Narratives of Schizophrenia: Constructing a Positive Identity

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Abstract: This paper explores how people with schizophrenia construct positive identities in the face of the negative and stigmatizing discourse of mental illness. The author regards identity not as a fixed characteristic of individuals but rather as something actively constructed and reconstructed in communicative practice. By analyzing the narratives of people diagnosed with schizophrenia, the author shows that people with schizophrenia do not simply take up the negative meanings of schizophrenia provided by cultural discourses. Instead, they use various strategies in social interaction to construct positive identities and in doing so reinforce or reshape cultural knowledge about schizophrenia.

Résumé : Cet article explore comment les personnes atteintes de schizophrénie construisent des identités positives à l’encontre de discours négatifs et stigmatisants sur les maladies mentales. Pour l’auteur, l’identité n’est pas une caractéristique fixe d’un individu; elle est plutôt quelque chose de construit et de reconstruit de manière active dans la pratique de la communication. En analysant les narrations de personnes ayant reçu un diagnostic de schizophrénie, l’auteur montre que les personnes atteintes de schizophrénie ne font pas qu’accepter les significations négatives de la schizophrénie que les discours culturels transmettent. Plutôt, dans les interactions sociales, elles ont recours à des stratégies diverses pour se construire des identités positives. Ce faisant, elles renforcent et réorganisent les connaissances culturelles sur la schizophrénie.

Keywords: Discourse analysis; Ethnomethodology; Psychology

In this paper, I explore how people with schizophrenia construct positive identities in the face of the negative and stigmatizing discourse of mental illness. While there is ongoing debate about the ontological status of mental illness in general, and schizophrenia in particular, I take the position that schizophrenia is a biological entity. It is an illness of, at present, unknown origin that causes certain changes in the brain. These changes produce a number of symptoms in its sufferers, including hallucinations, delusions, confused thoughts, and emotional and behavioural disturbances. But as with any serious chronic illness, the effects of schizophrenia are much more than simply the sum of its symptoms. The personal

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and social effects can be as troubling as the symptoms of the illness. Receiving a diagnosis of schizophrenia has implications for social identity, and it is to this aspect of the lives of people with schizophrenia that I turn my attention.

Social identity is a complex construct that has been discussed in a number of ways in a variety of literatures (see Holstein & Gubrium, 2000, and Widdicombe, 1998b, for detailed discussions). I begin by briefly reviewing some of these understandings of identity and then focus on the perspective that I draw on in my analysis. This perspective sees identity not as a fixed characteristic of individuals, something we simply are or have, but rather as something actively constructed and reconstructed in communicative practice. We assemble and negotiate identity in the course of social interaction as we take up or resist the larger cultural discourses within which our lives are embedded, and our identity negotiations in turn reinforce or reshape those larger cultural discourses. I examine this process in detail in the narratives of people with schizophrenia. Although it may seem that someone who has been identified as having schizophrenia has little choice in taking up the identity of “person with schizophrenia,” a diagnosis of schizophrenia does not determine or produce a particular identity. Instead, both life circumstances and available cultural knowledge provide resources for the active and ongoing process of the construction of distinctive selves. In my analysis, I show that people with schizophrenia do not simply take up the negative meanings of having schizophrenia. Instead, they use various strategies in social interaction to construct positive identities and in doing so reinforce or reshape cultural knowledge about schizophrenia.

Identity
Schizophrenia is sometimes described as a disorder of the self. People with schizophrenia experience themselves as somehow distanced or detached from themselves. For example, it is not uncommon to hear someone with schizophrenia say something like “It is not really me in here, it is the illness.” But the idea of the self, or identity, is a problematic construct, as evidenced by the fact that there are any number of ways of understanding what identity is. The person who describes him or herself as somehow detached from the self calls on the idea of a “real” autonomous and authentic self that resides deep within each of us. In this view, people simply have selves, have identities, in some unproblematic way. Another way to understand identity is as a social phenomenon. In this view, we have social identities by virtue of the social groups to which we belong or into which we are placed (e.g., Tajfel, 1982). We internalize various views of ourselves because of our membership in these social groups. Schizophrenia seems to be associated with both of these kinds of identity. People are described and describe themselves as being “schizophrenic” because they have the illness, schizophrenia, which in addition to placing them in a stigmatized group, also affects their internal sense of self in particular ways.

