome (Extract 2). By signing the post with the words “Psychiatric Survivor”, Fishsandwich is claiming that psychiatry is something that needs to be survived. In essence, psychiatry, rather than “schizophrenia”, is constructed as a cause of distress and therefore needs to be overcome. This contrasts the medicalised discourse, in that the profession that is meant to “treat” individuals and help them overcome, in this case, schizophrenia, is constructed as the cause of suffering.

The quote Fishsandwich provides in the signature (Extract 2) are lyrics from the song “Voices” by Chris Young (see Appendix). Fishsandwich uses this song (and the reference to it in quote provided) to further resist the medicalised discourses of schizophrenia. This statement identified him as someone that hears voices. The lyrics “walkin’ round with all these whispers runnin’ round here in my brain, I just can’t help but hear ‘em” and “I hear voices” identify the artist, as someone who hears voices (Extract 3). Fishsandwich, who is using the lyrics in order to say something, is in turn identifying as someone who hears voices.

Extract 3

You could say I'm a little bit crazy
You could call me insane
Walkin' 'round with all these whispers
Runnin' 'round here in my brain

I just can't help but hear 'em
Man, I can't avoid it
I hear voices

Because hearing voices is associated with schizophrenia, and Fishsandwich is posting on a website dedicated to individuals with a diagnosis of schizophrenia, by identifying with hearing voices it is implied that he has received a diagnosis of schizophrenia (see Extracts 22, 23, 24 & 32 for further examples of how he identifies with “being psychotic”). It should be noted that while the term “psychosis” is generally considered to be associated with schizophrenia, they are not always considered to be one and the same. The lyrics “you could say I'm a little bit crazy, you could call me insane” (Extract 3) demonstrates that the artist is aware of the fact that “hearing voices” is associated with being labelled. These lyrics construct experiences of hearing voices as insanity or madness (Extract 3). After admitting to hearing voices (Extract 3) the lyrics celebrate the hearing of voices in Extract 4.

Extract 4

Sometimes I try to ignore 'em
But I thank God for 'em
'Cause they made me who I am

In Extract 4 the artist of the song owns the experience of hearing voices and is showing appreciation for them by “thank(ing) God for” the voices. The artist then explains that the reason he is grateful for the experience of voices is that “they made (him) who (he is)”. The statement “they made me who I am” constructs schizophrenia as something that takes over and that becomes part of the self. This construction resembles the medicalised discourse that individuals with a diagnosis “become the disorder”. However, the display of appreciation is contrary to the medical discourse of schizophrenia that constructs schizophrenia as unpleasant and as needing treatment.

Fishsandwich uses the online platform to refer readers to the song. He is using the lyrics of the song to distribute the message of the song, adopting what the artist does (claiming that schizophrenia is not something he would wish away) by signing his own posts with a reference to the song. By knowing that the song Fishsandwich refers to, and quotes from, tells the story of someone that hears voices and is grateful for them, it is plausible that with the quote from Extract 2 Fishsandwich is embracing his experiences. He exclaims that he “hear(s) voices!” The exclamation mark can be seen to demonstrate that Fishsandwich embraces “hearing voices”. He is demonstrating that he is someone that hears voices but does not construct it as something negative. This is unlike the medicalised discourse which constructs schizophrenia as something inevitably negative. The fact that he exclaims that he does experience voices also demonstrates an owning of the experience, and a lack of shame concerning an experience often deemed a sign of insanity or madness (Extract 3).

Another participant, Amina, uses the online domain to resist the medicalised discourse of schizophrenia as something that cannot be conquered. She named her blog “Overcoming schizophrenia” (Extract 5). The word “overcoming” constructs schizophrenia as something that can be defeated. In this sense it challenges the medicalised discourse that it is usually a life-long

“disorder”. It also asserts agency as it means to successfully deal with, or to defeat something. It implies that the individual is an active player in the experience. She is constructing herself as someone with the power to actively change her situation. In essence, the name Amina gave to her blog serves to construct herself as someone who has hope.

Extract 5

Overcoming Schizophrenia

The online platform is also used as a resource for resisting the medicalised discourse by Jared Brown. At the top of his personal blog page he created a blog banner reading “beyond a label, because I am more than schizophrenia” (Extract 6). Through this banner, Brown is addressing and resisting the label “schizophrenia” and the traditional medicalised discourse of schizophrenia. The words “because I am more than schizophrenia” refers to the discourse that schizophrenia takes over the lives of those diagnosed with it. The individual with a diagnosis is constructed as becoming their label, “a schizophrenic”, according to this medicalised discourse. Brown resists this discourse by claiming that he is more than a diagnosis. He is constructing himself as someone with agency, someone that is not governed by his diagnosis.



In essence, Brown uses the online domain to resist the medical discourse that individuals with a diagnosis of schizophrenia become the label applied to them (becoming “schizophrenics”). He resists the same kinds of things about medicalised discourses that are also criticised in the literature. In Scheff’s (1970) critique of the medicalised discourse of schizophrenia he explained that the label “schizophrenia” is applied to individuals whose behaviour is considered “deviant” and that labelled individuals may accept their labels. These results indicate that resisting schizophrenia is not just something that academic researchers can do, but also something people with a diagnosis do. In this case, they also use a very similar set of discursive resources to those used by the academics to criticise medical discourses of schizophrenia.

2. Avoiding or resisting the use of the label “schizophrenia”

Participants avoided or resisted using the label “schizophrenia”. If the label is successfully avoided or resisted the entire discourse associated with that label is also avoided or resisted. In Extract 7 Gr3tta uses the word “so-called” to resist the label “psychotic”. This word serves to do one of two things: it can show that even though Gr3tta has received this label she does not agree with it or, that she finds the construct, “psychosis” itself problematic. Gr3tta resists constructing herself according to this label and its associated discourse.

Extract 7

I'm so-called psychotic

Euphemisms were also used for terms associated with the medicalised discourse of schizophrenia. In Extract 8 Dante13 gives an account of where he is confronted with the question “do [thoughts] have any power?” In this question the word “thoughts” is used instead of terms like “hallucinations” and “psychosis”. By using euphemisms the nurse asking the question refrains from using terms that are associated with the discourse of schizophrenia.

Extract 8

I can understand both, my nurse challenged me the other day he said "are thoughts real? Do they have any power?" To which I replied yes. He then went on saying "this chair will collapse under me in ten seconds" "I can move that book with the power of my mind" "I can push that wall down" none of which happened, I laughed out of nervousness, not because I thought it was funny, it brought it home; even last year I was like that. He's seen me like that, I felt silly, and ill (physically). It's hard to remember, when you've come so far! I know i don't want to accept that the person in hospital was me, it's like a world away

The words “it brought it home” indicates that the questions asked by the nurse resonated with Dante13. With these words Dante13 demonstrates that he accepts what the nurse was trying to do, convince Dante13 that his “thoughts” (his “hallucinations” or “psychosis”) are not real. By using this account of the moment he claims to have accepted that thoughts are mere thoughts, he is adopting the nurse’s construction of everything that the word “thought” could stand for (such as hallucinations or psychosis) as nothing more than thoughts. By equating constructs which according to the medicalised discourse are “symptoms of schizophrenia” to mere “thoughts”, Dante13 is resisting the pathologising discourse of “symptoms”. He constructs “thoughts” as not having power in themselves. This also contradicts the medicalised discourse that constructs “symptoms of schizophrenia” as having no power. The alternative discourse used by Dante13 resist this.

