Expanding the Epistemological Horizons of Insight in Psychosis: Toward an Anthropological and Phenomenological Re-Framing

Mark S. Dolson

Departments of Anthropology and Social Studies of Medicine,
McGill University,
Montréal, Quebec

August, 2003

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements of the degree of Master of Arts

Your file Votre référence
ISBN: 0-612-98433-8
Our file Notre référence
ISBN: 0-612-98433-8

Abstract

By re-examining the epistemological foundations upon which the ego-centric clinical construct of insight in psychosis rests, research conducted with the narratives of patients who participated in the clinical project, *Psychosis and Culture: The Role of Spaces of Negotiation (Between Patients, Families, and Practitioners) During Consultation* was aimed to explore and formulate a socio-centric model of insight construction more sensitive to patients' intersubjective and cultural milieus. Collected interviews—conducted with recently diagnosed psychotic patients using the Turning Point Interview (TPI) grid—were approached from a phenomenological and hermeneutical perspective in order to illustrate the processual manner in which patients' insight (into the cause and reason of illness) was the cognitive and epistemic derivative of dialogical relations with other persons set within a socio-cultural matrix. The results of this research indicate that the production of patients' insight in psychosis is an inherently intersubjective and dialogic phenomenon which, in the clinical context, occurs at two points of juncture: 1) a *synchronic* juncture where the patient is interpellated by the clinician and hence positioned as a speaking subject, and 2) a *diachronic* juncture where the patient, as a result of having been called into a speaking position, constructs and authors a narrative account of significant events related to his/her illness experience based on biographical memory. Insight was shown to consist of 3 stages: 1) *Detection of alteration of lived experience*, 2) *Causal attribution*, and 3) *Global construction of meaning*. Each stage was shown to form the intersubjective and dialogic basis for the production of a subjectively meaningful account of insight, using the lifeworld of the patients and the patients' entourage as subjective frames of reference.

Résumé

En réexaminant les fondations épistémologiques sur lesquelles se base le concept clinique et ego-centrique d'*insight* dans la psychose, cette recherche, basée sur les récits de patients ayant participé à la recherche *Psychose et Culture: Le Rôle des Espaces de Négociation (Entre Patients, Famille et Intervenants) Durant la Consultation*, visait à explorer et formuler un modèle socio-centrique de la construction de l'*insight*, plus sensible aux milieux intersubjectifs et culturels des patients. Les entrevues – réalisées auprès de patients récemment diagnostiqués comme psychotiques, avec la grille de l'*Entrevue des Points Tournants* (TPI) – ont été approchées d'un point de vue phénoménologique et herméneutique afin d'illustrer en quoi l'*insight* des patients (concernant la cause et la signification de leur maladie) était un dérivé cognitif et épistémique des relations dialogiques établies avec d'autres personnes intégrées dans une matrice socioculturelle. Les résultats de cette recherche indiquent que la production de l'*insight* chez les patients est un phénomène intrinsèquement intersubjectif et dialogique qui émerge dans le processus clinique à deux points de jonction: 1) une jonction *synchronique*, où le patient est interpellé par le clinicien et ainsi positionné comme sujet et interlocuteur, puis 2) une jonction *diachronique*, où le patient, après avoir été placé dans une position d'interlocuteur construit et signe, sur les bases de sa mémoire autobiographique, un compte-rendu narratif des événements significatifs reliés à l'expérience de sa maladie. L'*insight* apparaissait constitué de trois étapes : 1) *Prise de conscience d'une altération de l'expérience vécue*, 2) *Attribution causale*, et 3) *Construction globale de sens*. Chaque étape s'est avérée former la base intersubjective et dialogique de la production d'un récit subjectivement significatif de l'*insight*, en utilisant le monde vécu des patients et de leur entourage comme des cadres de référence subjectifs.

Table of Contents

Acknowledgements

At the outset, I would like to thank my supervisor, Dr. Ellen Corin and my two committee members, Dr. Allan Young, and Dr. Laurence Kirmayer, for their support, comments and suggestions both at the outset of and throughout the writing of this thesis. I would also like to thank Margaret Lock for taking the time to proofread the proposal of this thesis; I deeply appreciate your insightful comments. In particular, I must thank my thesis director, Ellen Corin, as she devoted a great deal of time, effort and energy to the materialization of this project. I am so very grateful that she took me on as one of her few students. I will always be stunned by her sharp perceptions, keen insights and boundless energy to cultivate knowledge and above all else, *understanding* in her students. As such, I feel very honoured to have worked with Dr. Corin through the formulations and re-formulations of an anthropological and phenomenological understanding of insight in patients newly diagnosed with psychosis. Although I have a long way to go yet, I can say that I am slowly on my way to understanding.

I must also thank the psychiatrists, nurses and patients at the Allan Memorial Institute, McGill Health Science Centre, Montréal, where I volunteered and conducted preliminary fieldwork in the form of many an open-ended conversation/debate. I must especially thank nurse Linda Rogers and Dr. Csvejic—both of whom help coordinate the psycho-geriatric day clinic—for their hospitality and kindness. To Andreas and Abdel, I hope you find the peace that you search for.

Acknowledgement also must go to the McGill Department of Anthropology, including the administrative staff: Rosemary Stano (thank you so much for your kind parting words, they will stay with me forever), Diane Mann and Cynthia Romanyk (sorry for so many trivial questions, really), and Professor Nadia Ferrara for helping me through my first experience as a teaching assistant, thank-you. I cannot forget my fellow students: Thank-you all for a truly great, albeit intense, two years. I must especially thank Annie Jaimes, I really appreciate your help.

I would like to dedicate this rather novice (as I have not yet been blessed with a mastery of maieutics) work to my parents, Leslie and Catherine Dolson (thanks for... where to start? Well, how about everything!); and the beautiful and understanding love of my life, Alexis E. Dolphin (your astounding beauty and radiance leaves me searching for words that I can never seem to find); and lastly, to my grandmother, Rosemond Philips: although you are not here in material form to read this, I must say thank-you for believing in me when I was a little boy. I am not sure where you are, but we will meet again some day.

Last but not least, I would like to thank a few of my favorite things: My dog 'Herr Ubu' (the *overly*-flamboyant Siberian Husky) for constantly showing me affection (especially my left leg), even when I did not want it—we will find a companion for you soon, buddy (I hope). In closing, I would like to thank the countless thrash and death-metal bands that have caressed my ears over the years; the music created by these revolutionaries captured the absolute *essence* of poetry in musical form—if there ever was a 'fountain of creative inspiration', it was there...

Mark S. Dolson, Northampton
Massachusetts, July 3rd 2003

Introduction

Insight and Psychosis: The Link to Medical Anthropology

> Thus the man who discovers himself directly in the *cogito* also discovers all the others, and discovers them as the condition of his own existence. He recognizes that he cannot be anything (in the sense in which one says one is spiritual, or that one is wicked or jealous) unless others recognize him as such. I cannot obtain any truth whatsoever about myself, except through the mediation of another. *The other is indispensable to my existence, and equally so to any knowledge I can have of myself... thus, at once, we find ourselves in a world which is, let us say, that of "inter-subjectivity"*
>
> (Jean-Paul Sartre 1946: 45, *Existentialism and Humanism*, emphasis mine)

> The single man for himself possesses the essence of man neither in himself as a moral being nor in himself as a thinking being. The essence of man is contained only in the community and unity of man with man; it is a unity, however, which rests only on the reality of the distinction between the *I* and *Thou*.
>
> (Ludwig Feuerbach 1843: 71, *Principles of the Philosophy of the Future*, emphasis mine)

γνώθι σεαυτόν! (Δείτε επίσης)

"*Know Thyself*!" Delphic Injunction

As a student of medical anthropology[1] interested in the area of psychopathology, my research interests fall along two broad, but not necessarily mutually exclusive axes: the anthropological/philosophical underpinnings of self-knowledge and the social, cultural, and epistemic correlates of psychotic disorders.

First, I am interested in probing anthropological and existential notions of the self and the knowledge the self is said to acquire through social praxis and experience. More

[1] Aside from the multitude of definitions of medical anthropology, the definition I subscribe to comes from the medical anthropologist, Allan Young. Young states that medical anthropology should not just centre on an analysis of how a disease enters into the consciousness of the individual, but should also centre on the social and epistemic links of what he calls 'sickness' or the process of 'socializing disease and illness' (Young, 1982: 270). This process, argues Martínez-Hernáez (2000), in support of Young's understanding, involves the analysis of social, economic, political and ideological forces; thus, medical anthropology can be seen as an 'anthropology of sickness', or a study of the nexus between social relations and conditions that are capable of producing disease and illness. This includes the analysis of what Young (1982) calls 'the social conditions of knowledge production'.

specifically, I am interested in the intersubjective, dialogical and socio-cultural construction of the self and the knowledge this self both acquires and utilizes in order to interpret and negotiate understandings of itself, others, and the social-cultural matrix in which it is embedded.

Second, I am interested in probing the notion of self and self-understanding and illness recognition in patients diagnosed with psychosis (particularly schizophrenic non-affective psychosis). Forms of psychosis, particularly those of the schizophrenias, represent a challenge to those psychiatrists, psychologists, medical anthropologists and sociologists interested in the economics of self and self knowledge, as the disease is said to erode and undermine the organization and overall functioning of the self and self/other-perception (Fabrega, 1989: 277). As a corollary, psychosis may overtake completely and redefine the very identity of the patient's sense of self (Estroff, 1989, 189), leaving him/her in a threatening and precarious position in terms of the understanding of self, other and the world in which he/she exists. Schizophrenia, as a notion of disturbed identity, has been a problematic engaged by phenomenological oriented psychiatrists, psychologists and anthropologists.

The anthropological notion of self is based on the understanding that agency of self and other—and their interactions with each other within their respective social and cultural matrix—is rooted in dialogicity and intersubjectivity (*vide* Schutz, 1962, Schutz and Luckmann, 1973; Davies and Harré, 1990; Neisser, 1993, 1994; Jackson, 1989, 1996 (see introduction), 1998; Neisser and Jopling, 1997; Jopling, 1993, 1997 and 2000). The notion of intersubjectivity should be understood as the space and oscillation between constantly shifting frames of reference and variegated subjective experiences. As Davies and Harré (1990) point out, intersubjectivity is composed of two elements: 1) conceptual schemes, which are static repertoires located in the mind of each self, almost like a personal possession, and 2) discourse, which is a multi-faceted public process through which meanings are dynamically achieved. Davies and Harré argue that the constitutional force which brings the self into being is located at the nexus between the self concept and the subject's discursive position: "once having taken up a particular position as one's own, a person inevitably sees the world from the vantage point of that position in terms of the particular images, metaphors, story lines and concepts which are made relevant within that particular discursive practice in which they are positioned" (1990: 46).

Thus from the discursive framework, selfhood is understood not as an essentialized existential given, but as a provisional, situationally defined project (Battaglia, 1995; Moore, 1999). Selfhood, as it is understood anthropologically, seeks to delimit the varying and contradicting socio-cultural layers available to the self for purchase in the ever-shifting economy of social relations. Concomitant with this line of reasoning, the self is constructed as a socially enacted agenda susceptible to conditional modifications both in self knowledge and knowledge of the world (Battaglia, 1995: 3).

From a strictly clinical point of view, what I find both fascinating and perplexing about 'insight' as self-knowledge[2] (of the presence and meaning of illness) are instances where there is an apparent inability of psychotic patients to recognize that they, according to Western clinical standards, are mentally ill and in need of treatment (Kumar and Sims, 1996: 1). Psychotic patients, especially those diagnosed with schizophrenia, often deny that their experiences are abnormal/discordant with established cultural codes and that they are unwell and in need of treatment. The resulting refusal to co-operate with treatment and rehabilitation based on the dominant Western psychiatric tradition may cause long term suffering for both patients and their families. Traditionally, a patient's capacity to evaluate and provide recognition of his/her own illness has been judged and analyzed clinically by evaluating his/her insight (Kumar and Sims, 1996: 1). Like so many other clinical psychiatric concepts, much confusion exists within medical textbook/dictionary definitions of insight which span the terminological gamut with such entries as 'the patient's capacity to form judgments about his/her own illness and mental state' to 'non-compliance with the imposed treatment regimen'. Recently, there has been a resurgence of interest in the role of insight in the psychoses with attempts to define the concept more reliably and to study its phenomenological, neurophysicological, cognitive, psychological, and anatomico-structural correlates (cf. Amador and David, 1998).

One of the purposes of an anthropological inquiry into notions of selfhood and the psychoses is to expand the seemingly parochial view of self that the dominant tradition of Western psychiatry most often imputes to patients with psychotic disorders, *viz.* a notion of self that is linked to the dominant values and mores of Western society and culture. This context insensitive understanding of the psychoses, understood from a traditional,

[2] Throughout this thesis, I shall refer to insight as 'self-knowledge' of the *presence and meaning* of a marked alteration in lived experience (i.e. the restructuring of the self concomitant with the onset of psychosis), and the subsequent interpretation and verbalization of said alteration.

biologically oriented psychiatry, may not be applicable or conducive to understanding the disease as a universal or cross-cultural phenomenon (Waxler, 1977; Kleinman, 1988, 1998; Jenkins, 1996; Fabrega, 1974, 1989; Martínez-Hernáez, 2000).

Characteristic of the dominant values of Western culture is a strict emphasis on the autonomous and free individual—the social atom as it were. This egocentric model of the individual affords very little room for paradigms of the self in which alternative views—for instance, those grounded in religion, spirituality, or Eastern philosophies—may be considered.