In the postmodern world, we also hear a lot about the fragmentation of identity. According to this view, the internal self, in the intuitive sense described above, has all but disappeared. We are bombarded in the media and in the many
different contexts of our lives by multiple versions of social identities that provide “endless possibilities for who we are and what we can be” (Holstein & Gubrium, 2000, p. 3). The self is saturated (Gergen, 1991); it is filled to overflowing, losing any sense of a distinct identity. And, in fact, the word schizophrenic is popularly (and, many would say, incorrectly) used in this context to describe the many pulls on identity experienced by people who certainly do not think of themselves as having the illness schizophrenia.

I have a lot of sympathy with this view of the self as assailed by multiple discourses, pulled in many directions, and having to play many roles. But I want to take a different view of the self than suggested by any of the approaches discussed so far. I regard the self as an ongoing project of social construction. In this view, the self is not simply something we are, and neither is it imposed automatically by social institutions; rather, identity is actively constructed, moment to moment, through social interaction. Individuals engage in what Loseke (2000) calls “identity work” (p. 108), in which “selves are crafted out of the ‘messy’ details of actual lives” (Gubrium & Holstein, 2000, p. 17) within the conditions of possibility provided by particular discursive environments. We draw on our biographical particulars and on culturally available knowledge to present versions of ourselves in specific social circumstances in order to tell ourselves and each other who and what we are. And this is as true for people with schizophrenia as it is for those of us lucky enough not to have schizophrenia.

This view of identity owes much to the work of Goffman (1959). He describes the self as presented to others through dramaturgical performance. Individuals “bring selves into view” (Holstein & Gubrium, 2000, p. 187) by managing their performances of self to create versions of social identity for particular audiences and social situations. Goffman (1963) developed these ideas further in relation to stigmatized individuals, showing how they actively use accounts to manage a “spoiled identity” such as that provided by a diagnosis of schizophrenia (see also Matza, 1969; Sykes & Matza, 1957). The interpretive approach drawn on here, however, goes further than Goffman’s ideas in showing that while individuals, in this case people with schizophrenia, do indeed manage identity in social interaction, the strategies they use to do so are not just embedded in particular social situations; they are in fact consequential for how the stigmatized group to which they belong is regarded generally in society.

At the risk of oversimplifying a complex construct, in this paper, I will use a definition of identity proposed by Antaki, Condor, & Levine (1996) as a starting point for discussing this view of identity: “To speak of someone’s social identity is to speak, at the very least, of what attaches to them by virtue of their membership in a category, usually a category constituted by social consensus or imposition” (p. 473). According to this definition, identities are constructed through the use of categories, both those people seek to put themselves into and those others impose upon them. Although this sounds somewhat similar to the social identity position outlined briefly above, Antaki, Condor, & Levine do not take identities to be static entities. Category membership is not an “immutable property of persons” (Rapley,
Rather, identity is a “matter of people’s situated and interested descriptions of themselves and each other” (Antaki, Condor, & Levine, 1996, p. 488).

In the ongoing stream of social interaction that makes up our lives, we make claims about who and what we are by invoking particular categories at particular moments in interaction. Social identities, whether they are sought by individuals or imposed upon them, are invoked to address the exigencies of particular conversational interactions and must be asserted and played out in social interaction. Self-categorizations are dynamic and fluid, even within the course of a single interaction. In this view, identity is something that must be accomplished over and over again, in every social interaction, constantly negotiated and maintained through communicative practice. And as something that must be accomplished, category membership is also something that can be contested.

Just as identities do not exist as “realities” separate from our use of them, so too categories do not exist apart from their use in social situations. Contrary to our intuitive assumptions, categories do not correspond to the real world in some straightforward one-to-one way. Rather, categories are constituted in social interaction and exist only through their application to specific cases. This view of the nature of categories rests on a view of language not simply as a transparent medium for the reporting and transmission of information and ideas but as actively constitutive of the social world. In making claims to category membership for themselves or others, speakers also make claims about the categories themselves. Categories take on the meanings they do because of the ways they are used in social interaction. Categories, like identities, are ongoing reality projects, subject to constant negotiation, requiring constant maintenance, and, as a result, open to contestation.