When using the label “schizophrenia” it was problematized by some participants. In Extract 9 Shrink resistant constructs who he is. He claims that he is “just a punk rocker that had

‘schizophrenia’”. He writes the word “schizophrenia” in inverted commas. This conveys his awareness of the traditional medicalised discourse, how it constructs the nature of schizophrenia, and that he does not want to employ the term. He is distancing himself from the term used. Therefore, even though the word “schizophrenia” is used, it is resisted. Here, the non-pathologised discourse itself reflects on its own way of speaking (Parker, 1992). The inverted commas are used to demonstrate scepticism concerning the existence of schizophrenia as constructed through the traditional discourse.

Extract 9

I'm none of the above, I'm just a punk rocker that had 'schizophrenia' and I've used a simple form of mindfulness to regain control of my mind.

Shrink resistant constructs himself as a “punk rocker” (Extract 9). The construct “punk rock” is associated with rebellion and the resistance of the mainstream (Herrmann, 2012). “Punk” is a subculture that confronts social and political issues. By using the term “punk rocker” Shrink resistant is constructing himself as someone who opposes what is mainstream. This construction of himself could also reinforce the construct of him being “shrink resistant”, since the use of a psychiatrist is the mainstream treatment for “schizophrenia”. The use of mindfulness on the other hand is less conventional. Therefore, the “punk rocker” self he constructs, is reinforced by the construction of mindfulness as an alternative approach.

3. Creating an alternative de-pathologised discourse

Some participants resisted the medicalised discourse of schizophrenia by producing an alternative discourse that constructs schizophrenia as something that can be recovered from. In Extract 10 Amina introduces her blog by claiming that “each of us are in recovery”.

Extract 10

Each of us are in recovery, whether that be from: mental illness, substance abuse, abusive relationships, homelessness, etc. Whatever the situation, lets be an example to others that we can and do overcome tough situations by sharing our testimonies... Here is mine...

The words “each of us” serves to naturalise her experiences of “schizophrenia”. She universalises and neutralises her experience. Amina equates “schizophrenia” with other situations such as “substance abuse, abusive relationships [and] homelessness” (Extract 10). By doing this she is constructing schizophrenia as nothing worse than other problems individuals could be facing and therefore as part of the human condition rather than a pathology. Even though the other situations she mentions may also be pathologised they are usually treated as social problems rather than individual pathologies. By equating schizophrenia with these Amina is challenging the distinction between mental (individual) problems and social (collective) problems.

Apart from resisting the pathologised medical discourses that schizophrenia is particularly severe, Amina also constructs schizophrenia as something that can be recovered from in Extract 10 by saying that “each of us are in recovery”. In Extracts 11 and 12 Amina reiterates that schizophrenia can be recovered from. She says: “I am overcoming schizophrenia, and I believe others can too” (Extract 11) and “I just want to make one point clear: it is a myth that someone with schizophrenia cannot recover...” (Extract 12). By stating that she wants to address a “myth” (Extract 12) she is constructing and opposing the traditional medicalised discourse. The word “myth” indicates that what the medicalised discourse constructs is not true. According to this traditional discourse, schizophrenia is a life-long condition.

Extract 11

I am overcoming schizophrenia, and I believe others can too. Here is how I am managing my condition...

Extract 12

I just want to make one point clear: it is a myth that someone with schizophrenia cannot recover, they just have not found the right treatment that works for them, yet, but they should keep looking and keep hope alive! A lot of my readers with a mental illness are success stories.

In Extract 12 Amina provides evidence to support the discourse of recovery she produces. She provides an explanation as to why the medicalised discourse might assume recovery is not possible. She attributes lack of recovery to not having found “the right treatment that works for them”. Amina provides anecdotal evidence supporting the alternative discourse that recovery is possible. She says that “a lot of (her) readers with mental illness are success stories” (Extract 12). The use of this personal experience of others “recovering” is difficult to object to because it is difficult to provide counter-evidence that someone’s personal experience did not occur. Anecdotal evidence is therefore hard to dispute because it is something that the individual that employs it has rights over (Sacks, 1984).

Even though the non-pathologised discourse Amina produces differs from the medicalised discourse in that it argues that recovery is possible, it adheres to the medicalised discourse by suggesting that treatment is necessary. The word “treatment” is associated with the medicalised discourse of schizophrenia. The sentence “a lot of my readers with mental illnesses are success stories” (Extract 12) also constructs that “mental illness” exists. Therefore, Amina resists the medicalised discourse while still employing it. This demonstrates that it is difficult to completely abandon the use of the medicalised discourse, even if parts of it are resisted.

Fishsandwich also resists a medicalised discourse that individuals with “psychosis” cannot recover (Extract 13). The phrase, “can’t get therapy”, insinuates that individuals diagnosed with schizophrenia cannot be successfully treated using the therapy. He resists this by exclaiming “We *can*” and by emphasising the word ‘can’. By adding “but I do think it needs to be adapted” Fishsandwich is acknowledging some aspects of the argument that “therapy doesn’t work for schizophrenia”. However, he is resisting the discourse by suggesting that the *way* the therapy has

been done is what has made it unsuccessful. Therefore, he problematizes the type of therapy currently provided rather than “therapy” itself.

Extract 13

I'm so tired of hearing psychotic people can't get therapy. We *can*, but I do think it needs to be adapted.

Fishsandwich is blaming the nature of the therapy associated with the traditional discourse of schizophrenia for the lack of effectiveness. He is implying that an “adapted” form of therapy would be successful. According to this discourse, treatment is constructed as a necessary for “psychosis”. Therefore, Fishsandwich, like Amina, resists a discourse that constructs that individuals with a diagnosis of schizophrenia cannot “reover”, but still aligns with a fairly mainstream approach by stating that an adapted therapy might be successful (Extract 13). This adheres to the medicalised discourse in that it argues that help is needed and that it will be achieved through formal therapy (albeit an adapted therapy). This use of the medicalised discourse while resisting it, again illustrates that resisting the prominent medicalised discourse is complicated.

In the process of resisting the discourse that “schizophrenia” cannot be “treated” using the approaches that are presently used, Fishsandwich produces an alternative discourse of schizophrenia. According to this discourse there is hope for successful treatment if the treatment is adapted. The alternative discourse constructs the outcomes of people with a diagnosis as hopeful and that recovery is possible.

The abovementioned alternative discourses resists the medicalised discourse that recovery for individuals with a diagnosis of schizophrenia is not possible, but still constructs therapy or medication as needed. Other participants used discourses that completely resist the discourse that medication or professional therapy is necessary. Shrink resistant uses an alternative discourse that

constructs that “recovery from SZ is very common” and that “many people fully recover without any contact with psychiatrists or meds” (Extract 14). The letters “SZ” stand for “schizophrenia” and the word “meds” is a shortened version of the word “medication”. Therefore, Shrink resistant resists the medicalised discourse that recovery from “schizophrenia” is rare and also the discourse that recovery is impossible without the help of psychiatrists and medication.

Extract 14

Recovery from SZ is very common, many people fully recover without any contact with psychiatrists or meds. There is a lot of evidence that shows being treated by psychiatrists slows recovery.

The alternative discourse Shrink resistant produces not only opposes the discourse that recovery is only possible with the help of professionals, but constructs that help from them hinders recovery. He says that “there is a lot of evidence that shows that being treated by psychiatrists slows recovery” (Extract 14). This alternative discourse constructs people with schizophrenia as having agency. In later posts Shrink resistant constructs that individuals can recover by themselves using mindfulness. In Extract 15 he states that “you can do the same thing yourself without harmful drugs and side effects with a technique called mindfulness”. In this statement he employs a discourse which constructs that it is possible to achieve what medication does without the help of professionals by using mindfulness.