Also, notions of subjectivity congruent with the dominant Western understanding of selfhood interpret and understand individuality, social action and behaviour, not as products of processes embedded in intersubjectivity (Jackson, 1989, 1996, 1998; Geertz, 1973; Morris, 1994; Kleinman, 1998; Desjarlais, 1997, 1999), but as the result of properties stemming directly from an isolated self grounded in a Manichean metaphysic—i.e., the mind/body divide. Such a fundamentally dichotomous conception of self tends to attenuate some of the major developments within social science and continental philosophy. According to Morris (1994), those in support of Cartesian rationalism and its ontological distinction between mind and body ignore the myriad critiques of the "dialectics of the Enlightenment" (Auguste Comte's positivism and John Locke's/Adam Smith's methodological individualism/social atomism predicated on social contract theory, *et cetera*) by figures in such fields as Marxism, post-structuralism, feminist theory, existentialism, American pragmatism, cognitive psychology, socio-cultural anthropology and sociology. According to Morris (1991), the crux of the aforesaid critiques of Cartesian rationalism is to intimate that the self is anything but a bounded, isolable social coordinate locatable on a static grid of social relations. Inversely, the self is something that is created and revealed to itself and other selves through social praxis[3] and dialogicity—it is both embodied and embedded within a nexus of provisional and plastic social relationships. Here, the anthropological enterprise places emphasis on an ontology of the social—i.e.

---

[3] Here, the term 'praxis'—based upon the Aristotelian understanding of the actualization of rational potencies determined by rational *choice* (*órexin é proairesin*)—can be understood simply as social action based on a specific motive. Action or praxis from the Weberian perspective "[includes] all human behaviour when and in so far as the acting individual attaches a subjective meaning to it…Action is social in so far as, by virtue of the subjective meaning [*gemeinten Sinn*] attached to it by the acting individual (or individuals), it takes account of [*Bezogen wird*] the behaviour of others and is thereby oriented in its course" (Weber quoted in Ricœur, 1992: 155).

relationships/reciprocity, or what Taylor (1989) called 'webs of interlocution'—as opposed to an ontology of the private, bounded, cognizing subject (Jopling, 2000: 299).

The synthesis of my interests in both anthropology and psychopathology has led me to the notion of insight as self-knowledge—and its clinical derivative, lack of insight—in psychosis. By responding to and investigating a psychopathological problematic (the notion of insight in psychosis) with an anthropologically-grounded framework and methodology, I seek to probe the notion of insight, or 'awareness of illness' and illuminate the social, cultural, and epistemic correlates which factor into the construction and configuration of this clinical phenomenon[4].

I first become interested in the dynamic between anthropology and psychopathology during the third year of my undergraduate degree. At that particular time, I was torn between a central academic focus in either paleopathology/skeletal biology or anthropological/social theory. I opted for the latter.

I recall embarking on a term paper for a social theory course where my purpose was to probe the relationship between culturally sanctioned codes of behaviour and instances where these codes are either transgressed or re-worked in different, albeit socially 'deviant' ways. I also recall having lengthy conversations with one of my professors, John Gehman, about possible sources/references to use for my paper. His first of many suggestions was to read the books *The Divided Self* (1960) and *The Politics of Experience and the Bird of Paradise* (1961), by Ronald David Laing—two seminal works in the phenomenology and hermeneutics of the schizophrenic or, according to Laing, the 'schizoid' experience. Although professor Gehman warned me to approach the aforementioned books with caution and to be highly critical of Laing's views regarding the etiology of schizophrenia, he did

---

[4] Regarding the limited scope of this thesis, I will need to bracket the purely neurophysiological/chemical and anatomico-structural aspects involved in insight in psychosis in order to give primacy to the often undermined social, cultural and existential correlate of insight as a clinical phenomenon. My intent is not to negate the biological correlates via the strategy of "opportunistic oversimplicication", an approach defended on the grounds of plausible neglect which states, to quote Dennett: "[That] things that are horribly complicated may be usefully and revealingly approximated by partitionings, averagings, idealizations, and other deliberate oversimplifications, in the hope that some molar behaviour of the complex phenomenon will prove to be relatively independent of all the myriad micro-details, and hence will be reproduced in a model that glosses over those microdetails" (1990: 48). Inversely, in this thesis I am not attempting to give precedence to the social at the expense of the biological—hoping that somehow the social aspects may be independent of the biological. Although the biological features as *causa sine qua non*, are important to the understanding of the role of insight in psychosis, I am merely attempting to shed light on the social, cultural and epistemic correlates—which are by no means independent of biological features—of this clinical phenomenon.

claim these works would open for me a door to a whole new world—that of the schizophrenic patient's interpretation of his/her lifeworld and existential predicament. From that point on, I became fascinated with topics such as culture, society, self-knowledge, mental illness, subjective experience/phenomenology and the methodologies involved in the interpretation of the dynamic between these complex phenomena. Now, just a few years later, I feel that the anthropological perspective is mandatory to adopt when exploring issues related to the social and cultural factors that undergird the very basis of self-knowledge and subjective experience in both mental illness and 'normality'.

In the following, I will present a research project which examines the notion of insight in psychosis from a social, cultural, intersubjective/dialogic and perspectival standpoint. By analyzing interviews with psychotic patients and their social entourage via the phenomenological/hermeneutic enterprise, I seek to answer the question 'how is insight in psychosis socio-culturally constructed'?

This meaning-centered approach is in accord with contemporary medical anthropology as it places patient narratives in the center of a holistic approach to illness interpretation: narrative, in this context, serves as a symbolic vehicle for understanding the *acts of meaning* wrought from the nexus between personal and cultural constructions/configurations of illness interpretations—of utmost salience is the processes underlying how these interpretations become crystallized and synthesized at the local level via interactive processes between self and other (Garro and Mattingly, 2000; Kirmayer, 2000).

Following Good (1994), one of the fundamental purposes of a study which focuses on narrative, and the processes by which meaning is attributed to illness, is to locate and describe the social, cultural and epistemic processes crystallized and embodied at the local level and cross-correlate it with the global, epistemological foundation upon which traditional, Western medicine rests. As Good states, a meaning centered approach that continues to be "'conversant with critical theory' is essential if medical anthropology is to comprehend the claims of medical science and biology while still recognizing 'the validity of local knowledge in matters of sickness and suffering'" (1994, ix, 63).

My intention for choosing to place the social and cultural correlates of insight under the analytic spotlight is to illuminate how insight as 'self-knowledge' is constructed and configured through culturally shaped and informed epistemic/cognitive schemata; through

collective representations and social/cultural practices that are represented and transmitted via social praxis/action (Kirmaryer and Corin, 1998: 214). Lastly, by centering on the social and cultural factors, we can see that insight is a form of self-knowledge and self-positioning characterized by an ever-shifting relation between the patient's local world and the existing global frame in which personal meanings and self-attributions are negotiated and sometimes disputed (ibid).

Statement of Purpose

In conducting this study, my concern has been to explore how psychotic patients come to know how they are ill and how this insight is constructed and configured via the role of different perspectives and voices in the clinical encounter. By analyzing the interviews—according to a framework inspired by phenomenology and hermeneutics—of three patients and a member from the patient's social entourage, I will approach insight as the provisional result of perspectival/dialogic, epistemic and socio-cultural forces. Thus, I will consider patients' insight form an *emic* perspective as an understanding or interpretation of experience from the standpoint of the patient's worldview. The *emic* perspective is largely opposed to the traditional Western psychiatric perspective, which may be glossed as an imposed *etic* perspective[5].

As such, my research findings are presented with the aim of deepening the current understanding of insight in psychosis by showing how the construction and configuration of insight is a relational affair between the patient and those actors and symbolic media involved within the patient's socio-cultural sphere and lifeworld.

This perspective on insight provides a particular angle from which to approach and operationalize the notion of *negotiation* between the various actors involved in the clinical context. Ultimately, my attempt in this project is to reveal that insight not only represents a 'half-silvered' mirror held between self and other (Kirmayer and Corin, 1998), but as a half-

[5] The word emic may be defined as follows: "examining society [or an individual] using concepts, categories, and distinctions that are meaningful to members of that society [or to the individual]" (Nanda and Warms, 2002: 421). Etic, by contrast, refers to: "examining a society [or individual] using concepts, categories, and rules derived from science; an outsider's perspective which produces analyses that members [or individuals] of the society being studied may not find meaningful" (ibid). Quite simply, emic and etic perspectives mirror the idiographic (which relates to something concrete, historical, individual, or unique) and nomothetic (relating to, involving, or dealing with abstract, general, or universal statements or laws) approaches respectively. For an interesting relation to emic and etic concepts as they apply to the understanding and experience of illness and disease respectively see Kleinman (1980).

silvered mirror, insight into the self is constantly changing hands to reveal that 'inner-truth' is at the mercy of ever-shifting and variegated interpretations.

In chapter one of this thesis, I will provide a review of the contemporary literature regarding insight as a clinical phenomenon. I will also problematize the theoretical and epistemological notion of insight as a heuristic, meta-analytic construct and situate it within an anthropological and phenomenological framework. My intent here is to place emphasis on the understanding that insight as self-knoweldge is a direct correlate of the results of perspectival and dialogic relations with other persons.

In chapter two, I will outline the methods of the phenomenological approach to mental illness. Here, I will describe and delineate briefly the development and applications of elements of the phenomenological approach to mental illness, stressing which elements are useful and which are not to the research presented in this thesis. In this chapter, I will also introduce the reader to the general background on the hermeneutic approach as a methodology for the textual exegesis of illness narratives. In addition, I will comment on the applications and limitations of this approach to data presented in this thesis. I then will present the materials and methods of the larger project, *Psychosis and culture: The Role of Spaces of Negotiation (Between Patients, Families, and Practitioners) During Consultation* — upon which this thesis is based—concluding the chapter with an outline of the specific format and methods employed in the analysis of interviews featured in this thesis.

In chapter three, my intent will be to introduce the reader to the various philosophical issues and debates regarding the notion of self and self-knowledge. This chapter will begin with a brief presentation of the Cartesian model of self and self-knowledge. I shall use this model as a frame against which to test and present more plausible approaches to self-knowledge. By reconsidering the epistemological and metaphysical foundations of insight as the result of transparent introspection, I argue for an inclusive, relational ontological framework from which to base and understand how insight 'comes to be'. Here, I will consider and discuss the proponents and key features of the philosophy of dialogue. I will then present Emmanuel Levinas' understanding of the ethics of *otherness* as a descriptive template upon which to delineate the clinical phenomenon of the synchronic and diachronic production of self-knowledge. As such, in an attempt to avoid any form of philosophical dogmatism, I have appropriated the work of Levinas in order to fasten not a rigid and 'photographic' application of his philosophy, but merely as a template from which to step

from, and, at points, think beyond. Speaking out against the dogmatization of thought, Michel Foucault, echoing the aforementioned sentiment I have just alerted the reader to, states with regard to the limits of Nietzsche's thought, that one should not be afraid "to use it, deform it, to make it groan and protest" (1980: 53-54).

In chapter four—the final chapter—I will introduce the reader to the results of the analysis of the interviews in the form of brief cases—three patients and a member of each patient's social entourage. My purpose is to provide and illustrate examples of the intersubjective and dialogic construction and configuration of insight as self-knowledge. By focusing on three narrative stages of insight production: 1) *detection of alteration of lived experience*, 2) *causal attribution*, and 3) *global construction of meaning*—my purpose will be to offer a new model with which to approach and understand insight in patients recently diagnosed with psychosis. The model will emphasize that in order to understand how insight is produced, we must shift our attention from models purporting insight as a solitary, introspective act of self-transparency, to new, more sophisticated models that emphasize the cultural, intersubjective and dialogic components of insight as self-knowledge.

Chapter One
Literature Review on Insight in Psychosis as Heuristic Clinical Construct

Insight in Psychosis: From Western Psychiatry to Phenomenology

The historical antecedent to the constellation of symptoms now known as schizophrenia first made its appearance in 1852, when the French psychiatrist Charles Lesègue described the 'degenerative' behaviour of one of his patients with the term *délire de persecution* (Firestone and Marshall, 1999: 347). In 1865, the Belgian psychiatrist, Benedict Morel (1809-1873) deployed the term *démence précoce* as a label to describe the condition of a 14-year-old boy who showed progressive signs of apathy, social withdrawal, and emotional instability (Comer, 1995: 520; Marshall and Firestone, 1999: 347). The term *démence* meant to describe severe intellectual and mental deterioration, while the term *précoce* meant to illustrate the early onset of the evidenced deterioration. Thirty-four years later, in 1899, Emil Kraepelin used the Latin term for Morel's label, *dementia praecox*, to describe similar constellations of symptoms (ibid).

In 1911, the Swiss psychiatrist, Eugen Bleuler, deployed the term 'schizophrenia' to disorders in similar nature to those first observed empirically by Morel and Kraepelin. According to Bleuler, the term schizophrenia, a combination of the Greek words for 'split-mind', was used to limn: 1) a fragmentation of cognitive processes, 2) a split between thoughts and emotions, and 3) a withdrawal from reality (Comer, 1995: 520). Bleuler improved greatly Morel's initial conclusions by correctly observing that intellectual deterioration was not an inevitable feature of schizophrenia, nor was progressive mental/emotional deterioration the ineluctable rule (Comer, 1995; Marshall and Firestone, 1999; Shorter, 1997).

The American Psychiatric Association has attempted to design a set of objective, atheoretical diagnostic criteria in order to operationalize a definition of schizophrenia and to attenuate the seemingly wide semantic field associated with the term. The process of attaining diagnostic objectivity and reliability has neglected key factors related to the disease, such as the relativity and context-bound nature of signs and symptoms. According to Kleinman (1980, 1988, 1998), the APA's most recent Statistic Manuals of Mental Disorders (DSM III, DSM III-R, and DSM-IV) have ignored these aforesaid key factors creating a tremendous potential for misdiagnoses, especially in cross-cultural contexts.

In contrast to Western psychiatry, a host of alternative means through which to interpret and understand mental disorders have developed through such disciplines as medical anthropology, phenomenological psychiatry and psychology. Researchers in medical anthropology (Corin, 1989, 1990, 1992; Corin and Lauzon, 1994; Corin *et al*, 2003 Young, 1980, 1993;1995; Good and Delvechio-Good, 1981; Good, 1994; Obeyesekere, 1981; 1990; Kleinman, 1980, 1988, 1998; Fabrega, 1974, 1989; Scheper-Hughes and Lock, 1996, 1998; Lock, 1993; Estroff, 1985; 1989; Kirmayer, 1994, 2000; Kirmayer *et al*, 1994, Kirmayer and Corin, 1998; Jenkins and Karno, 1994; Jenkins, 1996; Desjarlais, 1997, 2000; and Martínez-Hernáez, 2000) have attempted to formulate alternative approaches which take into account social, cultural and epistemological correlates of mental illness. These researchers place emphasis on the importance of meaning and context for the diagnosis and interpretation of psychiatric disorders.