**Narrative**

One of the ways in which we establish identity is through narrative. We tell stories about ourselves. As Kerby (1991) says, “[T]he self is delineated and embodied primarily in narrative constructions or stories” (p. 1). Giddens (1991) describes the self as a “reflexive project” (p. 32) in which people constantly make and remake themselves, connecting their personal histories to a larger social history. They do this by reflexively constructing autobiographical narratives. As Giddens explains, “A person’s identity is not to be found in behaviour, nor—important though this is—in the reactions of others, but in the capacity to keep a particular narrative going. The individual’s biography... must continually integrate events that occur in the external world and sort them into the ongoing ‘story’ about the self” (p. 54). Rather than seeing the self as fragmented in a postmodern world, Giddens sees the construction of identity as a process of integration, in which “a person with a reasonably stable sense of self identity has a feeling of biographical continuity which she is able to grasp reflexively, and, to a greater or lesser degree, communicate to other people” (p. 54). The main challenge for individuals in what he calls late modern society is to maintain a coherent narrative of self in the face of the overwhelming barrage of identity possibilities provided by modern life.
The stories we tell about ourselves are not simply recitations of “the facts” of our lives. Rather, they are artful constructions that draw on both our life experiences and on culturally available discourses to cast our lives and ourselves in particular ways (Holstein & Gubrium, 2000). Stories organize experience, and in telling stories, speakers assert the meaning of the stories for particular situations or audiences. A life offers any number of events or experiences that could be raw material for life story and identity construction. And our culture offers various resources or discourses that provide conditions of possibility for the framing of our stories. But both life experience and culture are available only as resources, not as determining factors in our stories. Any particular “fact” of our lives may or may not be relevant in any given story produced in a particular social interaction. People construct present selves out of the biographical events they choose to notice. Thus, people are actively involved in deciding which story, which self, to convey to others and how to formulate it. Although the diagnosis of schizophrenia offers a framework for making a person’s life story coherent past, present, and future, it does not require that the person invoke the social identity of “schizophrenic” in every social interaction or that the category schizophrenic mean the same thing in every social interaction.

Although neither life circumstances nor cultural discourses determine identity construction, stories are constrained by the conditions of possibility offered by our culture and by the expectations of others. Not just any story will do. Although coherence is imposed onto a life by the storyteller rather than waiting as a “reality” to be recognized by any observer, our accounts of ourselves must be coordinated with the accounts others have of us and of themselves. As Rosenwald & Ochberg (1992) point out, “[C]oherence derives from the tacit assumptions of plausibility that shape the way each story maker weaves the fragmentary episodes of experience into a history” (p. 5). If we do not present ourselves in terms of reasonably familiar histories and identities, we are likely to be regarded as, at best, eccentric and, at worst, mentally ill.

As those familiar with schizophrenia well know, in the absence of a definitive medical test for this terrible illness, the presentation of completely implausible identities, apparently fabricated histories, and fantastical or outlandish experiences are among the primary grounds for coming to a diagnosis of schizophrenia. That is, the stories of people with schizophrenia are regarded as a way to decide if they are mentally ill, whether or not they belong in the category of schizophrenia. However, I believe that people with schizophrenia engage in the same identity work in social interaction as those of us without schizophrenia. Rather than regarding how people with schizophrenia talk as a resource for assessing the progress of their illness, I treat their talk as a topic in its own right, as a way to understand how they construct identity in social interaction. In particular, I focus on the interactional work that they do to construct positive identities in the face of the stigmatizing discourse of schizophrenia, and how this in turn works back into that larger cultural discourse.
Methodology

In my analysis, I draw examples from interviews that were conducted with people with schizophrenia during a two-month period in early 2001. Participants for these interviews were recruited through an unintentional snowball technique. I mentioned to a colleague that I was interested in interviewing people with schizophrenia, and within days I received an e-mail from a student at our university who had heard about my study from my colleague. After I interviewed this student, she told others about my study. I began to receive phone calls from other people offering to be interviewed. In all, I interviewed six people with schizophrenia. Participants ranged in age from 18 to about 55. Four were women, two men. All had been diagnosed with schizophrenia and were taking medication to control their psychotic symptoms. Except for the 18-year-old who still lived with her parents, they all lived independently, some of them working part time or attending school. Four were either married or living with partners.

Some of the interviews took place in my office, but most of them took place in the homes of the interviewees. The interviews were unstructured and lasted about one hour each. I began each interview by explaining that I was interested in studying how people talk about schizophrenia. I told them I was interested in what they had to say about their experiences as a person with schizophrenia and how they coped with having an illness that is so feared in society. I had a list of questions and topics, including such things as how they learned what schizophrenia is, how their sense of themselves changed since their diagnosis, how their family and friends regard them, and whether what they see in the media about schizophrenia accords with their own experience of schizophrenia. I began each interview by asking participants about how they came to be diagnosed with schizophrenia, but after that, I was prepared to let the conversation go wherever it took us. The interviews were taped and later transcribed by a professional transcriber.

I take an ethnomethodological approach to the interview data. Founded in the work of Garfinkel (1967), ethnomethodology is an approach to studying social life that seeks to understand how the social world is produced as an accomplishment of situated actors. Rather than seeing the social world as external to and determinative of the behaviours of members of society, ethnomethodology regards the social world as the active production of members who possess practical linguistic and interactional skills. The focus in my study is therefore on how people construct identity in the course of particular social interactions rather than on what those identities are or on why they are the way they are.