Extract 15

You can do the same thing yourself without harmful drugs and side effects with a technique called mindfulness.

In Extracts 16 and 17 Shrink resistant constructs mindfulness as an alternative approach used to manage his thoughts.

Extract 16

I'm just a punk rocker that had 'schizophrenia' and I've used a simple form of mindfulness to regain control of my mind.

Extract 17

I wish someone had told me about mindfulness 30 years ago. I regained control of my mind and a now live in a wonderful place called now!

He states that he used mindfulness “to regain control of (his) mind” (Extract 16 and 17). Here Shrink resistant constructs schizophrenia as the loss of control of the mind. This construction matches how the traditional medicalised discourse constructs schizophrenia. However, unlike the medicalised discourse, Shrink resistant claims that the individual is also able to regain control of their mind. This alternative discourse contrasts the traditional discourse of schizophrenia. Schizophrenia is constructed as something manageable and as something that he can control without the use of medication and therapy. It is not constructed as something that merely “happens” to the individual. Therefore, Shrink resistant constructs himself as someone with agency in this statement.

In Extract 18 Shrink resistant also uses the discourse of mindfulness to construct himself as someone with agency. When explaining how mindfulness works he says “I say to it shut up brain and pull myself into the present moment where 99.9% of the time there is absolutely nothing to worry about”.

Extract 18

I say to it shut up brain and pull myself into the present moment where 99.9% of the time there is absolutely nothing to worry about.

This alternative discourse allows Shrink resistant to reclaim agency over his experiences. It constructs him as someone who is in control, someone that can command his thoughts to silence and that can bring himself back to the present. In this statement Shrink resistant is the active agent. Consequently, he constructs schizophrenia as something that can be controlled. This is in

opposition to the traditional medicalised discourse he implicitly reproduces: schizophrenia as something that creates “victims” without agency.

Shrink resistant constructs the present as “a wonderful place” (Extract 17) and as a moment “where 99% of the time there is absolutely nothing to worry about” (Extract 18). This construction of the present as something positive contrasts medicalised discourses of schizophrenia which constructs the lives of individuals with a diagnosis as stressful, devastating and preoccupied with “fighting their disorder”. The use of the mindfulness discourse of “being in the present” is what enables Shrink resistant to resist the medicalised discourse.

The discourse of using mindfulness, instead of professional help and medication to deal with what participants describe as schizophrenia, is also performed by MalkuthSamanera1. In response to an entry by Annie123456 (Extract 19), MalkuthSamanera1 (Extract 20) displays resistance to the medicalised discourse that schizophrenia is a disease requiring professional help. It is important to note that MalkuthSamanera1 misread what Annie123456 said. Annie123456’s statement: “a psychosis is not something a person cant deal with on their own and need help with it” (Extract 19) was interpreted as her claiming that individuals always require professionals help and medication. This mistake is irrelevant to the analysis because he is opposing the discourse he has treated her as having used. Whether or not Annie123456 actually adheres to the medicalised discourse is therefore, beside the point.

Extract 19.

Hello,

I believe telepathy is for real but also that all voice hearing is not telepathy. A psychosis it not something that a person cant deal with on their own and need help with it and if you want to take medicine and it helps you get into better balance it is a good thing to take it. Now you have at least tried to live without it and see what happens.

Extract 20

I would actually disagree with Annie and say from personal experience that you CAN do it without meds using various strategies...and meditation CAN be done 24 / 7...this is what is known as mindfulness, and once you get good at mindfulness it is with you every moment and is an antidote to the voices.

The discourse MalkuthSamanera1 claims Annie123456 is using is the medicalised discourse of schizophrenia. It assumes that schizophrenia cannot be handled without medication and the help of medical professionals. We know this because in Extract 20 MalkuthSamanera1 demonstrates disagreement by saying: “I would actually disagree with Annie and say that from personal experience you CAN do it without meds”.

MalkuthSamanera1 resists the discourse he believes Annie123456 is using, and employs an alternative non-pathologised discourse. According to this discourse, schizophrenia can be dealt with using mindfulness alone. This is seen in the statement “you CAN do it without meds using various strategies...and meditation CAN be done 24/7...this is what is known as mindfulness” (Extract 20). The fact that the word “can” is written in capital letters twice, emphasises the fact that he is opposing the traditional medicalised discourse’s notion that recovery is impossible without medication. He is opposing the discourse of inability and the word “cant” (Extract 19) specifically.

Like Amina, he invokes “personal experience” as an authoritative basis for his disagreement. The word “I” emphasises that it is his opinion and his experience. This use of personal experience makes his statement difficult to dispute. Anyone who would like to disagree with him will be disputing his own personal experience – something that, as mentioned, people are entitled to having superior rights over (Sacks, 1984).

MalkuthSamanera1, like both Amina and Fishsandwich, resists the traditional discourse without managing to escape using that discourse completely. In Extract 20 MalkuthSamanera1 does not construct mindfulness as a mere alternative to professional help, but as something that changes

the individual. He says “once you get good at mindfulness it is with you every moment”. However, he also calls mindfulness “an antidote to the voices” (Extract 20). This statement parallels the medical discourses of “cures”. Therefore, like Fishsandwich, he does not completely escape the medical frame of reference, but still resists the traditional sense of what counts as a treatment. He is suggesting mindfulness as an alternative way of dealing with schizophrenia and is opposing the idea that the use of medicine and professional help is necessary. This alternative discourse of schizophrenia is used to construct the experiences of the individuals in the forum he is addressing as hopeful. It also constructs individuals with a diagnosis of schizophrenia as having agency since they are argued to not need professionals to manage their experiences.

Similar to Shrink resistant and MalkuthSamanera1, Dante13 also employs an alternative discourse that constructs that no professional help is needed to “deal with” schizophrenia. He constructs himself as someone that can rid himself of his thoughts by ceasing to fight them. The words “accept that the thoughts are there and let them flow away” (Extract 21) indicate that Dante13 constructs the “thoughts” as something that does not need to be fought. This statement resembles the discourse of mindfulness that argues that thoughts should not be evaluated at all. In order to fight thoughts they need to be evaluated. They should merely be noticed and then let go of. This contradicts the medicalised discourse constructing “thought”-related symptoms of schizophrenia as something that needs to be fought. Dante13 constructs himself as the active agent responsible for *allowing* his thoughts to leave. The presence of schizophrenia is constructed as something that is not inevitable. It can be removed using mindfulness by “let(ting) them flow away” (Extract 21).

Extract 21

When it comes to your head, I'm going to quote you now, use mindfulness, accept that the thoughts are there and let them flow away.

The discourse Dante13 produces, constructs that he wants to get rid of schizophrenia. This is in accordance to the medicalised discourse. However, according to the discourse of mindfulness, this can only be done by accepting the “thoughts” without evaluating whether they are good or bad. This is contrary to the medicalised discourse that constructs schizophrenia and “thought-related symptoms” as inevitably bad.

All the above mentioned discourses construct schizophrenia as something that participants try to get rid of. The next participants used discourses of acceptance and utility in order to resist the medicalised discourse that schizophrenia is inherently distressing and that individuals with a diagnosis should try and be rid of it. These discourses resemble discourses of mindfulness. When describing experiences of “psychosis” Fishsandwich says: I “escape/go back /retreat into my psychosis” (Extracts 22, 23 & 24). By doing this he is constructing himself as being the one that uses “psychosis”.