The interpretive approach to mental disorders reached considerable attention from phenomenological psychiatrists during the early to middle part of the 20th Century (Binswanger, 1963; Jaspers, 1963; Blankenburg, 1971; Tellenbach, 1974; and Krueger, 1981). These foresaid researchers have stressed the importance of describing the existential correlates of mental illness; i.e. the description of the alteration/modification of the coordinates of psychotic's mode of being-in-the-world.

Insight: The Purview of Western Clinical Psychiatry

Poor or impaired insight is perhaps one of the most salient features associated with patients who have been diagnosed with a psychotic disorder (Amador and Kronengold, 1998; Marková and Berrios, 1992; Berrios and Marková, 1998; White *et al*, 2000). As such, lack of insight, according to the International Pilot Study of Schizophrenia (World Health Organization, 1973), is said to be one of the foremost symptoms of psychotic disorders, particularly the schizophrenias.

As a gold standard, the traditional Western psychiatric notion of insight comes from the definition created by the physician, Aubrey Lewis. In 1934, Lewis defined proper insight as "a correct attitude to morbid change in oneself". Other researchers have criticized the operationalization and systematization of insight insofar as it lacks a firm epistemological and ontological grounding due to the varying modalities and ambiguities in the very concept of 'knowledge' (cf. Richfield, 1954).

In contemporary clinical psychiatric practice, only certain aspects of insight are given importance, such as the patient's awareness of presence of illness and full compliance with a treatment regimen (Kumar and Sims, 1996, 1). Insight, as an analytic construct of clinical psychiatry, assumes importance in psychotic disorders as the potential discrepancy between the patient's view of his or her illness and that of, say, his/her physician or member of the social entrouage, and may precipitate great difficulties with treatment compliance and prognosis (ibid).

A review of the contemporary literature (Kumar and Sims, 1996; David 1990; David *et al*, 1992; Lysaker and Bell 1994; Lysaker and Bell, 1995; Amador *et al*, 1991; Marková and Berrios, 1992; Bebbington, 1995; Fleshner, 1995; Berrios and Marková, 1998; Sackeim, 1998) suggests that insight, as conceived from the perspective of the traditional psychiatric model, is an asocial, ahistorical, intrinsically self-referential and inferential epistemic adherence to objective and systematized clinical standards.

Insight, then, measured in the clinical context, contains an inherent value judgment: it can be understood as either full/intact (awareness of illness), partial (aware of certain features such as presence of illness, but not reason for cause), or poor/lacking (unaware of illness or adherence to alternate explanation). This implies that 'proper' or 'intact' insight should be judged in relation to an external socio-cultural norm (manifested as the practitioner's value judgment) or what a patient *should* know. Poor insight, in this context is then understood as an incorrect attitude of the patient toward a morbid change in him/herself, and, as such, is assessed as a deficit and ranked as a symptom indicative of disease.

Because of this highly particularistic conception of insight, it is understood as an object of medical knowledge—an understanding that is qualitatively dissimilar to a patient's personal illness belief/interpretation. As a result, poor insight is treated as a *bona fide* symptom and is understood as a deficit found within the individual, without reference to the patient's social, cultural, historical and intersubjective context (White, et al, 2000: 501).

In this instance the notion of insight, as a *proper* reflexive stance toward a pathological change in oneself, appears problematical, especially in the capacity of the semantic field associated with two key terms used in Lewis' definition. Coming from

traditional Western psychiatric perspective, the personal 'experience' of the patient may be dismissed merely as pathognomonic symptomatology[1].

From the traditional Western psychiatric paradigm, the notion of insight is construed in a fairly parochial sense, one that often dismisses the patient's personal experience/interpretation in favor of objectively verifiably and generalizable features. David (1990) has suggested that Western psychiatry's understanding of insight proper is comprised of the following: 1) the ability to re-label unusual mental events as pathological. 2) The recognition that one has a mental illness. 3) Following that one recognizes a pathological change in one's self, one complies with a specified treatment regimen (Kumar and Sims, 1996). Greenfeld *et al* (1989), have also summarized key dimensions of insight as it relates to psychosis. According to these researchers, characteristics relevant to insight fall into five main dimensions: 1) Symptomatology (patients' views about their symptoms). 2) Existence of an illness (patients' views about whether they suffered from a psychiatric illness or not). 3) Etiology (patients' views about the cause of their psychotic symptoms, if recognized as symptoms of an illness). 4) Vulnerability to recurrence (patients' views about their vulnerability to recurrent psychosis). 5) Value of treatment: patients' views about which of their treatments were beneficial, and which were likely to have continuing prophylactic value against recurrent psychosis (Greenfeld, *et al*, 1989: 249).

Following the aforementioned conventional psychiatric account of the dimensions of insight, Marková and Berrios provide a summary of three instances which explain the *lack* of insight: 1) impaired awareness, 2) self-deception (psychological defense mechanism), and 3) misattribution (1992: 859).

---

[1] Approaching insight as an isolated marker of morbidity is a highly problematic venture insofar as insight cannot be compared to the positive symptoms such as hallucinations or delusions. Insight should be understood as a process or continuum of lived experience (thinking, feeling, emoting, level of education, cultural beliefs, religious beliefs, *et cetera*), a process that cannot be separated from the patient's personal, existential and intellectual make up or from the underlying psychopathological processes of the psychotic disorder itself (Marková and Berrios, 1992: 858). Taking these foresaid elements into consideration, we can see the paradoxical nature of ranking insight and lack thereof as symptom: Since different models of insight exist for different psychiatric disorders (certain types of localized brain disease or brain trauma, for example), separate empirical explanations have been developed for the different disorders characterized by impaired insight. For psychosis, impaired insight has been assumed by definition since being psychotic denotes a loss or break with reality (Marková and Berrios, 1992: 857). Following this chain of logic, then, it does not seem plausible for psychotic patients to have objective knowledge (that which accords to the judgments of the attending physician) or awareness of 'true' changes taking place both within themselves and their environments, since it is with disordered minds that patients are perceiving and assessing themselves and reality (ibid).

The impaired-awareness explanation implies that the psychotic patient is unable to have insight into his/her illness because the biochemical/physiological and anatomical pathways have been altered by the disease. Psychosis, according to this view, arises from disruptions of processes of self-awareness, perception, and cognition; the presence of these disruptions leave patients liable to experience hallucinations and delusions.

The therapeutic goal according to insight-oriented psychodynamic approaches, is the 'attainment of insight' precipitated through the revelation and interpretation of symptoms. As Blum states: "Insight is a *sine qua non* of the psychodymanic process and is a condition, catalyst, and consequence of the psychoanalytic process" (1979: 47, quoted in Markovà and Berrios, 1992: 852). Lack of insight, then, from this perspective, is explained as a form of self-deception—this understanding purports that lack on insight is a form of defense mechanism (Kirmayer and Corin, 1998; Greenfeld *et al*, 1989; White et al, 2002). According to the psychodynamic view, then, lack of insight is explained as a motivated response or a form of self-protection against painful memories, thoughts and feelings (Kirmaryer and Corin, 1998: 196).

Misattribution, according to Kirmayer and Corin (1998), is a form of cognitive error based on lack of information biases or idiosyncratic beliefs. This implies that there is a correct attribution for symptoms and experiences that is given by congruence with others regarding recognition of disease and its symptoms. As Kirmayer and Corin (1998) point out clearly, we must understand that misattribution may really represent an interpretation of experience that is a result of neither cognitive deficits, nor psychological defense mechanisms, but may stand for a alternative construction and account of the patient's reality. This alternative construction and account of reality may not coincide with traditional Western psychiatry, but may make perfect sense within the patient's local world of meaning.

Returning to the Western psychiatric understanding of insight as a correct perception of assessment of illness, it appears that terms such as 'correct' and 'morbid' are loaded in that they connote a value judgment, especially on behalf of the inquiring physician[2]. This

[2] When focusing on a symptom like flat affect, one can see that the situation becomes highly problematic when one tries to discern the qualitative difference between something like 'normal' or 'correct' flat affect (associated with mood, such as in the case of boredom), or between 'pathological' or 'abnormal' flat affect (associated with the negative symptoms of psychosis). In line with this view, it seems that abnormality can be defined as 'excess' or 'more' of what otherwise may be considered within the tightly-knit parameters of normal social experience (Jenkins, 1996). Hence, any approach that seeks to quantitatively systematize and polarize the differences

perception is exemplified in the following quote from the questionnaire on insight and attitude to treatment (constructed to examine the relationship between acute psychopathology in schizophrenia), designed by McEvoy *et al*:

> Patients with insight judge some of their perceptual experiences, cognitive processes, emotions, or behaviors to be pathological in manner *that is congruent with the judgment of involved mental health professionals*, and that these patients believe that they need mental health treatment, at times including hospitalization and pharmacotherapy (1989: 43, emphasis mine).

That the notion of insight, from the clinical point of view, is associated with only one 'correct' understanding underscores the term possesses an inherent teleological feature: in this sense, the concept of 'correct' and 'morbid' can only be understood when associated with an ultimate goal: good prognosis, confirmation of clinical judgment, and correction of the morbid impairment (Kirmayer and Corin, 1998). Drawing upon David's (1990) understanding of insight proper, from the clinical perspective, we can see that the ultimate goal for the psychotic patient is total treatment compliance, which can be said (in theory) to be associated with good prognosis.

When deconstructing terms such as 'correct' and 'morbid', we can see that they are homologous to terms such as 'normal' and 'pathological'. In clinical reality, we can see that the normal and pathological are two polarized extremes, which can be measured quantitatively and assessed algorithmically according to a systematized diagnostic category[3]. As would seem, when one pries back the veneer that covers empirical clinical reality, a different picture emerges: Life as lived and experienced denotes that phenomena are encountered and experienced along an ever-changing continuum which sometimes resists reduction and categorization/systemization[4].

Recent studies on insight have predominantly been undertaken by researchers from such disciplines as psychiatry or clinical and behavioural psychology. Studies of insight from an orthodox psychiatric or psychological perspective have largely focused on the etiology of poor insight in psychosis; these studies can be roughly divided into two groups. To the first, poor insight can be said to occur as a defense mechanism: by denying illness on

---

between phenomena which lie across a continuum are, from a hermeneutic anthropological perspective, highly problematical and open to interpretation.

[3] For a groundbreaking discussion concerning the epistemology of the distinction between 'normal' and 'pathological' states in clinical medicine, see G. Canguilhem, 1966/1991.

[4] For a contemporary discussion of the radical empiricism of James and Dewey, see Jackson, 1989, chapter 1.

a psychological level, the patient somehow attempts to instill a sense of normality into their lives. In this sense, poor insight may be understood as a defense against depression or low self-esteem or other harmful psychological sequelae associated with psychosis. By denying illness, a patient can subvert the potentially harm-inflicting nature of illness attribution, which, to some is a genuine impetus of depression (White, *et al*, 2000).

The second group views the etiology of insight as a corollary of neuro-physiological/cognitive impairment, and associates lack of insight with such disorders as auto-noetic anosognosia (Kumar and Sims, 1996). This group implements a more biological-oriented take and roots its explanatory model in the natural sciences.

Alternative studies have been undertaken which approach poor insight from a social psychological trajectory. One such study (White *et al*, 2000), proposes that those patients with solid support networks and stronger relations with family and friends may have more insight than those with poor social networks and relationships. In this sense, it is proposed that social support is a normalizing mechanism that seemingly endorses the traditional Western psychiatric model regarding proper illness and disease acceptance and behaviour. According to this outlook, solid support networks are conducive to the instillation of proper insight in the patient, while on the inverse, social isolation is understood as promoting the development and adherence to delusional frameworks and ideation (Garety and Freeman, 1999).

Another such alternative study conducted by Johnson and Orrell (1995) focused on inter-cultural variation and prevalence of insight in the psychoses. They hypothesized that social and cultural variations lay in perceptions of mental illness, and the concomitant stigma attached to mental illness, are likely to be one of the major influences on the configuration of insight. Johnson and Orrell (1995) were able to extrapolate that there was substantial diversity in the representations of mental illness which members of different cultural groups bring to their transactions with clinicians. They also inferred that social stigma of mental illness suggests that an attempt to preserve a positive self-concept and social identity is a potential reason for lack of insight or denial of illness.

Insight, Toward a Reframing: On the Significance of Meaning, Subjectivity and Experience

Although useful for furthering research and knowledge of the social and cultural dimensions to insight, Johnson and Orrell's (1995) foresaid study falls short of a focus on the micro-politics of the intersubjective and dialogic encounter: the immediate socio-cultural context in which one comes to know one's self and one's epistemic and existential predicament as transformed by psychosis. Since the purpose of this thesis is to delimit the intersubjective, dialogical, socio-cultural and perspectival correlates that factor into the construction of insight in psychosis, I will provide evidence that insight, as a form of self-knowledge, arises out of intersubjectivity and dialogicity and is mediated by cultural/symbolic filters. I will also delineate and explain insight as both a synchronic and diachronic[5] phenomenon—a provisional form of self-knowledge based on historically-grounded frames of meaning that is recalled and narrated at a specific moment in time.

Insofar as my purpose is to delimit the intersubjective basis of insight, I have chosen to utilize a latitudinarian definition of insight based upon the phenomenological notion of subjective meaning. Before going on to define what I perceive subjective meaning and insight to be, let me briefly take an aside to situate illness as experience within a phenomenological model of illness experience[6].