My analysis shows not how schizophrenia determines what people say about themselves, but how it is used as a resource for constructing identity. Thus, rather than regarding the interview as a source of data about the identities of my respondents, I regard my interviews as conversations in which both interviewer and interviewee are active participants in constructing both their own and each other's identity. Both speakers call on widely available cultural categories to invoke identities for themselves and to ascribe identities to the other and, in doing so, construct a version of social reality and sustain a sense of social order. In the analysis
that follows, I show that both interviewee and interviewer call on commonly understood aspects of the category *schizophrenia* to construct identities and in doing so reproduce or contest those understandings as legitimate understandings of schizophrenia.

**Analysis**

In examining how people with schizophrenia construct positive identities for themselves, I call on Antaki, Condor, & Levine’s (1996) assertion that speakers attempt to do three things in social interaction: they invoke social identities (or categories), they negotiate the boundaries of the identities, and they establish a record of having those identities. All of these acts are performed by all parties in a social interaction. In the ongoing flow of the conversation, membership in categories, the boundaries and meanings of categories themselves, and the record of having those category memberships are all open to negotiation and contestation. If speakers want to contest a negative identity, in this case the ascribed identity of schizophrenia, they have two options. They can contest their membership in the category, or they can contest the boundaries and meanings of the category. In either case, they try to establish a record of having the positive identity they invoke in social interaction.

Denying membership in the category schizophrenia is a dangerous option for people with schizophrenia if they want to have their claims taken seriously. One of the grounds for putting people into the category of schizophrenia is that, in the face of others’ perceptions of their behaviour and speech as increasingly bizarre, they deny that they have a problem at all. Thus, if they are to mitigate the negative consequences of membership in the category, they must accomplish this with the utmost delicacy. In my study, the participants’ identities as people with schizophrenia was foregrounded; the interviews took place because I was interested in talking to people with schizophrenia. I began the conversations by asking them to tell me about their lives with schizophrenia, how they came to be diagnosed, and how they got to where they are now. Denying membership in the category of schizophrenia was, for this reason too, not an option. Nevertheless, my interviewees used various strategies to mitigate the negative implications of membership in the category schizophrenia. I have identified three such strategies for discussion here: denying possession of features commonly associated with the category; rejecting schizophrenia as a motive for every behaviour; and mobilizing descriptions of themselves as normal. I illustrate these strategies with excerpts taken from the stories that my interviewees told me about their lives with schizophrenia.

**Denying possession of features commonly associated with the category**

Categories are, as Widdicombe (1998a) says, “inference rich” (p. 53). They provide labels that carry with them a host of implications about the characteristics of members of the category. Categories “are conventionally associated with activities, attributes, motives . . . [that] make them a powerful cultural resource in warranting, explaining and justifying behaviour” (p. 53). They are used to make inferences about people—particularly in the case of schizophrenia, negative
inferences. One strategy used to mitigate the negative meanings of schizophrenia is denying the applicability, in one’s own case, of certain critical features associated with the category. In the following excerpts, Jane uses the category schizophrenia to classify the behaviour of others, but sees herself as a special case in the category. (In all the excerpts, Barbara is the interviewer. The names of the respondents have been changed.)

Barbara: So if you could begin by telling me a little bit about how you were diagnosed with schizophrenia.

Jane: Well, I was diagnosed with schizophrenia. I’m not your average schizophrenic, either. I lead a productive life and I’m attending college right now.

In my opening question, I ask Jane to speak as a member of the category person with schizophrenia. My question is in no way a neutral question; it immediately characterizes her as a person with schizophrenia, able to speak about what it is like to have this illness. Her identity in the interview as a person with schizophrenia is thus produced by my question. Jane begins her identity work in this interview with an immediate rejection of my characterization of her by making a statement designed to mitigate the negative implications of being in this category: she is not typical. Here she invokes one of the usual negative attributions of this category, that people with schizophrenia do not lead productive lives because most cannot work or attend school. Although she has schizophrenia, she sets herself apart from this particular aspect of the category by saying that she is engaged in the productive activity of going to college. This version of her identity does not appear by accident in this spot in the interview. It is a response to the identity “problem” presented in my opening question and cannot be understood without reference to the unfolding conversation.