Extract 22

Funny, I associate being present with being hyper-aware. I know everything that's happening in my surroundings. If I escape into my psychosis a bit, it's much more manageable/less intense.

Extract 23

I feel neither relaxed nor edgy when that happens. It's just very exhausting. I go back into my psychosis a bit to cope with it.

Extract 24

Quote:

Originally Posted by **bohogypsy** 

How do you feel when you bring your attention back to yourself? Do you have any discomforts? Are you actually able to do it or does your attention go back to your distractions (the voices and other things)?

I can bring my attention inwards just fine: I retreat into my psychosis-world. I'm trying to find a way to go inwards and stay in the consensual world.

The use of the word “escape” (Extract 22) constructs schizophrenia as something he *uses* in order to deal with his experiences of being hyper-aware. Schizophrenia is constructed as something valuable. Consequently Fishsandwich constructs himself as in control because he is the one employing schizophrenia. Again, in Extract 23 he constructs schizophrenia as a way of coping, he says: “I go back into my psychosis as a way of coping with it”. The word “it” refers to his experiences of noticing everything and being “hyper aware” (Extract 23). By saying that he goes “(back into (his) psychosis as a way of coping” Fishsandwich again constructs himself as the one that uses “psychosis”. In Extract 24 the word “retreat” also constructs schizophrenia as more of a reaction to other experiences as a disorder. It is important to note that Fishsandwich does not necessarily use “psychosis” deliberately; however “psychosis” is still used and constructed as helpful. These discourses of usefulness and agency, contradicts the medicalised discourse constructing schizophrenia as something devastating and overpowering. It also contrasts the medicalised discourse that people with a diagnosis are “victims of schizophrenia” and that schizophrenia is something that “affects”, or happens to, the individual.

The discourse of usefulness is used by another participant, Ozchic (Extract 25). The discourse Ozchic produces suggests that “voices” might have a function. In Extract 25, the word “voices” aligns with the medicalised discourse and describes “symptoms of schizophrenia”.

Extract 25

by Ozchic »

Gday.. I have struggled with my voices also.. I am on clozapine which helps.. but doesnt make them go away completely. I am in therapy at the moment. At present I am allowing space in my life for the voices..ignoring them never worked. I listen to them and try to understand there place. I at times talk to my voices..perhaps this may help you,. I also practice mindfulness.. I meditate on safe place and keep in check what is real to me.

In this extract Ozchic says that she “struiggled with (her) voices”. The word “struggled” suggests that the voices are unwanted or distressing. This aligns with the medicalised discourse of schizophrenia. Her discussion of the medication used also serves to align her with the medicalised discourse. However, Ozchic indicates that the “struggle” she experienced is in the past and that she is now dealing with them differently. The discourse of acceptance is demonstrated by the statement: “allowing space in my life”. This discourse constructs the voices she experienced as something that can be accommodated and lived with, rather than treating them as indicating an illness that needs to be eliminated. This is contrary to the medicalised discourse of schizophrenia.

Her claim that “ignoring them never worked” (Extract 25) reinforces this by suggesting that what may be taken as the correct way to deal with the voices (ignoring them and their possible significance) was not helpful for her, and is not the only way to deal with them. She states that she has tried alternative approaches, and received more positive outcomes. Ozchic constructs voices (a “symptom of schizophrenia” according to the medicalised discourse) as something that has a role. She says “I listen to them and try to understand there place”. This discourse differs from the medicalised discourse that views “voices” as a mere symptom of brain pathology.

In essence, Ozchic constructs schizophrenia as something that does not need to be something negative. The experience of schizophrenia as negative is, therefore, constructed as a choice. This discourse is in opposition to the traditional medicalised discourse which constructs

schizophrenia as a disease needing to be healed. It also aligns with the mindfulness discourse that constructs distress as a choice.

At the end of Extract 25 Ozchic says “I keep in check what is real to me”. Ozchic is doing one of two things: she is either saying the voices are real, or that she meditates to distinguish between what is real and what is not. The first option constructs “voices” as something real to her. This resists the medical discourse by constructing it as something more than mere hallucinations produced by a disordered mind. Hallucinations, are defined as perceptions or sensations that appear real to the person experiencing them, but that are not “real”.

The second option adheres to the medicalised discourse by constructing “voices” as being something she *incorrectly* believes to be real at times. Therefore, it is constructed as something that is not truly “real”. This discourse assumes that there is one reality that is shared by all individuals, and that “hearing voices” is not part of that consensual reality. The words “to me” (Extract 25) however, construct that she has to decide what is real *to her*. Consequently, these words construct that “voices” may be real to other individuals. Because the second possible meaning (that she meditates to distinguish between what is real and what is not) implies that there is a consensual reality for all individuals, the words “to me” are contradictory. This is because they construct a subjective reality rather than a consensual one. Therefore, the first interpretation of what Ozchic meant is more plausible.

In light of the discourse of acceptance produced if the first interpretation of what she meant is accepted, it is important to note that she constructs “voices” as something real *and* as having a purpose. She constructs that it might be useful to investigate this purpose by saying “I listen to them and try to understand there place...perhaps this might help you” (Extract 25). This discourse of “voices” as something with a role contradicts the medicalised discourse that neglects the search for

meaning in the experiences of individuals with a diagnosis of schizophrenia (Pilgrim, 2007). This discourse also resembles critique by Romme and Morris (2007) of the medicalised discourse by saying that it disregards meaning in the experiences of “schizophrenia”.

Dante13, Ozchic and Shrink resistant deploy discourses of acceptance or utility. However, these discourses they produce differ in the level of resistance they achieve. The discourse Shrink resistant employs constructs schizophrenia as a reaction and that is used by him to cope. Ozchic also uses a discourse constructing voices as serving a function. Dante13 uses a discourse of acceptance but the function of acceptance is to get rid of “the voices”.

Thus far all the alternative discourses, even though they resisted the medicalised discourse, still employed it by constructing schizophrenia as a disease. The next section discusses how participants in this study are able to resist the medicalised discourse of schizophrenia by constructing that schizophrenia is not an illness. In Extract 26 Lucitania is asking other individuals about the drug Seroquel and its effectiveness. With her question Lucitania invokes the medicalised discourse of schizophrenia by constructing that medication, such as Seroquel that is acquired from a professional, helps “hallucinations”. The word “hallucinations” is a description of “symptoms of schizophrenia” and therefore aligns with the medicalised discourse. The participant, Shrink resistant, responds to her question in Extract 27.

Extract 26

Seroquel

by **Lucitania** » Fri May 06, 2005 12:50 am

The doctor gave me Seroquel today...Have any of you taken it? Does it stop hallucinations? Any bad side effects?

Extract 27

by **Shrink resistant** »

Lucitania,

All that Seroquel is going to do is disrupt or disable your mind (with horrible side effects). It targets no disease or abnormality in your brain; it will just disrupt, dull and disable your mind so you don't think the thoughts everyone around you doesn't like.

You can do the same thing yourself without harmful drugs and side effects with a technique called mindfulness.

In his response (Extract 27) Shrink resistant is constructing two discourses of schizophrenia. He constructs an alternative de-pathologised discourse in opposition to the traditional medicalised discourse. He claims the function of the anti-psychotic medication used by the first participant is to “disrupt and disable [her] mind”. This claimed consequence of Seroquel is similar to what medicalised discourses claim schizophrenia does. What Shrink resistant is implying here is that the medication does what the disorder is supposed to do.