Toombs illustrates that the use of the phenomenological method is to give primacy to the experiential world of the patient. He explains that

> In discussing my illness with physicians, it has often seemed to me that we have been somehow talking at cross purposes, discussing different things, never quite reaching each other. This inability to communicate does not, for the most part, result from inattentiveness or insensitivity but from a fundamental disagreement about the nature of illness. Rather than representing a shared reality between us, illness represents in effect two quite distinct realities, the meaning of one being significantly and qualitatively different from the other (Toombs, 1987: 219-220).

We can see here the difference between the etic and emic approaches: on the one hand, understands illness as a set of signs and symptoms which point to or indicate a specific disease entity. On the other hand, the patient's and family's experience of 'living with' the

[5] The standard anthropological definition of the term diachronic is as follows: "Referring to phenomena as they change over time; i.e. employing a chronological perspective" (Renfrew and Bahn, 1996: 540). The opposite of diachronic is the term synchronic, which may be defined as the following: "Referring to phenomena considered from a single point in time; i.e. an approach which is not primarily concerned with change" (ibid).
[6] I shall only briefly allude to the phenomenological method here; however, I will explain the purpose of the phenomenological approach extensively the proceeding chapter.

disease is much different: Rather than understanding the disease as a set of observable and empirically verifiable signs/symptoms, the patient and family live the disease as a life-altering illness; they experience the effects of illness and feel the impact it has on their everyday lives (Walton, 1995: 16).

I shall now turn to the term *meaning* and its purpose in this thesis. In terms of an operational definition of the meaning produced from intersubjective relations, I will employ Patrick A. Heelan's understanding of the term taken from his essay, *The Lifeworld and Scientific Interpretation.* Heelan (2001) states, *a la* Heidegger, that all of human understanding arises from interpretation, and that the product or result of interpretation is meaning. Meaning, then, is not a private domain accessible via introspection. Inversely, meaning is a public 'domain' where actors in a social/cultural matrix "share the products of human understanding first by common habits of action (in which diverse [semantic] networks are recognized) and then by the use of language and language-like media (Heenan, 2001: 51). Further, in this regard, meaning must be understood as both a local, dialogic and intersubjective phenomenon: Heelan adds that

> [meaning] is the product of active local interests and social communities and is constitutive of... [these]... local interests. It is thus neither once-and-for-all fixed, nor ever in total flux. Finally, though subject to change under transmission, meaning is not on this account devoid of truth, but it is the place where *truth makes its appearance* (2001: 51, original emphasis).

In the spirit of Heelan's aforesaid definition of subjective meaning, insight may be understood as an attribution of meanings to illness experience wrought from contrasting and shifting social frames of reference, which are in turn embedded in a *cultural matrix.*

To qualify and explain: a cultural matrix—from a symbolic anthropological perspective—may be understood as a symbolic meaning system expressed by both individual and collective representation—or the dialectic between the two. According to Clifford Geertz, culture may defined as "an historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate and develop their knowledge about and attitudes towards life" (1973:89). Culture, then, is embodied, enacted and socially transmitted via interactional processes that involve symbolic media of various sorts, family, community, and social and bureaucratic institutions.

To recapitulate: by broadening the horizon of insight as self-knowledge of presence and meaning of illness—taking into consideration the socio-cultural, intersubjective and dialogic factors—we can now understand that insight arises in the *cultural context* as a result of shifting perspectival interpretive frames/viewpoints which are subsequently crystallized at the local[7] level within the patient. Insight, then, can be understood as an *attribution of subjective meanings* to illness experience or event. Interpretations and imputations of meaning to experiences, whether they pertain to illness or not, cannot take place within an insular space (the individual by him/herself) divorced from the interconnections of his/her dialogic matrix. The construction, interpretation and overall intelligibility of all human experience is made possible only through relations with *others*. This sentiment is best summed by the English metaphysical poet John Donne when he wrote, "no man is an island entire of itself".

[7] To qualify and operationalize my use of the term local, I will provide a working definition. Local refers to the personal and particular means by which a patient borrows, negotiates and re-configures cultural repertoires. In this sense, it is the personal *way* and the *means* by and through which a patient interprets, re-organizes and understands his/her experiential/existential difficulties. So as not to reify the culture-subject dynamic, one must keep in mind that these personal expressions of experience are configured at a meta-level by the dialectical interplay between social interaction and the cultural matrix the social interactions are set within. In this sense, culture, as a set of internalized symbolic/ideational/cognitive schemata, is constantly being transformed, re-routed, and negotiated through the interactions with others. Again, so as not to be charged with an essentialist take of the dynamic between culture and the individual, the concept of the local interpretation is configured and internalized at a cultural level via the interaction with others (what I would call social diffusion through social interaction), and then expressed at a personal level. In the case of the psychotic patient, this can be thought of as the attempt to unify various levels of seemingly contradictory discourses into a singular discourse, or a 'discursive pastiche' as it were—albeit in a very fragmentary state as psychotic patients not only have to negotiate their own disrupted interpretations of their illness experience, but they also have to contend with the potential conflicting interpretations of their social entourage.

Chapter Two
Phenomenology and Hermeneutics: Methodological Implications for Approaching Insight in Psychosis

On the Relevance of the Phenomenological Approach

For this thesis, I will approach psychosis from a phenomenological-inspired perspective[1]. As stated at the outset, this approach gives primacy to the patients' subjective experience of their illness—as the locus of analysis, subjective experience (*Erlebnis*) *precedes* the assessment of empirically observable signs/symptomatology manifest in patients' behaviour/physiognomy. The importance of a phenomenological approach to a mental illness such as psychosis is manifold. Perhaps most important, a phenomenological approach can re-insert 'subjectivity' into the relationship between practitioner, patient, and disease.

Although phenomenology does give primacy to patients' illness narratives, as a descriptive approach it is much more than a simple restating of the reported experience of the patient. As Burch (1989) claims, the pragmatic benefit of utilizing a phenomenological approach lies in what the method does to the researcher—how it ultimately changes him/her. A phenomenological approach is useful insofar as it aims to change the inquirer's understanding of the phenomenon under question.

Burch expands,

> Phenomenology does not simply iterate what is already given and understood in lived experience in the way that it is given and understood. It seeks a transcending theoretical understanding that goes beyond lived experience to situate it... to comprehend it, endowing lived experience with new meaning. without this transcendence, phenomenology would be superfluous (Burch, 198:192).

---

[1] It must be stated at the outset of this section that phenomenology, in the sense that I am using it, is not to be construed as radically opposed to conventional psychiatry. On the contrary, a proper phenomenological analysis is *propaedeutic* to a standard empirical approach. This means that phenomenology *qua* preparatory descriptive tool is complementary to the traditional psychiatric approach. Phenomenology merely provides the clinician with the necessary *qualitative* data to supplement his/her empirical/quantitative findings. I must draw attention to the distinction made between the definition of phenomenology as used in the traditional psychiatry and European phenomenological psychiatry. Whereas the former deploys the term in reference to an *objective explanation* of psychiatric phenomena as experienced by the patient, the latter, conversely, deploys the term in reference to the *subjective understanding* of psychiatric phenomena. From the framework of conventional psychiatry, the symptom is approached as an indexical sign (cf. Piercian semiotics) that indicates the presence of disease. On the contrary, the phenomenological approach, the symptom is understood as a phenomenon: *qua* phenomenon, the meaning may only be revealed when situating it in relation to the patient's lived experience—this allows the researcher to understand the phenomenon globally as an expression of an underlying shift within the patient's immediate life context, the lifeworld (Corin, 1990).

The perspectives developed by European phenomenological psychiatrists are germane to understanding the subjective experience of patients with mental illnesses. Influenced for the most part by continental phenomenological and existential philosophy (cf. E. Hüsserl, M. Heidegger, J. P. Sartre, M. Merleau-Ponty, *et cetera*), the pioneering European phenomenological psychiatrists were primarily interested in the specific experiential world their patient occupied[2]. Through obtaining a descriptive account of a patient's lifeworld, these researchers were interested in understanding the specific mode of being-in-the-world or existence that characterized the experience of mental illness.

It was from the German mathematician/philosopher Edmund Hüsserl (1859-1938) that phenomenological psychiatrists borrowed the concept of 'intentionality'. Hüsserl, building on the work of Franz Brentano, was particularly interested in phenomenology[3] applied to individual psychology; more specifically, he was interested in uncovering 'pure consciousness' or the 'essence' of human consciousness (Collins and Selina, 1998; Corin, 1990; Corin and Lauzon, 1994; Corin *et al*, 2003; Buckley: 2002, personal communication). To Hüsserl, human experience was understood as a way of situating oneself within the world: experience was to be thought as a basic 'intentional' stance, position or orientation to the world. This basic stance conceptualized by Hüsserl is not to be understood as an empirical reality, which would be part of conscious experience and which could be susceptible to systematic description (Corin *et al*, 2003: 6). Phenomenology, to Hüsserl, was to discover the world of 'essences' which were understood to lie beneath the world of 'facts'—intentionality, then, is prior to the reflecting/objectifying processes that separate subject from object.

Phenomenological psychiatrists have appropriated Hüsserl's concept of intentionality and lifeworld[4], applying it to the lived experience of mental illness. By applying these

---

[2]Characteristic of this world is, the 'being-in' of space and time, and the 'being-with' of the patient's shared world with other people and things.

[3]The Swiss-German mathematician Johann Heinrich Lambert first coined the noun 'phenomenology' in 1764 (Lanteri-Laura: 1982: 51). According to Elwell (2001) and Lanteri-Laura (1982) Lambert originally used the word to refer to the setting forth or articulation of what shows itself in subjective experience.

[4]In a technical sense—an issue not applied to the research or results of this thesis and thus not covered beyond this point—the lifeworld of the patient is not directly accessible via discourse alone: an understanding of it must be gained through a phenomenological reduction (*ελάττωση*) called the *epoché* (*εποχή*). The *epoché* is a means by which to set aside prior theoretical understandings, or to bracket out presuppositions about the world in a way that the phenomena under question are given to us[4] (Sartre, 1972; Levinas, 1999; Buckley: 2002, personal communication). This method provides a chance to 'return to the things themselves' in order to gain a new understanding of something we already know and take for granted—it is an act of withdrawal from the natural assertiveness of consciousness regarding what does and what does not exist in the lifeworld (Sartre,

concepts to psychiatric disorders, they can then be understood as a pathological phenomenon which precipitates a basic alteration or shift of the patient's intentional position toward the world (1989, 1990; Corin and Lauzon, 1994; Corin *et al*, 2003; Good, 1994). As such, the fundamental crux of Hüsserl's concepts stresses the importance of bracketing theoretical or common sense presuppositions.

According to Corin, the phenomenological psychiatrist has to "abstract the transcendental implications of empirical behaviours, and to blend them with empirical data in a back-and-forth movement" (1990: 160). Corin explains,

> We have to multiply perspectives and move back and forth between explicit discourses that describe forms of relationship to the world, as well as activities and behaviours that enact and reveal a specific stance toward the world... what is experienced (*le vécu*) is not something located in front of the subject; it is rather a self-feeling, a self-finding... This kind of experience is difficult to attain in empirical research, but it can be taken as a general horizon that enriches our interpretation of data (Corin, 1990: 161).

Psychosis, from a subjective perspective, may be characterized by a feeling of intense fear, confusion and instability of the experienced world. Psychosis has a systemic effect on the patient and his/her social world: here, the experience of time becomes either compressed or expanded in an ineffable way; the patient may become hypersensitive to external auditory and visual stimuli; social and personal boundaries may become blurred and confused adding a sense of frustration and confusion to previous levels of intimacy towards friends, family and strangers.

As explained by Blankenburg (1983, quoted in Corin,1990) , psychosis can be understood as shifting world marked by agony and suffering; this experience involves a loss of the 'natural evidence' (referring to Hüsserl's term) that is concomitant with a pre-conceptual, pre-theoretical understanding of the world and oneself. Such a loss of the sense of co-belonging in the world or to a common sense/ taken-for-granted orientation may leave a patient without any defense to the world, other people, and the pressures associated with everyday functioning. As described by Minkowski (1932), in schizophrenia, it is the patient's *élan vital* and desire to progress toward the future that conjointly 'die'. In this case, not only is the patient's future closed before him/her, but the boundaries of the "sphere

---

1972; Walton, 1995). By suspending any attention to extraneous particulars, the phenomenological approach calls to 'bracket' particulars out. According to Hüsserl, once we bracket the extraneous particulars and 'remove them from the scene', what is left will be the essential, universal and unbiased structures of the mind, or as Hüsserl had termed it, 'pure consciousness' (Levinas, 1999; Collins and Selina, 1998).

of having" disintegrate. "The phenomenon of having is upset; the faculty of attributing something to ourselves is therefore affected and does not exert itself as before. The individual makes this intelligible to both himself and others by saying that he 'hasn't a cent'" (Minkowski, 1932: 193).

Karl Jaspers, one of the pioneers of the European phenomenological psychiatric approach, claimed that psychiatric problems must be grasped concurrently at two levels of analysis: as objective analysis or what Jaspers termed 'static'; and experiential or 'genetic' understanding. *Static* understanding is what most of us employ when we listen to others' accounts of their experience and record these accounts as such. This form of understanding can be thought of as an empathic approach that does not deploy and impose a pre-conceived theoretical orientation to the phenomenon it seeks to describe. According to Eilan (2000), with a static understanding, the phenomenologist deals with fragments of narrative; it is such theory/concept-free documentation of fragments that Jaspers called 'doing phenomenology'.

Inversely, in *genetic* understanding, Jaspers states, the phenomenologist is concerned with understanding how "one mental state 'emerges' from the other, and in making sense, from the subject's point of view, of the occurrence of a mental event in terms of others it emerges from and generates" (Eilan, 2000: 98). As Jaspers states, via the genetic approach to understanding, "we sink ourselves in the situation and grasp its significance from the inside (1913: 301).