The strategy Jane uses in this exchange has been identified as “distancing” in the work of Snow and Anderson (1987) on homeless people. They describe this strategy as an attempt to assert a more favourable personal identity and in doing so recover a sense of self-worth. Clearly, Jane is doing this in her response to my question. But distancing has implications beyond those pointed out by Snow and Anderson. It is not just a personal (although widely used) strategy for constructing a more positive identity. It also has implications for how the category—in this case, of schizophrenia—is understood generally. By invoking the idea that people with schizophrenia do not lead productive lives, Jane not only acknowledges this as a perception that I, as a person without schizophrenia, am likely to have about schizophrenia, she also reinforces this as a legitimate understanding of the category. In this brief exchange we have both established identities and have invoked and legitimated a larger social world in which particular kinds of moral judgments are made about people with schizophrenia because of their membership in this category.

Later in the interview I came back to this characterization of herself.

Barbara: You said at the beginning that you aren’t the typical schizophrenic. How are you different from other people with schizophrenia?

Jane: Well, I have seen other schizophrenics and I see them in Calgary, and . . .
Barbara: There’s lots of them here.

Jane: Yeah, and they’re um . . . the perception of their um . . . lifestyle and their perception are different than mine. My standards are higher, probably because I work at it, but I think that a lot of people that live on the streets are probably schizophrenic or manic depressive. That’s what I think when I see them. So, um . . .

Barbara: Yeah, I think the same when I see them.

Jane: Or, you know, I heard stories, I heard a story the other day about a schizophrenic that was paranoid, a paranoid schizophrenic, um . . . and who’s doing illicit drugs and the illicit drugs that he did, well, one of the symptoms was paranoia. He was a paranoid schizophrenic doing paranoid drugs. I guess the guy was just, uh, totally manic, so . . .

Barbara: You look after yourself better.

Jane: Oh, I don’t know if I look after myself any better, I, uhhh, I don’t think I’ve changed that much. My life, my eating habits and so forth, haven’t changed that much. My perception has changed on um different things.

Barbara: Give me an example of one where your perception has changed.

Jane: Well, I don’t hang, I don’t, I guess my friendships changed. I’m not with a lot of drug addicts and I’m not with a lot of alcoholics, and I don’t go with . . . you know, with people that have problems. It just adds to me, it stresses me and so I just don’t deal with them.

In this stretch of talk, Jane invokes several more characteristics of the category schizophrenia. People with schizophrenia live on the streets and are drug addicts and alcoholics. She again distances herself, pointing out that she, on the other hand, has higher standards. She does none of these things and no longer hangs out with people who do. In fact, it stresses her out to be with people with these kinds of problems. She and I both accept her description of the category and together ascribe category membership to people neither of us knows on the basis of the fact that they appear to live “on the streets.” In using the category in this way, we again reproduce it as a legitimate understanding of the category.

Our talk in this section of the excerpt also shows the way in which the medical understanding of schizophrenia has influenced our understanding of the category. In a previous time, and often still now, people living on the streets would have been seen as living there by choice or because they are somehow lacking in moral fibre. Jane and I, however, see them as being there because they have mental illnesses. Jane’s story about the paranoid schizophrenic who takes drugs that make him more paranoid displays the medical vocabulary used to describe the symptoms of schizophrenia and knowledge about the effects of certain kinds of drugs on people with schizophrenia. In our conversation about street people, we draw on the resources provided by the medical view of mental illness to constitute and ascribe meaning to the behaviour of others. We have “reskilled,” in Giddens’ (1991) terms, to an understanding of schizophrenia arising out of expert knowledge about the behaviour a member in the category schizophrenia is likely to engage in.
When I suggest that she looks after herself better than other people with schizophrenia, I assist her in doing her identity work (or so I thought at the time) by giving her another opportunity to distance herself. In this statement, I actively participate in enabling her to construct a positive identity. She, however, hears this as a suggestion that she looks after herself better than she used to. That is, she hears it as a charge that she was once like these people. She rejects this by saying that she always looked after herself, again distancing herself from the category. Her narrative throughout this section of the interview does not simply tell the story of her life with schizophrenia; rather, it constructs a coherent version of her life as different from that of others with schizophrenia and establishes a record of it having been that way over a long period of time. Ironically, the identity work accomplished through distancing, intended to construct a positive identity, may undermine the very efforts of those using it. It has the larger effect of reproducing and reinforcing negative societal understandings of the category and ensuring that those negative understandings will continue to be used to make ascriptions about members of the category.

**Rejecting schizophrenia as a motive**

Another strategy for deflecting the negative aspects of a category is to deny that the category provides the motivation for behaviour in a particular instance. As noted above, categories are powerful resources for the imputation of motives and are used to explain past or present actions and to predict future behaviour. In the following excerpt, Marie rejects schizophrenia as the appropriate category for understanding her participation in a hospital protest.