Shrink resistant argues that the function of the medication is not to treat a disease but rather to contain undesirable behaviour: “It targets no disease or abnormality in your brain; it will just disrupt, dull and disable your mind so you don't think the thoughts everyone around you doesn't like” (Extract 27). Hereby, he is opposing the traditional discourse which constructs schizophrenia as a disease with a tangible aetiology in order to highlight and critique the assumptions this discourse makes. He does this to refute the assumption that schizophrenia involves an abnormality or disease of the brain.

While using the traditional discourse, Shrink resistant is creating his own non-pathologised discourse of schizophrenia, a discourse that resists the medicalised discourse. According to this alternative discourse, schizophrenia is not constructed as a disease or disorder but as an identification of thoughts that are not liked by society. Through this claim Shrink resistant is

reducing the label “schizophrenia” to the preferences of the majority of people as opposed to it being a “disorder” of the brain. By doing this he is also shifting the blame to “everybody around you” as opposed to the “victim” with the diagnosis.

The alternative construction of schizophrenia as “thoughts everyone around you does not like” does not emphasise individual pathology but societal control of behaviour and thoughts that are not liked by others. Shrink resistant does not refer to the construct “thoughts” as negative in any way. Unlike the medicalised discourse that might refer to the thoughts of an individual with a diagnosis of schizophrenia as “fragmented” or “distressing”, Shrink resistant constructs them merely as not being liked by other individuals. By saying “everyone around you” he further implies that it is not the individual with the diagnosis that does not like the thoughts but other individuals. Schizophrenia is not constructed as belonging to him at all. Therefore, this discourse does not construct the individual in a negative light. It also constructs a sense of agency. “Schizophrenia” is not controlling or overpowering the individual, in fact Shrink resistant is constructing it as not being part of him at all. The use of the discourse that the label schizophrenia is a form of social control is identical to Scheff’s (1970) argument that schizophrenia is an ideology. He argues that the “symptoms of mental illness” are violations of implicit social understandings. Essentially, Shrink resistant provides the same critique of the medicalised discourse that Scheff (1970) and other critics provided.

In response to Shrink resistant’s post (Extract 27) Lucitania congratulates Shrink resistant for “getting over schizophrenia” (Extract 28). This first comment “congratulations on getting over schizophrenia” serves to single Shrink resistant out as a special case. By congratulating him it is implied that what he has done is exceptional and simultaneously that her struggle with her

experiences is normal. Constructing what he has done as exceptional is explicitly reinforced in the second sentence of Extract 28. She says “you must be an extremely strong willed person to do that”.

Extract 28

Congradulations on getting over schizophrenia! You must be an extremely strong willed person to do that. I'm going to check out 'mindfulness', sounds very interesting, but it's going to be a lot of work for me...My emotions really control me, and it's like my mind is not even my own to control...

Even though Lucitania commends Shrink resistant and shows interest in what he is doing, (by saying that she will “check out mindfulness”) she resists the suggestion that she, and other individuals, would be able to achieve what he did easily. In the third sentence she says that it will be “a lot of hard work” for her. She justifies this claim by constructing herself as someone that does not have control over her mind and therefore, as someone that might have difficulty being helped by mindfulness. By doing this she is constructing herself as an exception to his construction of the category schizophrenia. She acknowledges his claim that he has regained control of his mind. However, she argues that her mind is not hers to control. Therefore, she constructs herself as someone that does not have as much agency as him. Even so, she leaves some room for change in this regard, albeit subject to “a lot of hard work” on her part.

In response to Lucitania’s reply (Extract 28) Shrink resistant tells Lucitania that schizophrenia “is not a disease” (Extract 29). Here he is resisting the medicalised discourse’s construction of schizophrenia as a disease. The word “disease” implies a need to treatment and that the individual is sick. It implies that there is something wrong with the person.

Extract 29

It's not a disease Lucitania! No disease acts like this!

The use of the exclamation mark serves to emphasise the claim he is making. It produces the claim as undisputable and implies that Shrink resistant will defend it if presented with a counter-claim. The exclamation mark here also serve as an attempt to convince Lucitania to construct herself as Shrink resistant constructs himself, as someone that is not ill. Lucitania belongs to the same category as Shrink resistant (as someone diagnosed with schizophrenia). We know this because the forum is specifically for individuals with a diagnosis of schizophrenia. Lucitania self-identifies as someone with a diagnosis in Extract 28 by congratulating Shrink resistant for “getting over schizophrenia” and then by constructing herself as someone that shares that diagnosis but not the degree of agency. Shrink resistant identified as having received a diagnosis in Extract 9 where he says that he is “just a punk rocker that had ‘schizophrenia’”.

Even though both participants employ opposing discourses of schizophrenia, they both identify themselves as having a diagnosis of it. Shrink resistant is therefore, writing as an “insider” and the way he is constructing himself, therefore, translates to the way he is constructing her. The opposite is also true: the way Lucitania is constructing herself (as an ill person due to schizophrenia) applies to Shrink resistant; she is also constructing him as “recovered”. In this way she treats schizophrenia as an illness but as one that can be overcome. Shrink resistant’s claim that “it is not a disease” (Extract 29) is not only a resistance to her construction of herself but to the construction of all individuals with a diagnosis of schizophrenia.

The alternative discourse produced by Shrink resistant constructs schizophrenia as the identification of deviant behaviour. One discourse used by a participant constructs schizophrenia as not existing at all. This is clearly a resistance of the medicalised discourse. This resistance to the traditional discourse and the questioning concerning the existence of schizophrenia is illustrated by the next statement:

Extract 30

Funny, I had an autism diagnosis as a child. I don't put any faith in the diagnoses anymore 🙄

In Extract 30 Fishsandwich constructs schizophrenia as something that might not exist. He provides a personal example of where a professional diagnosis of autism was wrongly provided. He produces it as an incorrect diagnosis by firstly, using the word “funny” to describe the situation, and secondly by adding that he does not “put faith in diagnoses anymore”. The last sentence is presented as a consequence of what happened in the first sentence. He is saying that *because* he received an autism diagnosis, he lost faith in diagnoses. This implicitly constructs the diagnosis of autism as incorrect because if it was considered to be a valid diagnosis, he would not have claimed to have lost faith in diagnoses.

He is demonstrating that because he was diagnosed with something that he did not experience, it is plausible that he received a diagnosis of schizophrenia even though there is nothing wrong with him. His use of the plural word “diagnoses” provides evidence of how he is equating the autism diagnosis (which he treats as being clearly invalid in hindsight) with the schizophrenia diagnosis. The schizophrenia diagnosis is treated as similarly invalid. Fishsandwich’s use of a personal experience serves to justify his current questioning of the nature of schizophrenia as constructed by the medicalised discourse.

During this resistance of the category schizophrenia, Fishsandwich constructs himself and other individuals with a diagnosis. In the above two statements he constructs himself as someone who has a diagnosis but not necessarily a “disorder”. In other words, he is resisting the conflation of the diagnostic label with the supposed underlying condition as suggested by medical discourse. He is saying that having a diagnosis does not mean there is any underlying disorder. In Extract 30

Fishsandwich is displaying that he will not use a diagnosis in order to define himself as he does not believe in diagnoses.