Like Jaspers, Ludwig Binswager, another German phenomenological psychiatrist, was influenced greatly by the psychodynamic theories of Sigmund Freud, and by the German phenomenologists, Edmund Hüsserl and Martin Heidegger. Binswanger, and later European phenomenological psychiatrists, took from Heidegger the ontological concept of *Dasein*, or existence as being-in-the-world. As explained by Binswanger, *Dasein* is comprised of two facets that should, in most 'normal' cases, develop in correspondence. According to Corin, the first facet "is a sense of the situation through which the patient experiences himself as being 'thrown' into the world; this involves a direct bodily experience and the feeling of being part of a shared world; second, an 'understanding' that involves a movement toward the world" (1990: 160). The lifeworld of the schizophrenic patient, according to this understanding, is marked by a disproportion between these two dimensions (Corin, 1990: 160).

For the phenomenological psychiatrist, the patient's experience shows itself via his/her mode of being-in-the-world: this can be through behaviour or discourse (both spoken and

written). The phenomenological attitude 'eliminates nothing' (Blankenburg, 1991): the understanding of the patient and his/her existential predicament occurs in the 'give and take' between attention to both mundane empirical particulars of existence and extreme sensitivity to the underlying foundations of the patient's experience (Corin *et al*, 2003: 6). From this stance, the lifeworld of the schizophrenic must be understood from a 'pathic' position: "...a global affective pre-cognitive connection...which precedes any individuation subject-object, or with a style, as opposed to a Gnostic position that would involve issues of significance and content. It is with such a pathic position that we must study and understand" (1990: 160).

In line with this aforesaid conception of the lifeworld, Ludwig Binswanger's fusion between existentialist philosophy and Freudian psychoanalysis, what he called *Daseinsanalyse*, attempted to breach the *res extensa* and the *res cogitans* by approaching the patient in all his/her psychic/corporeal capacity as an ontological 'whole'. Through his writings, Binswanger emphasized the non-heterogeneity of the pathological experience with regard to the experience of normal, healthy individuals (Corin: 2003, personal communication).

Daseinsanalyse approached the ontological bifurcation of the patient's existence (what Descartes managed to rend into the province of mind and the province of body) and corrected for it via the ancient Platonic notion of *koinonia* (*συναναστροφή*), or the alliance/community between soul and body. Soul and body in this sense are approached as an 'existential whole', inseparable and irreducible from itself and the surrounding existential plane, or the world. As Jacob Needleman (1963) stated in his article *Heidegger's analytic of existence and its meaning for psychiatry*, when one negates the *koinonia* of *Dasein's* ontological possibilities, potentialities, and vicissitudes—or what Aristotle understood as *syntheton* (*σύνθεση*)—one precludes a *full* or *complete* understanding of the patient and his/her inseparable connection with his/her lifeworld.

The central concept of *Daseinsanalyse* psychiatry is to examine and interpret the world-view of *Dasein*[5] or the existential *being* of the patient and the way he/she interprets and

[5] It must be pointed out that Binswanger's view of Dasein differs from Heidegger's. "Binswanger's understanding of Dasein and its existential composition can be said to be a 'modification' of Heidegger's. This modification, I believe, is necessary for the discipline of phenomenological psychiatry, insofar as it deals with individuals and their lifeworlds. This said, Heidegger's ontology is limited to human 'being' in general. His analysis centres on the question of human being and its implications for further understanding the ontological basis of the human condition. By contrast, Binswanger's approach focuses on the ontic level of analysis; he is more interested *in particular entities* (individual patients). Needleman (1963) claims that Binswanger's approach exceeds the ontic level of analysis in that what he seeks to gain is knowledge, not just of particular entities, but of what makes the particular experience of an individual possible. One of the main characteristics

navigates his/her world. In this light, mental illness is viewed as a fundamental modification of *Dasein's* structure of being-in-the-world. According to Kruger (1981), *Daseinsanalyse* approaches psychosis, not as a sickness, an external entity that attacks patients, but as an alternate state of being in which the ways the patient relates to the world and to other people are not immediately comprehensible when compared with socially-sanctioned behaviour. Following this logic, the physician naturally becomes both listener and interpreter, a veritable hierophant of a seemingly intractable experiential idiom.

The phenomenological approach to mental illness outlined above is of paramount concern in this thesis as it affords an understanding of how psychosis is interpreted and experienced by the patient, according to the patient's own words. The phenomenological approach offers a comprehensive complement to the general trend in North American psychiatric research—a trend that, in most cases, places the requirement of objectivity and neutrality in the observation and recording of symptoms. Insofar as this is the case, traditional psychiatry often excludes reference to issues involving the patient's and family member's interpretation of subjective meaning (Corin, 1990). With regard to this recent empirical trend, phenomenological psychiatry approaches a complementary interpretation to the notion of symptom in mental illness. For example, without ignoring the empirical framework and approach to symptoms of traditional psychiatry, a phenomenological approach treats the very notion of symptom as double-sided: 1) as an indexical sign that indicates pathology, and 2) a *phenomenon* (behaviour/discourse) that reflects a hidden mechanism, the meaning of which can only be uncovered through an investigation of the patient's lived experience.

Since phenomenology is a purely descriptive approach, it affords the researcher a highly personal glimpse into the patient's lifeworld; it also approaches the meaning of mental illness such as psychosis, not from a pre-configured diagnostic grid, but from within the patient's lifeworld as expressed through the *patient's own* use of diction, metaphor, metonymy, synecdoche, and other dialogic tropes the patient may draw upon when recounting his/her illness-narrative.

---

which makes Binswanger's analysis of Dasein a modification of Heidegger's is his approach to the care structure. To Heidegger, it seems that care (being-in-the-world) is an invariable, universal structure of Dasein. As such, it is invariable in that all individual differences are to be viewed as falling within the strictly defined *a priori* rule of the interrelation of the existentials which constitute the care structure. Binswanger, on the other hand approaches the concept of care as an 'existential *a priori*', or what Needleman aptly titles the 'meaning-matrix' of Dasein. Care as an ontic structure, to Binswagner, differs between individual to individual—it is an idiographic feature" (Dolson, 2002: 2).

As I was not in the position of a phenomenological psychiatrist/researcher—since the research parameters regarding this thesis were constrained in numerous ways, such as the purely textual basis of the research[6], sample size, length and nature of the interview schedule used, space allotted to presentation of results, *et cetera*—I was not able to track the featured patients and members of their family for months on end, nor was I granted the ability to conduct multiple in-depth interviews. Apropos of insight in psychosis as illustrated in this thesis, the ability to track the featured patients over time (as opposed to focusing on the results of just one interview[7]) would have allowed me to further explore the temporal dimensions of this phenomenon, i.e. the evolution of insightful interpretations over longer periods of time in single patients and members of their family. As such, patients' and family members' accounts are narrated according to a highly provisional framework: illness narratives are in a constant state of flux so as to modify and adjust new experiences, knowledge and information in order to build on and develop existing interpretive frameworks. The interviews discussed in this thesis serve as mere glimpses into the patients' and family members' ever evolving quest for certainty in the face of severe mental illness.

Since the fundamental aim of European phenomenological psychiatry is to refine psychiatric diagnosis and not to understand how meaning is constructed and produced in a particular context (Corin, 1990), I found that there were certain elements of this approach that were orthogonal to the analysis of data for this thesis: To begin, it is deeply pathology-oriented, and as such, the particular notion of subjective meaning relevant to this perspective centers on the inner-psychic experience of individuals; a relative disinterest in the embeddedness of the personal experience in a larger social and cultural frame; and the evolution of psychotic patients (Corin, 1990). As such, owing to the foresaid elements, I have utilized a phenomenological-inspired approach to the analysis of the featured interviews. The interview content was approached from an open perspective such that judgments and preconceptions were bracketed out to focus on the lived experiences of the patients and their family members. By complementing this approach to psychosis with perspectives gleaned from medical anthropology and the philosophy of dialogue, I was able to re-introduce the roles

[6] Had I been in the position of a phenomenological psychiatrist, I would have been afforded the opportunity to document the patients' and family members' behaviour in open-ended, face-to-face encounters.
[7] Each interview discussed in this thesis was the result of a single meeting with the interviewer lasting approximately one to three hours in duration.

of intersubjectivity, dialogicity, and multiple perspectival interpretations in order to broaden the notion of insight in psychosis.

The derivative use of the generalized phenomenological approach to psychosis used in this thesis may be organized into two distinct, but not mutually exclusive modes. 1) As a broad framework from which to approach the patients' lived experience—revealed through the patients' and their family members' narratives—as altered by the manifestation of pathological phenomenon accompanied with the onset of psychosis; and 2) As a hermeneutic method to approach the narrative content of patients' narratives.

On the Relevance of the Hermeneutical Approach to Illness Narratives

Hermeneutics, as phenomenology[8], is an interpretive process through which one attains understanding of a primary source, such as a text. The hermeneutic method is implied whenever meaning is potentially hidden within a text—the question of "hidden meaning" reflects both on the knowledge and knower (Galaty, 1995: 196). The term hermeneutics originally referred to the formulation of principles of interpretation that were applied specifically to the Bible. These principles incorporated both the specific rules regarding a valid reading of biblical texts, and exegesis—a formal analytical commentary on the application of the meanings expressed in the biblical text (Abrams, 1993: 91). Hermeneutics, from the 19th century onward, came to signify a general theory for interpretation: a formulation of specific principles and methods utilized in arriving at the meaning of all written texts[9] (ibid).

Friedrich Schleiermacher (1768-1834), the German theologian, was the first to frame a general theory hermenetuics. Schleirmacher's views were predicated on the German philosopher Wilhelm Dilthey (1833-1911), who proposed for a science of hermeneutics in order to function as the basis for the interpretation of all forms of writing in the *Geisteswissenschaften*[10], or the Human Sciences (Abrams, 1993: 91). The human sciences, according to Dilthey, dealt with the temporal, concrete and lived experience of human existence. To Dilthey, the aim of hermeneutics was to establish a general theory of

[8] Phenomenology, here, is to be understood in the Heideggarian sense that phenomenology is based on *interpretation*.
[9] Written texts including legal, historical, literary, and religious texts.
[10] *Geisteswissenschaften* (human sciences as in social sciences and humanities) as opposed to *Naturwissenschaften* (the natural sciences).

understanding—the understanding of both verbal and written texts where "...texture of inner life comes fully to expression" (Dilthey quoted in Abrams, 1993: 91). Thus, the contemporary purpose of textual hermeneutics is to attempt to gain meaning through understanding the goal and perspective of the text's author.

More recently, philosophers such as Hans-Georg Gadamer, a student of Martin Heidegger, called for a dialectical approach, emphasizing the "back-and-forth" dynamic between the horizons of the text and the reader—he is said to have radicalized comtemporary reader-response oriented textual hermeneutics (Osbourne, 368-369: 1991).

The French philosopher, Paul Ricoeur, sought to maintain a balance in hermeneutics between pure subjectivity (which is inherently associated with textual-based hermeneutics) and objectivity—he maintained that while remaining objective, that is, firmly grounded in the text under interpretation, one needs to remain 'open' to what the text 'has to say' (Robinson, 1995: 1). Ricoeur's hermeneutic of suspicion represents an attempt to practice hermeneutics as both science and art. Ricoeur states, "hermeneutics seems to me to be animated by this double motivation: willingness to suspect, willingness to listen; vow of rigor, vow of obedience" (1970: 27). Thislton expands by claiming the two-fold purpose of Ricoeur's hermeneutic of suspicion:

> The first addresses the task of 'doing away with idols', namely, becoming critically aware of when we project our own wishes and constructs into texts, so that they no longer address us from beyond ourselves as 'other'. The second concerns the need to listen in openness to symbol and to narrative and thereby to allow creative events to occur 'in front of' the text, and to have their effect on us (1992: 26, quoted in Osborne, 1991:1).

Within this thesis, I will employ Van Manen's understanding of hermeneutics as it applies to the social sciences. As an increasingly thorough study of primary resources is paramount to the successful interpretation of the phenomenological method (Walton, 1995), Van Manen (1989, 1990) suggests that 'writing' is the method of a phenomenological hermeneutics. As Walton (1995) states, it is essential to *practice* phenomenology in order to understand it: The hermeneutic method of textual interpretation is absolutely central to phenomenological research based on textual material gathered from interviews and from own personal notes taken during the process of data gathering and analysis (Walton, 1995: 79).

Packer adds that interpretation aims at "a progressive uncovering and explication (which is, of course, never fully completed) of the researcher's practical understanding of what is being studied (1985: 1089). Benner (1985) explains that the researcher deploying a hermeneutic approach aims to uncover the latent meanings embedded in day-to-day practices in a way that obviates the distortion, destruction and decontextualization of the integrity of the original text.

Van Manen (1990) suggests that in conducting a phenomenological hermeneutic investigation of text-based materials, there are numerous sources of data, such as personal experience, words/idiom, and the 'borrowing' of others' narratives.

Heidegger, commenting on the nature of interpretation, states, "any interpretation which is to contribute understanding, must already have understood what is to be interpreted...an interpretation is never a presuppositionless apprehending of something presented to us" (Heidegger, 1962: 194, 195). One can see the cyclical, dialectical nature behind Heidegger's claim. Says Heidegger,

> In the circle is hidden a positive possibility of the most primordial kind of knowing. To be sure, we genuinely take hold of this possibility only when, in our interpretation, we have understood our first, last, and constant task is never to allow our fore-having, fore-sight, and fore-conception to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out these fore-structures in terms of the things themselves (1962: 195).

Following Heidegger's notion of the hermeneutic circle[11], Packer and Addison (1989) have formulated a two-fold understanding of the back-and-forth (forward arc and backward arc) process involved in the hermeneutic endeavor. If one considers the *forward arc*, this involves both understanding and misunderstanding. When approaching an object of interpretation, we have some fore-conception or preliminary understanding of the phenomenon we seek to uncover. "We inevitably shape the phenomenon to fit a 'fore-structure' that has been shaped by expectations and pre-conceptions, and by our lifestyle, culture and tradition" (Packer and Addison, 1989: 33). The researcher must remain 'open' to what the text has to say and preserve (by bracketing pre-conceptions) his/her attempts to

[11] The application of the concept of the hermeneutic circle to the texts interpreted in this thesis can be summed thus: "...in order to understand the determinate meanings of the verbal parts of any linguistic whole, we must approach them with a prior sense of the meaning of the whole; yet we can know the meaning of the whole only by knowing the meanings of its constituent parts. The circularity of the interpretive process applies to the interrelations between the single words within any sentence and the sentence as a whole, as well as to the interrelations between all the single sentences and the work as a whole" (Abrams, 1993: 91).

understand, unfettered by theoretical interference. In this fashion, the interpreter may establish a dialogic relationship with the text he/she is analyzing. This echoes Gadamer's (1975) statement that the interpreter should not attempt to approach the text as an isolable or independent object cut from its historical and contextual locatedness.