Marie: We did a hospital protest . . . . The union got together and they decided they’d have someone anonymous come in and do the protest . . . . I volunteered for it, and the stress issue was a big thing . . . . And my psychiatrist took me aside, and she said, “Are you thinking you’re someone really important? Are you feeling like you are delusional, or do you think that your grandeur . . . ?” Just went on and on. It was like just to do something out of the rut, I had to explain myself.

Barbara: Defend this as not a symptom.

Marie: Yeah, exactly.

In this excerpt, Marie tells a story about her decision to participate in a protest at a local hospital. This was a well-known local issue at the time, and many people were participating in such protests. It was an ordinary kind of thing to do. Her psychiatrist, however, invoked Marie’s membership in the category schizophrenia to explain her participation as a symptom of her illness. According to the psychiatrist, her participation is the result of her ongoing symptoms in which she has delusions of grandeur and thinks she is someone special. Marie, however, says that her participation is the result of her desire to do something out of the rut and is not connected with her schizophrenia. She rejects the psychiatrist’s characterization of her motive and replaces it with a motive that anyone might have. Schizophrenia, she claims, should not be seen as the cause of her every action. In
so doing, she does not deny her membership in the category, but instead rejects the invoking of the category in this particular instance as a motive for her actions.

Being a person with schizophrenia means displaying cultural knowledge of the category schizophrenia (Baker, 2001). In this excerpt, we can see that Marie has internalized the language and vocabulary of schizophrenia symptoms as a way to talk about herself. She is proficient in its use and its application to herself. After a number of years of treatment, she knows that one of the ways in which she departs from reality is that she “has” delusions of grandeur. The medical discourse of schizophrenia thus provides resources for her to understand her behaviour and constitute herself as a person with schizophrenia. However, it does not determine that she will take up this medical discourse in a particular way and in every situation. In this excerpt from the interview, she rejects schizophrenia as a determining aspect of her identity, and specifically she rejects it as the appropriate way to talk about herself in this particular instance. Instead she characterizes her desire to take part in the protest as an expression of a personal preference, an assertion of an identity that has nothing to do with schizophrenia.

The issue here is not whether the psychiatrist is correct in identifying Marie’s behavior as a symptom of her illness. Rather, we can see her using this story as a way to resist the application of the category schizophrenia as relevant for understanding her behaviour in every situation. We can see her insisting that, as Gubrium & Holstein (2000) say, “[T]he possibilities for who we might be as troubled persons are not set in stone, but vary across time and social circumstance” (p. 14). As Widdicombe (1998b) points out, ascription of social identity can be understood as a form of social control, and application of the category to someone without consulting with them can produce a sense of social injustice. In telling this story in her conversation with me, Marie presents a moral universe in which she has been judged unfairly through a totalizing application of the category schizophrenia to herself. She does not deny membership in the category schizophrenia. Instead, she contests the way in which the category is applied to her on this particular occasion. Although Marie’s conversation with me does not reinforce negative societal understandings of schizophrenia in the way that Jane’s does, it also does not disrupt them in any significant way. She resists the application of the category schizophrenia to every aspect of her life and personality, but leaves the category itself available for interpreting the behaviour of people with schizophrenia.

**Mobilizing descriptions of themselves as normal**

Another strategy for deflecting the negative implications of a category is to suggest that characteristics generally seen as specific to the category are shared by others outside the category. This discursive strategy has been called “normalizing” (e.g., Estroff, 1989; Garfinkel, 1967). Garfinkel (1967) describes this strategy as an attempt to reduce the difference between the “abnormal” and normal person by redefining the so-called abnormal behaviour as simply an extension of normal conduct. According to Estroff (1989), it is used by people with schizophrenia as a way to “stress and reassert their similarities with others and to
retain claim to their... not-disordered selves” (p. 191). Like distancing, normalizing is, however, more than just a personal strategy; it also has implications for how we understand the category of schizophrenia. While distancing reinforces the meanings of the category, normalizing instead attempts to change the meanings of the category. In the following excerpts, the respondents mobilize descriptions of themselves as normal, descriptions that are implicitly more appropriate than the negative ones implied by the category schizophrenia.

Marie: I also get those delusions during exam time [she is a university student]. During exam time I go through this and I just see it as a natural process of having stress in accordance to schizophrenia. So other people have stress in other forms. Because I have these unique perceptual experiences, I experience the stress in a different form.