Fishsandwich contradicts himself by using the medicalised discourse at other times in constructing his experiences as “psychosis” (Extract 22, 23 & 24) and himself as “psychotic” (Extract 32). The word “psychosis” cannot necessarily be used interchangeably with the term “schizophrenia” but is associated with schizophrenia in the medicalised discourse. In Extract 32 Fishsandwich is replying to an individual, Costello, (whose son has a diagnosis of schizophrenia) stating that he wished his son would practice mindfulness (Extract 31). Fishsandwich does this even though he clearly stated (in Extract 30) that he did not believe in diagnoses. This finding reflects the complexity of resisting the dominant discourse shown in many extracts above. Although participants can (and sometimes do) resist particular discourses, does not mean they consistently do so. This finding demonstrates that escaping these discourses is difficult, even for people who may have a critical or resistant orientation to them.

Extract 31

Thich Nhat Hanh compares mindfulness to the sun. When you touch your negative emotions with mindfulness, they're transformed - with or without your intention to do so - just like the sun making a seed grow. I find this is true for me.

I hope that my son can experience that too, because it seems to me that much of his problem is a complete overwhelm of negative emotions. Fear is huge. And anger. And a great deal of shame. And lately depression, but I wonder if that's partly from the meds.

Extract 32

I hope he gets it, too. It sounds like a very peaceful state and peace is hard to come by when you're psychotic.

4 Using professional discourses and empirical evidence

Professional and academic discourses were used by participants as discursive resources for legitimising their positions. Participants used these discourses to show that their positions are supported by “science” or by individuals that are associated with science. Science is a source of legitimacy used to convince individuals of certain absolute truths (Scheff, 1970).

In Extract 33 Shrink resistant uses a professional discourse as a discursive resource in order to resist traditional discourses of schizophrenia. He uses it in order to convince Lucitania of his argument concerning the nature of schizophrenia, especially of the argument that schizophrenia is something you can recover from. In reply to Lucitania’s resistance towards attempting mindfulness (Extract 28) Shrink resistant uses a professional discourse by providing evidence supporting the alternative discourse he produces. In Extract 33 he states that “there is a lot of evidence that shows being treated by psychiatrists slows recovery”. He then provides a quote in which the author states that schizophrenia does not resemble a “cerebral and metabolic disease” and that recovery is common (Extract 34). This quote substantiates the discourses he produced in Extracts 27 and 29 that schizophrenia is not a biological disease.

Extract 33

There is a lot of evidence that shows being treated by psychiatrists slows recovery.

Extract 34

Here are some stats and stuff on recovery.

"the belief that schizophrenic psychoses are essentially a progression toward dementia and death... is ... a tragic error.... Nearly a third of schizophrenics recover for good. In general the psychosis does not progress more after five years from its outbreak but, rather, improves...These and other facts concerning the course and outcome of schizophrenic psychoses are certainly not characteristic of organic cerebral and metabolic disease" (p. 1407).

The quote is placed in inverted commas and an attempt is made to reference the quote (page numbers are provided in brackets but not the author's surname). By not using the author's name Shrink resistant makes it impossible to verify what is said. However, the use and presentation of the quote still resembles an academic or professional discourse. The use of the quote legitimises his argument by demonstrating that his argument is supported by published works. This argument is further reinforced in Extract 35, where Shrink resistant constructs that "psychologists, Buddhists, yoga teachers, medical health workers all acknowledge and recommend" mindfulness. Here he is constructing that mindfulness is something that is supported by many disciplines and professionals.

Extract 35

If you type mindfulness techniques into google you will see that psychologists, Buddhists, yoga teachers, medical health workers all acknowledge and recommend it.

The page number "1407", in Extract 34, shows that the source from which he is quoting is a very large work. This serves to further contribute to the legitimisation of his argument by suggesting that he has done thorough research and has read thick books. This validates him as someone able to make the claims about schizophrenia he is making. He is constructing himself as someone knowledgeable. Shrink resistant is invoking a professional discourse to resist other professional authorities that align with the traditional discourse of schizophrenia. He continues to use this professional discourse in order to strengthen his argument in Extracts 36 and 37.

Extract 36

Indeed, longitudinal studies of thousands of ex-patients in many countries show that one-half to two-thirds of the individuals diagnosed as schizophrenic have achieved full recovery or significant improvement many years later. The percentages are:

Shrink resistant proceeds to give the percentages of individuals diagnosed with schizophrenia who have recovered or are in remission, as found by ten studies (Extract 37). The use

of empirical research serves to provide evidence for his discourse of recovery. The participant produces references in a recognisably academic format. By doing this he is not only providing empirical evidence to support his claim, but is using professional practices himself in order to legitimise his position and his alternative discourse of schizophrenia. The use of ten studies functions to suggest that he is a well-read individual that is knowledgeable about the topic. It shows that his alternative discourse, that recovery is possible, is supported by many. By presenting the results of these studies, and by doing so in an academic format, he makes it difficult for others to dispute his claims. Any objection to his discourse of recovery would have to be thoroughly substantiated by empirical evidence.

Extract 37

World Health Organization (1979), world-wide two-year follow-up: 26% very favourable, 25% favourable, 51% total.

Ciampi (1980), Lausanne study: 29% fully recovered, 24% significantly improved, 53% total.

Harding et al. (1987), Vermont study: 34% fully recovered, 34% significantly improved, 68% total.

Tsuang et al. (1979), Iowa study: 20% fully recovered, 26% significantly improved, 46% total.

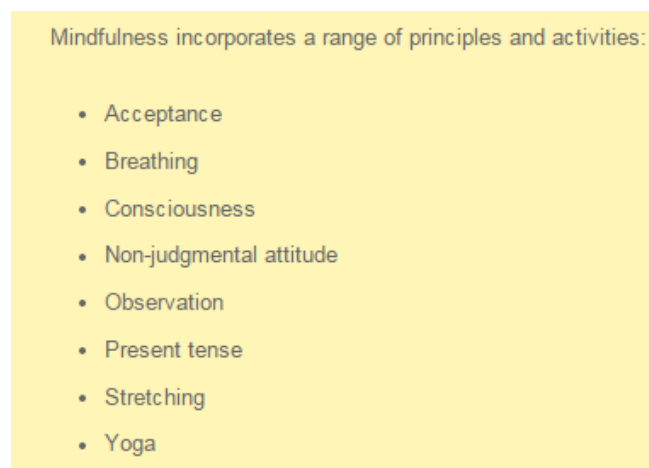
Hegarty et al. (1994), meta-analysis of 320 outcome studies covering all countries, all decades, with 51,800 subjects 5-6 years after being diagnosed schizophrenic with broad criteria: 46.5% improved.

Warner (1994), review of 85 outcome studies during 1956-1985: 20-25% complete recovery, 40-45% social recovery, 60-70% total.

Wiersma et al. (1998), 15 year follow-up of a dutch cohort: 27% complete remission, 50% partial remission.

The use of empirical evidence as a discursive resource is also used by Amina. Amina summarises the essence of mindfulness into bullet points for the readers (Extract 38). The use of a bullet point format is reminiscent of a textbook or other academic document, therefore, it invokes the same kind of authority that such an academic source would. The use of bullet points therefore helps to construct Amina's argument of mindfulness as valid.

Extract 38



In Extract 39 Amina states that she was introduced to mindfulness “in a NAMI course called, “Peer-to-Peer”. She is also mentioned that she is “certified to mentor the course”. These two statements construct that Amina learned from mindfulness at an institution. “Course(s)” are programs presented by institutions like universities, colleges and other authorised organisations. Being “certified” is an action associated with such institutions. Certification acknowledges that an individual has been given the authority to perform actions that can only be performed by certain people. Therefore, by saying that she is a certified mentor Amina is constructing herself as someone knowledgeable and as someone with a kind of authority. The association of mindfulness with institutions results in the construction of mindfulness as something legitimate.