Now considering the *backward arc*, it is here where "we gain an increased appreciation of what the 'fore-structure' involves, and where it might best be changed" [by our understanding, and thus 'altered' approach to the phenomenon under question] (Packer and Addison, 1989: 33-34).

The hermeneutic circle, thus, is a necessary and positive movement used to attain a more thorough understanding of the 'truth' of the phenomenon in question. Truth with respect to my study, cannot be understood in any *absolute* sense, but must be understood as the production of knowledge in the form of a tentative answer to the social, cultural and intersubjective focus of this study: how is insight formed? As Gadamer (1975) states, hermeneutics does not afford static, finalized understanding of truth: since the meaning of a text, in this case, as the written interview content is always codetermined by the specific temporal and personal horizon of the interpreter, there can never be a stable and correct interpretation. Conversely, the meaning of a text is synchronic, yet provisional—the meaning of a text is based on the 'here and now' perspective of the interpreter.

In the context of this thesis, the hermeneutic approach afforded me a thorough and systematic interpretive framework for approaching patients' illness narratives. Insofar as the crux of the hermeneutic approach is to specify meanings within a text—particularly obscure, equivocal or figurative passages (Abrams, 1993: 91)—I felt that the application of such an approach to the narrative content of psychotic patients featured in this thesis was particularly apposite in terms of reaching an adequate understanding of the patients' perspectives.

Methodology

The research for this thesis took place in the context of a larger research project undertaken at the Douglas Hospital, Psycho-social Research Division in Verdun, Quebec. The project's title is, *Psychosis and Culture: The Role of Spaces of Negotiation (Between Patients, Families, and Practitioners) During Consultation.* This project will be conducted over the course of two years, and is led by Drs. Ellen Corin, Cecile Rousseau, Alain Lesage, and Ceclie

Marotte[12]. The notion of "spaces of negotiation[13]" refers to the creation of different modes of intervention which would permit the coexistence and recognition of perceptions and practices reflecting a wide diversity of patients', family members' and practitioners' narratives and explanatory models. The project proposes that a better understanding by practitioners of the problems encountered in the area of cross-cultural psychiatry would encourage the establishment of services better adapted to immigrant populations, and would simultaneously enrich clinical practices for recently diagnosed psychotic patients who belong to the cultural majority. Below is a brief outline of the project:

The fundamental aim of the project is to: 1) To enlarge and reformulate the notion of need for services for patients (health seeking behaviour and choices patients make when seeking treatment, if at all) who have received a full diagnosis of non-affective psychosis in the last two years, and their entourage with respect to mental health services at the onset of psychosis. 2) To clarify the significance, meanings and interpretations (from the perspective of patients and their entourage) associated with non-medical, cultural, symbolic and religious resources in the help-seeking process. 3) To contribute to the establishment of "spaces of negotiation" between practitioners, patients and their entourage by deploying a clinical frame sensitive to culture, social context and alternative meaning systems. 4) To define the parameters of a training programme that seeks to take into consideration social, cultural and symbolic variables and their relation to patient/entourage interpretive frameworks.
The project will test the following hypotheses:

1) The creation of spaces of negotiation between patient, family and practitioner will yield an improved communication and understanding. The patients will feel more accepted and will be more likely to continue long-term use of the mental health services available. 2) The differences of perception and interpretation, expectations and practices do not in and of themselves constitute a source of discontinuity in the use of services. 3) The pressure toward a resolution of differences of interpretation by imposing a homogeneous perspective is more likely to produce patient dissatisfaction and the irregular use of mental health services.

---

[12] At the time of completion of this thesis, the larger aforementioned project, of which mine was part, was still active (the project still has one more year of research to conduct before its completion).
[13] This term is meant to refer to different standpoints actors maintain in the clinical context and the creation of a space of dialogue between them. A patient diagnosed with psychosis may hold perceptions and explanations that differ from that of his/her family or practitioner. To reduce conflict within the clinical context (which could have adverse effects on treatment regimens and the therapeutic relationship overall) it is paramount that practitioners and health care professionals *negotiate* with patients and family members the different opinions and meanings that each actor brings to the clinical context.

The outline for the methods and instruments are as follows:

1) The interviews are conducted with the aid of the TPI (Turning Point/Period Interview)—an ethnographic tool which systematically explores each actors' perceptions of the development and temporal significance of signs, reactions, and help-seeking behaviour. The TPI is an open-ended, ethnographic interview created by Drs. Ellen Corin and Alain Lesage.

The TPI functions to illuminate a chronological reconstruction of the perceived evolution of the patients' problems beginning at the onset of psychosis and any subsequent changes. According to the TPI, 'turning points' are defined as specific moments which correspond to significant changes in the evolution of the patient, as they are perceived and reconstructed by the person interviewed; the turning points are defined as units of time that correspond to particular periods meaningful for the actors, and are associated with a series of dimensions or aspects that the TPI manual systematically explores: signs, symptoms, behaviours; coping mechanisms of the patient, interpretations and explanatory models; reactions of entourage; help-seeking behaviours; and contextual events, such as changes to the patient's social network. 2) An open-ended interview with the primary practitioner is conducted at the beginning of the project and again, after a six month interval; then another interview is conducted at a twelve-month interval. The interviews are conducted to document the practitioner's perception of the reactions and practices of the patient and the social entourage regarding problems, help seeking, and the relationship with mental health care services. 3) A member of the research team participates in a meeting with the clinical team at the moment the patient has entered the study.

The research sample used in this project consists of the following: fifty patients, ten from the following major cultural areas: Africa and the Caribbean, South Asia, Latin America, and Quebec (to include both Francophone and Anglophone Quebecois).

A list of patients is established who have received a diagnosis of non-affective psychosis during the last two years using computer records from psychiatric and general hospitals and CLSCs (*centre local des services communautaries*). From these files the selections are based upon both culture of origin and the date of first consultation for psychosis (information that is often not included in computer files).

The patients are recruited from various health care settings, including: 1) Two psychiatric hospitals (The Douglas Hospital, and L.H. Lafontaine); 2) Four general hospitals with psychiatric services—one specializing in early detection and intervention (Royal Victoria

Hospital, Montréal, Quebec); one with a consultation service in cultural psychiatry (Jewish General Hospital, Montréal, Quebec); two more hospitals with departments of psychiatry (Jean Talon Hospital and St. Luc Hospital) 3) One general children's hospital with a clinical programme in cross-cultural psychiatry (Montréal Children's Hospital) for children that includes psychotic adolescents from a variety of cultural origins; 4) One CLSC that serves a multiethnic population and has a mental health programme (CLSC *Cote-des-Neige*). The patients are initially contacted by the clinical team secretary or a member of the team (or by the interpreter assigned to their files in those cases where the patient spoke neither French nor English). The team then contacts the patients to explain the methods and goals of the research and to invite them to participate.

The anticipated impact of this project is to reveal the role of various social and cultural aspects which imbued the response to psychiatric services, as well as the types of dynamics (according to the patient, the entourage, and the practitioners) most likely to have positive and negative repercussions on the creation of an alliance between the different categories of actors. The main goals of the project are to enable the proposition and creation of a more globally-oriented training programme for teams working with psychotic patients, particularly those from multiethnic locales; and to expand the current parameters of the clinical space by emphasizing the role of culture and social relations and their salient impact on the treatment and evolution of psychosis.

My study was undertaken in conjunction with the aforementioned research project, *Psychosis and Culture: The Role of Spaces of Negotiation During Consultation.* This larger research project provided the base and materials from which I was able to conduct my own research on insight and psychosis. My study fits into the larger research project according to the following:

My aim is to explore how patients come to know how they are ill, and how insight is constructed and configured via the role of different perspectives and voices in the clinical encounter. By approaching insight as the provisional result of perspectival/dialogic, epistemic and social/cultural forces, we are able to understand that the construction and configuration of insight is a relational affair between the patient and those actors and symbolic media involved within the patient's social sphere or lifeworld. This perspective on insight provides a particular angle from which to approach and operationalize the notion of negotiation at the centre of the broader project.

Data Collection: The Application of the Hermeneutic Approach to this Study

The process of data analysis in a phenomenological hermeneutic oriented project is sometimes not easy to explain systematically. According to Walton (1995), while it is common to read of researchers who are able to uncover themes in their textual data, this process is not always systematic, unequivocal or entirely straightforward. Van Manen explains the 'processual' nature of the phenomenological hermeneutic process:

> Making something of a text or a lived experience by interpreting its meaning is more accurately a process of insightful invention, discovery or disclosure—grasping and formulating a thematic understanding is not a rule-bound process but a free act of 'seeing' meaning. (1990: 79).

Van Manen (1990) has identified six research objectives providing the basis for a phenomenological hermeneutic research. Concerning my approach to data interpretation, I employed, albeit loosely, Van Manen's six research objectives. These objectives can be summarized as follows:

1) Turning to a phenomenon of interest: this process comprises the identification of a research topic, or concern about a specific phenomenon. For this study, my main concern is approaching the phenomenon in question—the social, cultural and intersubjective construction of insight—as a student of medical anthropology. As I formulated and developed my research question, I had to become aware of my pre-conceptions regarding the social and cultural dimension of insight in psychosis.

2) Investigating experience as it is lived rather than as it is conceptualized: to study an experience that is lived, the researcher must approach the phenomenon free from all theoretical pre-conceptions, pre-understandings and prejudices. As Walton (1995) states, this process involves examining in close detail one's own experience: first and foremost, this means forming a close relationship with interview data—becoming familiar with idiosyncratic uses of words, phrases and idiom. Also, reading literature and examining other sources of information in order to broaden one's aids in coming to a more empathic understanding of the phenomenon under study.

3) Reflecting on essential themes which characterize the phenomenon under study: According to Van Manen (1990), during data analysis, the researcher seeks to understand the essential meaning of the phenomenon under study in order to identify key themes which

characterize the experience—this is done in order to be able to communicate the meaning of the phenomenon under question.

4) Describing the phenomenon through writing and re-writing: writing, to Van Manen is necessary to 'bring to speech' that which is to be communicated (1990:32). Through the process of writing, ideas are given form and thus can be reflected upon by the researcher. Van Manen states, "to be able to do justice to the fullness and ambiguity of the experience of the lifeworld, writing may turn into a complex process of re-writing (re-thinking, reflecting and re-cognizing) (1990: 131).

5) Maintaining a strong and oriented relation to the phenomenon: Throughout the research process, the researcher needs to stay centered on the question which drives the research, refusing to fall back on any pre-figured theoretical constructs. The two orientations that I had to maintain throughout this project were: the nature of the phenomenon as experienced, lived and narrated by the patients, and the meaning of this 'narrated experience' for my medical anthropological endeavor (to uncover the processes of the social, cultural and intersubjective construction of insight).

6) Balancing the research context by considering parts and whole (the advent of the hermeneutic circle): This process is constituted of a dynamic shift in perspective between the parts and the whole, or, between the way the question is set forth and the answers provided—between interview material and the subsequent interpretive comment.

Regarding data upon which this thesis was based, I focused on three separate sets of TPI interviews—from both patients and a member of their social entourage—collected in the context of the foresaid project. Each interview was randomly selected by the coordinator of the research team so as to eliminate any potential biases. The featured interviews consisted of the following: One interview with an Anglophone patient residing in Montréal, and a separate interview with this patient's mother; one interview featuring a patient and the patient's husband, both from Bangladesh who now reside in Montréal; one interview with a patient from Ghana now residing in Montréal, and a separate interview with a consociate whom the patient met upon arrival to Montréal. By focusing on a small sample size, I was able to conduct more intensive, qualitative explorations of the patient's lifeworld. Walton (1995) offers an explanation regarding the purely qualitative basis for phenomenological hermeneutic analysis: She states that inasmuch as no mathematical probabilities are deployed or absolute truth involved in this method of analysis, there is no attempt made in

phenomenological hermeneutics to find a statistically-significant representative sample of research participants. Purely qualitative in orientation, this form of inquiry seeks a range of narratives from those who have lived the experience of psychosis.

With respect to the textual content of the interviews, my focus was to locate specific nodes or themes within each interview pertaining to both the patients' and family members' interpretation of the experience associated with the illness. The exegetical format I adhered to consisted of giving each interview several pre-analytical readings so as to build a relationship, albeit textual, with each of the actors involved in each actor's narrative. By engaging in an intimate textual dialogue with the interview content, I felt that I was able to familiarize myself with each actors' use of linguistic idiosyncrasies, colloquialisms, and metaphors in order to a promote a more empathic, comprehensive understanding of the perspectives and opinions that each actor maintained.

Regarding the analysis of the interview content, I centered on common nodes or themes expressed in each actor's interview. Major nodes consisted of patient/family interpretation of illness, models of explanation of the illness, and the particular meaning systems utilized to impute meaning to these interpretations, and also the local social and cultural matrices in which each actor was rooted. Emphasis was placed upon those sections of the interviews where I was able to locate evidence of patient/family member or patient/practitioner relationships which intimated some form of influence, implicit or explicit, on the construction and configuration of the patient's interpretation of his/her illness event.

Upon completion of the textual analysis, I was able to code for specific common and consistent themes pertaining to the relational configuration and construction of insight and, thus, was able to cross-correlate them with the content of each actor's interview. After coding was completed, I was able to triangulate and situate common narrative themes along three broad axes pertaining to the evidence of intersubjective and dialogic construction and configuration of insight, each of which will be explained in detail in the forthcoming sections of this thesis.