In this excerpt, Marie describes having symptoms of schizophrenia brought on by the stress of exam time. She experiences delusions, something the rest of us do not generally have to deal with, at least not to the extent someone with schizophrenia does. But she normalizes this by saying that it is a natural process, in the context of schizophrenia, that stress will bring on symptoms. She further normalizes it by saying that everyone experiences stress and has negative effects from stress. Her effects are somewhat different, but still a normal result of the stress of exam time, which she has to manage, just like everyone else.

In the next excerpt, Jennifer also normalizes being mentally ill.

Barbara: Do you think of yourself as mentally ill?

Jennifer: I think of myself as a person with an illness, and like I said, everybody has an illness, so not everyone is perfectly healthy, especially once you hit 40 or 50. Usually there’s something or other. So I don’t label myself as a person with an illness. I don’t even think of myself as a person with schizophrenia. I think of myself as a person who has an illness like everyone else, and has to learn to cope with how it is.

In this excerpt, I have again presented the interviewee with an identity problem by asking if she thinks she is mentally ill. Jennifer moves immediately to deflect the negative implications of being in the category mentally ill. She describes herself as being just like everyone else. Everyone has something wrong with them and has to adapt and cope with it. She may not be perfectly healthy, but then neither is anyone else. She is normal in having to cope with her illness. In the next excerpt, she again describes herself as normal, even though there are many aspects of her life that are not like others’.

Jennifer: But there are days, when I have a day off or something, I’ll lay in bed all day and sleep. And it’s not necessarily because I’m tired, it’s just I need a down day and that’s what I do. I don’t know too many perfectly healthy people that do that... And with [her husband, who also has schizophrenia] working full-time, we’re in bed by eight o’clock at night. And again, I don’t think most people are in bed by 8:00. But that’s what we’ve had to adapt to do for him to go out and work full time. So we have as normal a life, as normal, whatever that is, as we can, making adaptations.
In this excerpt, Jennifer describes herself as different from other people in what she thinks are significant ways. When she has a day off, she will often stay in bed all day; she and her husband need to be in bed by 8:00 p.m. every night in order for him to be able to work full time. Nevertheless she characterizes her life as normal, at least as normal as possible, whatever normal might be.

Neither of the speakers in these excerpts denies membership in the category schizophrenia. Rather, they assert the normal aspects of being in the category. I think it is safe to say that as a cultural category, schizophrenia carries almost no meanings that are generally understood as normal. In fact, as I have pointed out, in the absence of any medical tests for mental illness, a diagnosis of schizophrenia results precisely when speech and behaviour are perceived as abnormal. And this speech and behaviour are usually frightening and bewildering to the people around the “misbehaving” person. In addition, there is no cure and sometimes very little recovery from schizophrenia. Unpredictable behaviour can appear at any time and without warning. All of this produces an understanding of schizophrenia as a frightening condition very much outside the norm.

The speakers in these excerpts, however, reject schizophrenia as a category having only negative and “abnormal” meanings and instead assert the “normalness” of schizophrenia. Having effects from stress is normal. Having something wrong with you and having to cope with it is normal. In fact, these days, not having something wrong with you is not normal. In spite of having to make unusual adaptations in lifestyle for one partner to be able to hold down a full-time job, life is normal. Again, it is not a question of who is right about what schizophrenia is really like. Instead, we can see what Baker (1997) calls the “local production of versions of a moral order” (p. 131). In these excerpts, the speakers present a moral universe in which schizophrenia is not a frightening condition providing grounds for exclusion from ordinary social life, but rather something that produces experiences that are similar to those of people who do not have the illness and are therefore normal and ordinary. Marie’s and Jennifer’s descriptions of the things they have to do to cope with having schizophrenia reduce the difference between themselves and people without schizophrenia, and in so doing change what it means to have schizophrenia. Normalizing does not simply contribute to the construction of a more positive personal identity in the context of the interview. By undermining the negative characteristics of schizophrenia and asserting the normal aspects of having this illness, normalizing changes the meaning of the category schizophrenia itself.

Conclusion
One of the difficulties in discussing identity in people with schizophrenia is that, as a consequence of having a mental illness in which they lose contact with reality, they are generally not regarded as what McHugh (1970) calls “theoretic actors.” That is, they are not seen as people who understand what is going on and are able to account for their actions in ways understood to be competent. They typically have very different stories about themselves than do their medical practitioners and family members. And they often have great difficulty maintaining a coherent
biography that will be regarded by others as plausible. If they stake claims to normal or competent identities, this is often seen as evidence that they are not normal—they don’t understand the “real” nature of their illness.