Extract 39

Learning about Mindfulness

I was introduced to the idea of mindfulness in a NAMI course called, "Peer-to-Peer," back in 2009, when I became certified to mentor the course with peers who also live in recovery from mental illness.

Later in her blog Amina explains that “(her) understanding of mindfulness from friends is...” (Extract 40). What is interesting is that she justifies learning about mindfulness from friends by constructing them as people that would know a lot about mindfulness. This could be because “friends” may not be deemed legitimate sources to learn from. Her one friend is constructed as a student, someone that “studies (mindfulness) in a class setting”. Her other friend is constructed as someone that “performs extensive research”. By constructing her friends as people that are knowledgeable concerning mindfulness she justifies the fact that she learnt from friends about mindfulness. Consequently what Amina says about mindfulness is supported by individuals involved in academic practices.

Extract 40

My understanding of mindfulness from friends is it revolves around the idea of focusing on the present moment. Concentration on breathing patterns coincides with the habit of mindfulness. In fact, I have a couple of friends who practice mindfulness. One friend studies it in a class setting while the other performs extensive research alone, and uses it occasionally.

In Extract 41 she also states “I did some research”. By stating that she did research her explanation of mindfulness resembles an academic format, and therefore serves to construct mindfulness as a legitimate alternative way of managing her experiences. It also shows her participation in an academic or professional practice such as research. The use of this professional or academic discourse in her blog serves to make it difficult to dispute her position. If someone

were to disagree they would essentially be disagreeing with the authority of the source she invokes during her presentation of “research”. Any disagreement would have to be justified and supported on an academic basis in order to demonstrate an incorrectness of her position. A mere contrary opinion would not be sufficient to oppose her academically supported opinion.

Extract 41

I know there is more to mindfulness than that so I did some research to have a better understanding of the practice.

In Extract 42 Amina provides a quote to further strengthen her discourse of mindfulness. In providing the quote from Kabat-Zinn in Extract 42, Amina is demonstrating that she did indeed do “some research” (Extract 39). By stating that he is affiliated with the “University of Massachusetts Medical Center” and that Kabat-Zinn is the founder of the Mindfulness-based Stress Reduction program, she is constructing him as a person with the authority and therefore as a legitimate person to learn about mindfulness from. Not only is he constructed as an academic, he is constructed as a “special academic”. He is “a famous teacher of mindfulness”. Therefore, the research she did is constructed as being valid.

Extract 42

I learned that mindfulness is based on Buddhist philosophy and was developed by Jon Kabat-Zinn who is "a famous teacher of mindfulness meditation and founder of the Mindfulness-Based Stress Reduction program at the University of Massachusetts Medical Center."

The construction of Kabat-Zinn as an academic in turn serves to construct mindfulness as a legitimate approach. She constructs him as a person associated or familiar with “science” and science provides certainty about “truths” to laymen (Scheff, 1970). Therefore, the use of the professional discourse serves as a discursive resource by associating the argument provided with science and thereby constructing it as a “truth”.

Discussion and conclusion

Participants in this study resisted the medicalised discourse by making use of the online platform on which these discussions took place, by avoiding or resisting the term “schizophrenia”, by creating alternative non-pathologised discourses using mindfulness as a resource and by employing professional and empirical discourses.

According to the medical discourses resisted by participants, “schizophrenia” is a tangible biological illness only treatable with the help of health professionals and medication. Schizophrenia is constructed as something negative and distressing. According to the medicalised discourse, an individual with a diagnosis “becomes the disorder” since it overpowers and controls them. Schizophrenia is represented as something that is seldom recovered from and therefore individuals with a diagnosis are constructed as “having” a life-long disease. The medicalised discourse used by the participants is similar to the medicalised discourses identified by research (Rudge & Morse, 2001; Frese, Knight & Saks, 2009).

Alternative non-pathologised discourses were used by participants in order to resist the medicalised discourses of schizophrenia. The alternative discourses differed in the level of resistance they achieved. One alternative discourse resisted the medicalised discourse by constructing recovery from schizophrenia as possible. Another alternative discourse resisted it by constructing that medication and professional help are not needed in order to “recover” and by constructing mindfulness alone as sufficient to achieve recovery. In fact, health professionals and medication were constructed as hindering individuals with a diagnosis. These discourses still resembled the medicalised discourse by constructing schizophrenia as something that needs to be recovered from.

A third set of alternative discourses resisted the medicalised discourses by constructing that there is no need to “recover” from schizophrenia. Schizophrenia was constructed as something that can be lived with and as something that is not inevitably distressing. It was constructed as something potentially useful. According to this discourse, fighting schizophrenia is disadvantageous. This set of discourses still employed the medicalised discourse by constructing schizophrenia as an existing disorder.

The last set of discourses construct that schizophrenia is not a disorder. It is constructed as something that might not exist as a biological disorder but as a form of social control. Schizophrenia was constructed as something that is not “real” and independent of social processes. According to this set of discourses a diagnosis of schizophrenia does not necessarily indicate underlying pathology. These discourses are similar to arguments that mental illness, schizophrenia in particular, is not an illness at all if the concept is properly understood (Szasz, 1960; Pickard, 2009). Bodily illness is used as the foundational paradigm for all illnesses, including mental illness (Pickard, 2009). Szasz (1960) claimed that mental illness has more to do with psychosocial, legal and ethical norms than physiological and functional abnormalities of the human body. He argued that mental illness is not an illness at all but rather the identification of cultural deviation. It is the failure to conform to psychological or physical behavioural expectations that causes difficulty or disturbance to a degree that exceeds ordinary human experiences of difficulty (Szasz, 1960).

Scheff (1970) too argued that schizophrenia is a label applied to individuals that are thought to exhibit deviant behaviours. He stated that public order is made of numerous social understandings. These social understandings and norms are continuously reinforced by social interactions. Violations of these rules and understandings are usually categorised in some way

(Scheff, 1970). “Schizophrenia” is a label that is applied to individuals whose deviant behaviour is difficult to classify. Such “deviant behaviours” are a threat to the status quo (Scheff, 1970).

Individuals with a diagnosis of schizophrenia, who have used mindfulness-based approaches, critique the medicalised discourse of schizophrenia by employing a similar set of discourses to those developed in these classic critiques (such as those by Szasz and Scheff). These participants are coming from a different subject position (as supposed “sufferers” of schizophrenia) than the academic researchers but are nonetheless engaged in a similar process of critique and resistance to what the academic researchers have engaged in over a number of decades. This resistance is significant because it shows their agency in the face of the power of the medical-psychological profession and its discourse.

Participants in this study often constructed their ability to overcome and control their experiences as being due to mindfulness. The alternative non-pathologised discourses they produced also often resembled discourses of mindfulness. Participants used discourses that constructed schizophrenia as not inherently distressing. They constructed themselves as accepting and “letting go” of their “experiences of schizophrenia”. Participants claimed that getting rid of the experience of schizophrenia is unnecessary and that fighting “schizophrenia” did not help.

These discourses are similar to discourses of mindfulness that constructs unhappiness as the result of the formation of attachments to experience, rather than the experience itself (Hirst, 2003; Abba, Chadwick & Stevenson, 2008; Shapiro & Carlson, 2009), and that letting go of phenomena prevents individuals from developing or reinforcing unhelpful or harmful habitual cognitive, emotional or behavioural patterns (Hirst, 2003). The discourse that schizophrenia is not an independent disorder, and might not exist, resembles discourses of mindfulness that argue that no phenomenon or conceptualisation can exist independently from the person that conceptualises them.