Perhaps a major drawback to a hermeneutic approach to psychotic patients' narratives lies in the degree of empathy and understanding the researcher is capable of investing/projecting—especially when dealing with varying degrees of severity of psychosis. For this thesis, all patients had been diagnosed with non-affective psychosis during the past two years. As such, patients' were in the initial stages of adjusting to the

drastic cognitive/existential modifications concomitant with psychosis. Insofar as this was the case, patients' were still able to maintain (to varying degrees) at least some contact with reality and themselves. The results of the interviews may have been entirely different had they been conducted with patients suffering from chronic psychosis over the period of many years. If this were the case, the constant destabilizations wrought by chronic psychosis may have rendered some patients' narrative content more difficult to understand. As such, an empathic standpoint may not have underwritten pure incomprehensibility of narrative content. Chronic psychosis can render communication (and thus interview content) utterly incomprehensible—although persons may share a language, they may, as Wittgenstein says, share a single 'form of life'. Wittgenstein describes,

> One human being can be a complete enigma to another. We learn this when we come into a strange country with entirely strange traditions; and, what is more, even given a mastery of the country's language. We do not *understand* the people. (And not because of not knowing what they are saying to themselves.) We cannot find our feet with them (1953: 223, quoted in Sass, 1992: 110, original emphasis).

As such, taking the aforementioned sentiment into account, I do not claim that the processual model of insight construction/configuration discussed and advocated in this thesis applies to *all* psychotic patients as I was only afforded the opportunity to work with three patients' and three family member's interviews. Due to the limited scope of this thesis, it would be interesting—regarding further research possibilities—to apply the model of insight construction/configuration outlined in this thesis to a much larger sample of patients/family members along with the patients' practitioners. By increasing the sample size and base of participants, it would be of significance to look for similar stages of insight configuration and construction (see the three stages of insight configuration outlined and discussed in chapter 5) in each participant's interview. Or, if entirely different stages are present or occur at entirely different temporal points of rupture, it would be of interest to explore the basis, content and evolution of these stages and their expression through the participants' narratives.

Chapter Three
A Case against Cartesian Metaphysics of Mind: The Genesis of Self and Self-Knowledge

Questions raised about insight are inseparable from a broader reflection about the process of self-knowledge acquisition. The purpose of this chapter is to complement my brief discussion on the contribution of phenomenology and hermeneutics to a theory of insight in questioning the ideas of self and subjectivity and the possibility and pathways toward self-knowledge. This discussion will set the ground for discussing the epistemology of the research encounter and the way that the research encounter plays a role in the construction of insight.

Let us first consider the larger background. I argue in this thesis that insight is not a purely *individual* and invariable *situs* in one's mind's eye, where access to self-knowledge occurs simply by 'reaching in', or through putative introspective or apperceptive ability to attain consensual error-free knowledge of one's condition and, in general, knowledge of the self[1]. The claim that insight is a purely individual phenomenon, where one reaches deep within oneself for an accurate explanation of his/her behaviour so as to attain a high degree of adequation with an external set of norms will be refuted here.

In order to delimit the framework for the claim that insight is a dialogically-based socio-cultural process set within a relational ontology of inclusion (*umfassung*[2]), I shall first need to limn the opposing framework that approaches self-knowledge (and the self, for that matter) as a singular, non-relational acquisition of intuitively-grounded truths—what I call the philosophy of atomistic subjectivity.

It was the mathematician and philosopher Rene Descartes (1596-1650) who formulated the idea that the mind is separate from the body, and that the mind itself is a source of knowledge. Descartes was determined to hold that absolutely nothing was certain

---

[1] Consensual as in accord with the attending physician who serves as the singular datum point from which the patient's illness interpretation is tested/assessed. In this view it seems that other selves (members of the patient's entourage) serve no function in the production of self-knowledge; in this light, other people within the patient's social sphere seem only to serve as singular datum points (for cognitive/ideational/delusional error-checking) from which the patient may test/re-test discrepancies in illness interpretation. Here, the patient is *not* used as a frame of reference from which to assess understandings/observations concomitant with psychosis.

[2] According to Martin Buber (1959), the ultimate nature of dialogue is based on the *experience*—and not knowledge—of the reciprocity of inclusion (the 'I-Thou' relation). I shall later take up the theme of the dialogue between self and other in explicit detail (drawing on the work of E. Levinas who expanded on Buber's philosophy of dialogue) in the proceeding chapter.

in the world until he had established the grounds for admitting it as such. Believing his senses to be 'tricked' or 'fooled' by the devil, or what he referred to as 'an evil genius', the sole category of knowledge to be taken on faith alone was the existence of the thinking being, conveyed by Descartes by his maxim *cogito, ergo sum.* The crux of his maxim is that we, as thinking beings, know ourselves in a purely individual, unmediated manner; self-knowledge, according to this view, is sought directly and apodictically from within—as the unitary subjects of experience, we are immediately aware of the contents of our minds. According to Descartes, solipsistic introspection was the only way to achieve consistent and apodictic truth, *a fortiori*, truth about the self: "I know plainly that I can achieve an easier and more evident perception of my own mind than of anything else" (Descartes, 1641/1968: 157).

He then utilized the concept of the 'thinking being' to establish proof for the existence of God whom Descartes understood as the sole creator of the physical world (Lock and Scheper-Hughes, 1996: 47). Descartes, who was a devout Catholic, understood that one should not in any case question what God had created. Through the "creation" of the concept of the separate mind, Descartes was able to attain a state of resolution between his religious beliefs and his scientific endeavors (1996: 47). Descartes' plan was to formulate a philosophical framework which would, in essence, remove the "rational" mind from nature. This plan allowed him to remove man's higher essence, the rational mind, from the natural world to allow for a purely objective examination of nature, more specifically of the human body—that spatial and mathematically measurable extension (ibid).

To Descartes, *a priori* truths, those attained via intuition and the intellect, were fundamentally different from *a posteriori* truths, or those based on input from the senses. Descartes' central claim was that as "truths of reason", *a priori* truths attained via the mind *qua* mind were unchanging and immune from the fallibility and potential error that contaminates knowledge based on observation/comparison (induction or empiricism) (Jopling, 1993: 292).

Our use of commonsense, everyday natural grammar dichotomizes the world into subjects, things and objects, sometimes effacing relations and processes (Bourdieu and Wacquant, 1992). In a pre-reflective sense, we think of ourselves as subjects *of* experience. We do not usually understand ourselves as a series of experiences; inversely, we are entities that *have* experiences. In a pre-reflective sense, we understand the cognizing subject to have

access to a privileged window into his/her own mind. We know, from the inside what it is like to be ourselves and how it feels to experience things (Jopling, 1993: 293).

When thinking about the role of the self in the constitution of self-knowledge from the Cartesian or the everyday, pre-reflective viewpoint, one is brought to ask: Is Descartes' rationalism an irrefutable epistemological and metaphysical framework? How exactly does one, according to this framework, approach the problem of other minds? What about the knowledge these 'minds' are assumed to possess? How do minds attain knowledge? How is it verifiable if the self is understood as a singular datum point from which to judge and assess all forms of knowledge? Below I shall delimit some of the inherent problematical aspects of this philosophical viewpoint, paying special attention to the self and the knowledge it is said to hold. This will be followed by an introduction to a less problematical framework, one that situates self and self-knowledge within a relational economy of being.

Problematizing the Philosophy of Atomistic Subjectivity: The Other in Opposition to the 'I' (*Solus Ipse*) of the Self

Approaches to the self and other minds influenced by Cartesian rationalism usually leads to the understanding that conscious mental states are not observable to external points of view (Jopling, 1993: 293). According to this view, the subject experiences conscious mental states and can know them directly without having to resort to any form of inductive inference or observation. This understanding leads to a Manichean metaphysic: the dualism of subjectivity and objectivity, or simply between the provinces of inner and outer. From this view, conscious mental states are known from the inside only by their subject (or the body in which they take place)—everyone else experiences these mental states as behavioural markers or expressions from the outside. Jopling states that in collapsing the dualistic frame, "the history of the person comes to be pictured as a history of two things that are in some particular way meshed together—an inside and an outside, a private mental life and an overt behavioural life" (1993: 294).

Do we, in our everyday, pre-reflective experience, really see other selves as psycho-corporeal patchworks—part mind, part body? What one can see upon closer interpretation of mind/body rift, especially in everyday sociality, is that it is purely a metaphorical conception: the dualism between inner and outer or subjective and objective is misleading; in actuality, minds are not spatial or even material measurable extensions. This very

understanding leads to the uncovering of an astounding problematic: if minds are described as repositories or containers of private, subjective representations, how then does one account for the existence of other minds and the contents they are assumed to hold?

Each and every one of us has undeniable access to our own thoughts and mental lives; so, by way of this understanding, we then can only know *ex hypothesi* what is going on in others' minds—this is an irrefutable truism as we are separated from others by the limits of our bodies. We can hear, touch and experience other bodies, but inasmuch as we are permanently fastened by corporeal moorings, we remain closed off to the access of the subjective experience within others' bodies.

Following this understanding, it is assumed that all we can know of another person and the presence of his/her mind are objective indicators such as behaviour markers or facial expressions. But, save for the existence of another's body, how does one suppress doubts about another's mind? Yes, it informs the person who is observing the behaviour or facial expressions of another that there is indeed another body in front of them, yet does not underwrite assurance of the existence of the other's *mind.* The question is: How, then, does one come to the conclusion that they are relating to another mind and not just a body?

Logically, *inference* is the only route to disclosing the existence of another mind. When we are confronted with another body displaying coherent behaviour, we draw an analogy between our state of consciousness and the other's state of consciousness. More clearly, insofar as we are certain of our own conscious experience and its manifestations, we can logically infer that another person's behaviour is a manifestation of a related state of consciousness. The difficulty with this assumption is that it is based purely on inductive generalization which rests only on a single datum point: for example, from my own conscious experience, I infer that you are experiencing a *related* cognitive/epistemic state. A major drawback to this assumption is as follows: Cartesian metaphysics approaches the self as an alienated and detached social atom. The Cartesian hypothesis states that in social space the self interacts with material objects or bodies, and only establishes *ex post facto* that these bodies have minds and therefore must be persons. To circumvent the self's alienation, it first posits, upon encountering another body, that it is indeed a body first, then subsequently attributes the existence of a mind to that body. *Prima facie*, one can see that this approach to the self/other relation is too one-dimensional and self-exclusive. Jopling states succinctly,

> Given the masses of internal mental processing that is required to model the other person as a "re-edition" of oneself, it is questionable whether the self really encounters anything that is genuinely other than itself. It seems to be trapped in the web of its own mental life, unaware of the difference and otherness of the other. To rework a phrase that was once directed against overly cognitive theories of rat behaviour, this view leaves the other person lost in the maze of the self's own thought. The interpersonal relation begins and ends in the head (1993: 296).

My rejoinder to those advocates of Cartesian dualism is that, in the pre-reflective world as locally experienced, it would be unfaithful to human experience to claim—when encountering the other—we first encounter a body, attribute a mind to this body, then infer that it must be a person. Surely this is far too much of a cognitive and epistemic undertaking for immediate or unexpected social interaction!

In our everyday or common sense world of social interactions experienced from the natural standpoint (Schutz, 1967), we encounter *persons*, not bodies, and then, after close scrutiny, minds. The Cartesian conception of modeling the other person as an analogue of oneself leads to a debilitating scotomata in the visual field of everyday human understanding and interpretation: i.e. by modeling the other person as re-edition of myself, I perforce efface the other's differences and idiosyncrasies as I can only seek recourse within myself as a singular coordinate of comparison (since I, according to Descartes, am the only irrefutable, apodictic source of true knowledge from which to measure external minds or bodies against). Here we can see that Descartes has created for us an unbridgeable impasse. But is there a way to span this corporeal and mental divide?

The self-transparency assumed by the Cartesian view understands the self as being capable of critical, truthful reflection measured only against itself. According to proponents of this view, this is the self's 'natural shape': the self working as a norm against which all pathological deviations and metaphorical representations can be measured (Jopling, 1997: 259). Self-knowledge, then, according to proponents of this view is said to be undeniably *consistent*, *infallible*, and *apodictic*. Self-knowledge, once it is attained, seems to represent a singular truth and stability, attributes which are understood as temporally consistent.

This unchanging, unified approach to the self and the seemingly unchanging knowledge it is said to have attained appears, upon closer inspection, far too problematical. Realistically, when placing this 'cognitively rigid' self alongside other selves in social

space, it surely would not be able to adapt and survive the pressing nature of social life; and would ultimately, in the words of Charles Darwin, be 'selected against'.

A model far more compatible with the modular model of mind maintained by the cognitive and neurological sciences would give precedence to social and behavioural adaptation. Says Jopling, "[h]uman beings are adaptive creatures whose cognitive competences have evolved to tolerate—not eradicate—selective stupidity, information insensitivity, and self-opacity" (1997: 259). To start, according to Rorty, "[w]e would not have survived as the creatures we are if our sole capacities were those of unified or transparent critical inquirers" (1988: 219).

The aforementioned rigid unity may be contrasted with two more plausible approaches to the self: 1) social contingency model of the self, and 2) the multi-layered model of the self. I will briefly discuss these two approaches and build on them for presenting elements of a relational ontology, discussing the implications for my research.

The Social Contingency Model of the Self: Self and Selfhood as Protean Construct

Antipodal to the unitary and rigid understanding of self the Cartesian rationalists hold, the social contingency model of self posits that the potential forms the self may take are at the mercy of language: the self, depending on social context, can be shaped or constructed in as many ways as linguistically possible (Jopling, 1997: 260). With this view, there are no limits to the different ways in which the self can be 'made and 'un-made' as there is no pre-configured mode of being for the self[3]. The proponents of this view hold that the self is anything but a determinate and stable entity. Rather, the self is a protean, amorphous and provisional potential. The social contingency view approaches the self as a construct or a text: the self must be constructed via a process that draws upon cultural metaphors, narratives, symbols and categories (Jopling, 1997: 260). In line with this understanding, there is only a body of precarious, ever-shifting and ambiguous evidence upon which the self is based—a corpus of evidence which affords manifold interpretations and re-interpretations.