However, my analysis demonstrates that people with schizophrenia are skilled in the interactional construction of identity. In this regard, they are not different in any essential way from people without schizophrenia. In some sense, we all “fabricate,” or at least perform, identities in the narratives we present in our interactions with others. It is not the “truth” of identities that is at issue. Nor is it the success or failure of the strategies used to accomplish positive identities in any particular interaction. Rather, my analysis reveals the active work that people with schizophrenia do to establish themselves as moral actors, individuals to whom this negative discourse cannot be applied in a totalizing way.

Adopting a view of identity as constructed in social interaction makes it possible to use the stories of people with schizophrenia not as a diagnostic tool or as a source of information about the progress of their illness, but as a way to acknowledge and understand people with schizophrenia as people first, individuals with the same needs and desires as the rest of us. In the excerpts I have presented, we see how strongly the interviewees feel the need to disassociate themselves from the negative meanings of the category schizophrenia and the effort they expend to do so. This tells us something about the degree to which this negative discourse influences their lives and the sense of injustice they feel at being judged according to it when they have surely not chosen to have schizophrenia. We see them striving to construct what Potter (1996) has called “locally coherent versions of their moral and social worlds” (p. 88).

My analysis also demonstrates the larger implications of how the category schizophrenia is invoked in particular social interactions. Cultural discourses are generally seen as somehow swirling around beyond the reach and influence of mere individuals. People who contest category meanings in isolated conversations, particularly people who have a tenuous grip on reality, can surely have little or no effect on larger cultural discourses. In the view of identity presented here, however, categories exist only in use. That is, while ideas may indeed be experienced as being “out there,” we only know what these ideas are and come to think of them as “out there” through their use in particular local circumstances and their application to specific cases. Our only hope of changing larger cultural discourses lies in our use of them in particular local circumstances. The approach to identity I have advocated here opens the possibility both to understand the narratives of people with schizophrenia in a new way and to influence the larger cultural discourse of schizophrenia. This can only help those with schizophrenia to cope with their membership in the category schizophrenia and to construct more positive identities.

The three discursive strategies discussed in this article work in different ways in relation to larger cultural discourses. Distancing reinforces existing negative understandings of schizophrenia; rejecting schizophrenia as a motive contests the application of the category in every instance but not the meanings of the category.
itself; and normalizing challenges the wider understanding of what it means to have schizophrenia. The first two are clearly important ways for individual speakers to construct positive identities in interaction. But because they either re-assert or do not challenge the negative meanings of the category, their potential to affect how people with schizophrenia are regarded in society is at best limited and at worst negatively reinforcing. Only the third strategy, normalizing, has the potential to accomplish the change in public understanding that people with schizophrenia and their advocates strive for. This conclusion clearly has implications for how activists, whether they are people with schizophrenia or those who speak on their behalf, talk about schizophrenia. Some rhetorical strategies for reducing the stigma associated with schizophrenia will work better than others. Advocates surely want to use strategies that have the potential to change the meanings of schizophrenia rather than inadvertently use strategies that reinforce negative meanings. Further research might profitably analyze written and spoken materials, for example television specials that are designed to increase awareness and change attitudes about schizophrenia, to see which discursive strategies dominate and how such materials might be better designed to accomplish their purpose.

My analysis also raises questions about the nature of theorizing itself. My choice of theoretical and analytical framework has led to an analysis that, at least in regard to the interactional construction of identity, narrows the gap between people who have schizophrenia and those who do not. It leads to the conclusion that people with schizophrenia are more like the rest of us than we have generally wanted to admit. It might, in fact, be seen as an example of the third strategy identified in my analysis, normalizing. And, as noted earlier, of the three strategies I have identified, normalizing is the one with the potential to affect larger cultural discourses about schizophrenia.

My choice of theoretical framework illustrates what Seidman (1996) is talking about when he says that theorizing has moral consequences. In a postmodern world in which theory can no longer offer access to objectivity or truth, theorists must find another rationale for producing knowledge. Seidman suggests that “the value of knowledge in a postmodern era [is] related to the kinds of lives that it shapes and the ways that it anticipates a good society” (p. 326). He offers theorists not just a ground for making theoretical choices, but indeed the obligation to produce “social knowledge [that] can contribute to making a better world” (p. 14). In analyzing the narratives of people with schizophrenia I have used theory to construct my own narrative, a story that advocates that we tell a different story about the talk of people with schizophrenia, and through this a different story about people with schizophrenia themselves. The stories that people tell about themselves and that are told about them are, of course, consequential for their lives and for how they are regarded in society generally. As Rosenwald and Ochberg (1992) so astutely point out, “Life stories will make history” (p. 12). It matters which stories people tell about themselves and each other.
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References