These results indicate that mindfulness as a discourse was utilised to resist the medicalised discourse and to construct alternative non-pathologised discourses of both schizophrenia and the self.

The role of resisting the medicalised discourse and the use of alternative discourses, by participants, was to reclaim agency over their experiences and to construct a positive self. Resisting a discourse of stigma empowers individuals that would have been stigmatised (Howe, Tickle & Brown, 2014). A lot of the research focusing on agency in schizophrenia examines a lack of agency as a symptom and not a consequence of receiving a diagnosis and the associated discourses. Proust (2006) records four features of impaired agency in individuals diagnosed with schizophrenia. Two are of importance for this study. The first feature is that there is a supposed ownership/agency asymmetry. Proust (2006) claims that individuals with a diagnosis of schizophrenia experience ownership of actions but not agency of those actions (Proust, 2006). Individuals are said to perform actions without feeling responsible for the action. The second relevant feature Proust mentions is that individuals with a diagnosis of schizophrenia deny being responsible for their actions only in some cases.

The results of this study suggest a higher degree of agency among participants than Proust's claims allow for. All the participants constructed themselves as having control over their experiences to some degree. Hearing voices (arguably one of the defining characteristics of the construct schizophrenia) was constructed as something that can be controlled by the participants. Some reported *using* "schizophrenia" for their own benefit and as a reaction to other events. Those that did not claim that they could control their "symptoms" stated that they can overcome them using mindfulness.

The results of this study revealed how powerful this medicalised discourse is. Even though participants strongly resisted the discourse, they often did not manage to completely escape from reproducing it. This was especially so for the first three sets of discourses. At points participants addressed the medicalised discourse and called its constructions a “myth”. They wrote numerous threads and created online profiles dedicated to the resistance of the medicalised discourse, and despite this, they frequently found it difficult not to reproduce the medicalised discourse when constructing themselves. These results are consistent with Drapalski et al.’s (2013) findings that individuals with a diagnosis frequently use the dominant discourse of schizophrenia, as it is used by others, to construct themselves.

One of the values of this study is that naturally occurring data was used. Therefore, the findings were not influenced by prompts in form of questions from the researcher. The use of discussion forums also enabled the positions of participants to be challenged by other individuals that do not take part in mindfulness. These interactions provided the opportunity for participants to defend their discourses. Naturally occurring data was also beneficial due to the fact that individuals were not led or prompted in any way, what they wrote on the forums and blogs were things they felt important to write. Therefore, by using this kind of data it was possible to see what is important to those diagnosed with schizophrenia and acquainted with mindfulness. Again and again what was found to be important, and what was done the most frequently, was resisting the medicalised discourse and how it constructs these individuals.

It was also beneficial to investigate mindfulness as it is a newly explored area of study and much debate exists concerning the effectiveness of mindfulness and the mechanisms of it. Abba, Chadwick and Stevenson (2008) state that to investigate the effectiveness of mindfulness-based approaches qualitative methods exploring the discourses of the experiences of individuals are

needed. This study contributed to the knowledge concerning mindfulness and its benefits. It investigated mindfulness as a discourse as opposed to an approach for dealing with “schizophrenia”. The findings of this study demonstrated how mindfulness as a discourse is used by participants to resist the traditional medicalised discourse of schizophrenia. It also showed how discourses of mindfulness are used by the participants to construct themselves as individuals with agency and hope.

This study reminds us that discourses can be deconstructed and that because the concept of mental illness forms the core of essentially all contemporary psychiatric theories and practices, a critical examination of the concept is vital (Szasz, 1960). Szasz (1960) argued that mental illness is not a physical object and that it exists only in the way that any theoretical concept exists. However, familiar theories are often mistakenly taken to be “facts” or “objective truths” by those that support them (Szasz, 1960). He said that to combat this complacent use of the concept, mental illness, it is necessary to ask a few questions: “What is meant when it is asserted that someone is mentally ill?” (p. 8), and “what kinds of behaviour are regarded as indicative of mental illness, and by whom?” (p. 11). These questions were implied by the participants. Therefore, the construct schizophrenia should also be viewed with flexibility by those in the field, especially because its existence is challenged by those diagnosed with it.

This research urges academics and professionals to evaluate who the medicalised discourse serves. It questions the relevancy of the diagnosis of schizophrenia when it fails to foster hope and agency in participants. The alternative non-pathologised discourses of schizophrenia demonstrate that individuals that are familiar with mindfulness do not construct their experiences as the medical discourse constructs them. For these participants schizophrenia is not inevitably bad. Lysaker, Buck, Hammoud, Taylor and Roe (2006) state that for professionals to foster hope and agency they will need to allow for, and encourage a more active role for those they aim to help. They will also

need to critically examine whether their discourses encourage and empower those they claim to want to help.

In essence, this study contributed as it increased the understanding of how individuals construct discourses of schizophrenia through talk. It revealed how participants actively use the discourses of mindfulness to construct a particular kind of self, selves that they are choosing to be associated with. Some authors claim that by studying the self in “schizophrenia” we are studying the formation of the self in all individuals (Rudge & Morse, 2001). Therefore, this research does not merely relate to individuals with a diagnosis of schizophrenia but to all individuals. Doubt (1996) said that the abovementioned position suggests that we can learn from the people with a diagnosis of schizophrenia if we are prepared to listen. This study formed a platform for further studies investigating the role of the language used and the discourses of professionals on the personal discourses of patients. It revealed that individuals with a diagnosis of schizophrenia challenge the very nature of schizophrenia (and in turn other psychological disorders) and criticise the use of such a diagnosis.

Participants in this study invite persons in the field to also challenge the nature of schizophrenia. We should never become complacent in our constructions of “mental illness” and need to constantly evaluate the relevance of these categories, especially to those who are categorised according to them. This research urges us to critically evaluate who these labels serve and what they communicate and construct. As researchers, practitioners and public, we need to ask “to what extent we collude with medicine in maintaining . . . dominance over the lives of the people in our care and over our practice?” (Waters, 1999, p. 115). This study hopes to have contributed to that goal.

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Appendix

"Voices" by Chris Young

You could say I'm a little bit crazy

You could call me insane

Walkin' 'round with all these whispers

Runnin' 'round here in my brain

I just can't help but hear 'em

Man, I can't avoid it

I hear voices

I hear voices like

My dad sayin', "Work that job

But don't work your life away"

And mama tellin' me to drop some cash

In the offerin' plate on Sunday

And granddad sayin', "You can have a few

But don't ever cross that line"

Yeah, I hear voices all the time

Turns out I'm pretty dang lucky

For all that good advice

Those hard-to-find words of wisdom

Holed up here in my mind

And just when I've lost my way

Or I've got too many choices

I hear voices

I hear voices like

My dad sayin', "Quit that team

And you'd be a quitter for the rest of your life"

And mama tellin' me to say a prayer

Every time I lay down at night

And grandma sayin', "If you find the one

You better treat her right"

Yeah, I hear voices all the time

Sometimes I try to ignore 'em

But I thank God for 'em

'Cause they made me who I am

My dad sayin', "Work that job

But don't work your life away"

And mama tellin' me to drop some cash

In the offerin' plate on Sunday

And granddad sayin', "You can have a few

But don't ever cross that line"

Yeah, I hear voices all the time

Yeah, I hear voices all the time

All the time