[3] According to this model, the self is formed from context dependent dialogic/symbolic interactions. Thus, the self does not strive toward some determinate form, essence or goal as proponents of vitalism, in support of the Aristotelian notion of entelechy, would claim. Inversely, the social contingency model approaches the self purely as *potential*; as the accretion or product of unpredictable contextual interactions or 'accidents'.

Debbora Battaglia, an advocate of the social contingency model of the self states that,

> Basically, discourses of contingency flow from the premise that persons, their subjectivities and identities (selves) are shaped by and shape relations to others, under the press of historical and cultural contingency. From this it follows that selves are "not given to us" by natural law (Foucault, 1984: 341), not fixed or unchanging. And certainly they are not ontologically prior to relations of power; any such notion is simply unreal. Rather, selves are from the start an open question: subject to the constraints and manipulations of cultural forces, on the one hand, and on the other hand capable, upon reflection, of breaking with and transforming the situations in which they are formed (1999: 115).

Pushing this line of reasoning further, Battaglia (1995) describes the self as a "representational economy" which sits precariously at the cross-roads between a multiplicity of rhetorics and a diversity of socialities. Battaglia defines rhetoric as an uncertain and provisional purposive social project, a project that is characterized by a smudging of "'the limit separating expression from disguise, but also [allowing] that oscillation succinct expression' (Barthes 1977: 57), its aesthetic has less to tell us about style in some pure form than about political judgments it inscribes"(Battaglia, 1995: 2).

The conceptual lattice supporting Batagglia's notion of self supports the notion that the self, *qua* representational economy, is nothing more than a reification that is continuously constituted, reconstituted, defeated and decentered by the "mutable entanglements with other subjects' histories, experiences, self-representations; with their texts, conduct, gestures, objectifications; with their 'argument of images'" (Battaglia, 1995: 2). Selfhood, according to this view, is nothing more than a figuration, a chronically unstable mirage which is defined only situationally and attains only a semblance of 'imaginary' order or integration—an order or temporary state of stability which is purposive in origin, and is at the mercy of culturally defined patterns of interaction and power dynamics (Battaglia, 1995: 2). We can see that, according to this view, the self seems to appear as a deictic[4] 'man of clay' whose only hope for some form of consistency and homogeneity lies within an ephemeral context of discursive practice—only to be shaped and re-shaped in the next decentering encounter with an Other. But, what about those significant traces of selfhood that remain the same across time, and in multiple contexts?

[4] I use this term to express that the self, according to the social contingency model, becomes a mere construct, the determination of whose referent is purely dependent on the interactive context in which it participates.

Although highly useful in understanding the multiplicities the self can take, I think the social contingency model glosses over some salient features of selfhood, namely, 'core' (temporally consistent tastes, behavioural disposition, idiosyncrasies, cognitive traits, fears and desires) personality traits, and the historical situatedness of the acting agent. However fuzzy or blurred these foresaid 'core' features may be, do they not retain at least some degree of consistency across time, space, and even in certain mental (organic and non-organic) psychopathologies? If the self, then, is to be understood as a desultory socio-linguistic construct susceptible to the whims of social positioning, fragmentation and power, does this view not instantiate the self as a ghost-like image whose only agential consistency lies at the crossroads of speech-acts, power differentials and discursive contexts[5]?

Although highly plausible, the social contingency model seems to bypass two salient aspects of the self: consistency through time and historical locatedness (accessed through and by autobiographical memory). According to Jopling (1993), the social contingency model bears an affinity with the 'creative self-deception' hypothesis: a hypothesis "based on a culturally parochial set of beliefs about the self [that] is being actively tested and realized in clinical and institutional settings" (Jopling, 1993: 260). The creative self-deception hypothesis[6] states that sometimes people hold unrealistically positive self-evaluations, hyperbolic perceptions of power/control, and an unrealistic sense of optimism, all of which are favorable to maintaining a sense of well-being and productivity (ibid).

The social contingency model, like the creative-deception hypothesis, seems to posit a potential to write and re-write a personal social history in however many ways and however many forms discursive encounters can take. Regarding issues of morality and responsibility, it seems that a drawback to the social contingency model is that one can literally efface elements of social/historical constitution at will. Jopling explains this point aptly,

---

[5] I am not refuting that the self 'comes into being' as a result of discursive practices and social positioning. I am only attempting—for the purposes of this thesis—to set up a claim that the self indeed does posses some characterological consistencies predicated on significant socio-historical antecedents.

[6] According to Taylor and Brown (1988), the creative self-deception hypothesis acts as a bulwark against myriad social distortions and negative feedback. They state that "the individual who responds to negative, ambiguous, or unsupportive feedback with a positive sense of self, a belief in personal efficacy, and an optimistic sense of the future will, we maintain, be happier, more caring, and more productive than the individual who perceives this same information accurately and integrates it into his or her view of the self, the world and the future. In this sense, the capacity to develop and maintain positive illusions may be thought of as a valuable human resource to be nurtured and promoted, rather than an error-prone processing system to be corrected" (Taylor and Brown, 1988: 205).

> Without a grounding in historical and psychological fact and objective epistemic backdrop that provides shared standards of epistemic appraisal and criticism, self-description [according to the social contingency model] will be no different from Stalinist history writing. Just as Stalinist historians rewrote the Soviet encyclopedia, thereby correcting fortune by remaking history, so the history of the self can be narrated and renarrated in the most morally [and purposively] convenient manner. This allows people to "get off the hook" for past misdeeds; and this way the logical and referential stability of the agent-designating moral concepts of responsibility, blame, desert, and punishment is underdetermined. The price of creative self-definition is the evasion of personal and interpersonal responsibility (1993: 261).

Also, another area not covered by the social contingency model is that the self can not be said to hold what Marilyn Strathern has referred to as the 'integratory capacity' (1991: 5). Although Strathern couples the concept of the self's intergratory capacity with essentialist reification, one can still account for the diversity of social and cultural experiences and yet not have to write off the social, historical and cultural locatedness of the self. Although modernity and capitalist commerce do have a destabilizing effect on the self to a certain extent, one should not efface any possibility of a self's sense of consistency and coherence through time, no matter how much it is said to dwell in a social and economic state of "bi-focality"(Battaglia, 1999).

Deflecting the charge of essentialist or hypostatical reduction, I will now briefly outline a model of the self that appreciates both its dialogical plasticity and its tendency to maintain certain core traits through time and multiple contexts.

The Multi-Layered Model of the Self: Self and Selfhood as Non-Static Configuration

Like the social contingency model of the self, the multi-layered model also understands the self as a product of dialogicity[7] and discursive positioning (Gergen 1977;

[7] I will use the term 'dialogue' or 'dialogicity' throughout this thesis to refer to interpersonal communication broadly defined. As such, dialogue is not only used to refer to two interlocutors communicating via verbal utterances and speech acts, but also to paralinguistic features (pauses, intonations, silences) and proxemics/ kinesthetics enacted via social praxis. Grouped together, these latter features may be referred to simply as what Bruner (1986) terms 'expressions'. As Bruner states, "[an expression]...always involves a processual activity, a verb form, an action rooted in a social situation with real persons in a particular culture in a given historical era. ..Expressions are constitutive and shaping, not as abstract texts but in the activity that actualizes the text. It is in the sense that texts must be performed to be experienced, and what is constitutive is in the production...As expressions or performed texts, structured units of experience [such as dialogic interactions]...are socially constructed units of meaning (Bruner, 1986: 7). Applying these foresaid sentiments to insight as self-knowledge, Gergen's states: "Thus, through social observation, interaction, and language acquisition the individual acquires an inventory of self-attributes or conceptions, and knowledge as to their relationship with other classes of stimuli (1977: 143). My broad definition of this term will become especially

Davies and Harré, 1990; Neisser, 1988, 1993; Rorty, 1988; Jopling, 1993, 1997, 2000); however, it approaches the self pragmatically as having certain diachronic consistencies.

Like the social contingency model, the multi-layered model of the self understands the self not as an essentialist or hypostatical pre-existent, but as dialogic/symbolic construction. The multilayered model approaches the self as having contingent components, susceptible to transhistorical and interpersonal/dialogic shifts and modifications (which are contextually and purposively precipitated), but the underlying essence of this model is that the self may be understood as a complex, multi-layered, more or less integrated configuration[8]—albeit in a fuzzy sense. This configuration, made up of several 'core' characteristics or traits[9], does have a determinate structure and a developmental history, however fuzzy or blurred its points of articulation are. The characteristics or traits may be dichotomized as *primary* characteristics or traits which hold a number of *secondary* characteristics or traits in place—each characteristic is specified by certain kinds of information and is also subject to certain kinds of pathology (Jopling, 1997: 262).

Following Alfred Schutz (1967), and Schutz and Luckmann (1973), it can be said that these core traits are rooted in historical antecedents, i.e. 'stock experiences'. Stock experiences (similar to what is known as 'cultural schema theory', see L. Garro, 275-315: 2000) are wrought from intersubjective interactions both with fellow persons and objective structures like material reality over a period of time. Applying this to the concept of core characteristics, it may be said that idiosyncrasies, personality and character, *qua* self-

---

important in the sections dealing with the intersubjective dimensions to self-knowledge acquisition/insight. Accordingly, my understanding of language use is that all language is used from a *point of view*, i.e. in a specific context, from a speaker to an intended or non-intended audience (whether real or imagined), hence, all language is inherently dialogic.

[8] Integration in this sense is achieved *post hoc* through dialogic configuration. As stated by Rousseau, "In the course of the day, and throughout life, we join a number of trans-individual subjects, and this very mobility makes us look for continuity, and makes us work at establishing an integrated self" (1995: 295). Taken in this sense, integration is not an existential given; on the contrary, it occurs after the fact through dialogic interaction set within a socio-cultural matrix comprised of communities of like-minded individuals. I argue that once a certain element of "integration" has been achieved that integration may remain consistent through time; but this does not necessarily preclude certain layers from modification or shifts. Traits that may maintain a certain degree of consistency through time are tastes in food, music or artwork; behavioural dispositions or behavioural idiosyncrasies; religious convictions; creative proclivities capabilities, *et cetera*. The temporal consistency of the foresaid characteristics or traits may be glossed simply as 'personality'.

[9] Core traits, according to Rorty and Wong, "make systematic differences in a person's action, behavior and thought; have a whole network of other traits dependent upon them; are difficult to change by means of deliberation; persist across time as salient patterns; take precedence over other traits when competing in the psychological economy; if lost or weakened, result in a person experiencing him or herself subjectively as significantly changed; and manifest themselves across different domains of life (private/public, work/leisure)" (1990: 19).

knowledge, emerge in a centripetal manner through dynamic interactions with others and the world. These experiences accrue processually from the outside in and form the epistemic frame upon which selfhood may be hung. In this sense, the accretion of experiences—those rooted in the past interactions—serve as a reference frame or schema for the self's explication of the world and self (Schutz and Luckmann, 1973: 7). It is through subjective, practical interactions and experimentations early on in one's life with others and the world that one comes to a familiar understanding of certain objective and subjective structures—structures pertaining to both self and other, whether social or material—which can be said to form, through the process of sedimentation, the very basis of certain core traits[10].

These characteristics which comprise the self configuration are held together by non-static layers and form a dynamic system characterized by shifting patterns of importance and dominance that are subject to modifications/permutations across time depending on social/cultural context. The layers—acting somewhat like scaffolding—that support the characteristics are the following: the somatic and perceptual motor, the interpersonal, the cognitive, the moral and the cultural. Each of these layers is specified by different forms of information (Neisser, 1988); also, each of these layers is acquired in diverse ways and across manifold contexts at certain stages throughout the ontogeny of the self.

In similar fashion, Rousseau (1995) states that a person is composed of several autonomous sectors which can, in most cases, exist entirely independent of each other—these "sectors" or layers are susceptible to their own differential evolution. Some core characteristics are plastic regarding their articulation and representation; some traits are inchoate and may appear and develop at different rates and points in relation to other characteristics. Like the social contingency model, the multi-layered model states that the self is also provisional regarding temporal coherence/consistency of certain characteristics: certain core characteristics or traits are subject to attenuation and are prone to weaken over time, while other, more peripheral traits may become centralized (Jopling, 1997: 262). The idea of a core characteristic is not an essentialized *factum brutum* or a coalescence of unalloyed elements enjoining a static and unproblematized gestalt. Conversely, core characteristics 'come into being' via face to face dialogue with an other—they do not

[10] Core traits may be understood, albeit in a loose manner, from Schutz' (1967) and Schutz and Luckmann's 1973) perspectival notion of the quotidian, taken for granted 'self-evidences' of the self and lifeworld—a subjective perspective which lies at the basis of the 'natural attitude' determined by one's day-to-day pragmatic motives.

precede the individual[11]. Thus, depending on context, some core traits will be more salient and defined than others; also, not all core characteristics are susceptible to empirical analysis or description[12].

Self-representation and self-inquiry precipitates the possibility of shifting or modification in the layers of the self. The multi-layered model acknowledges some degree of coherence/integration between the layers of the self, although the layers across the configuration are not at any given moment constant with each other[13]—the configuration is more of a fractionated, shifting dynamic at the whims of meaning and purposeful acts, than a unified entity.

The principal layer of the self configuration, however many modifications or shifts the self's core characteristics or peripheral traits may undergo through time, is embodiment. Embodied agency makes up the self's subjective sense of continuity both temporally and spatially. As such, "the embodied person and not any particular self is the locus of moral responsibility" (Young, 1990: 82). Building on the work of Ulrich Neisser (1988, 1993) and James Gibson (1979), Jopling (1997) notes that the self of selves as embodied agent may be summed as the relation between what Neisser terms 'the ecological self' and 'interpersonal self'. The ecological self is understood as an active agent within an immediate environmental context. Such a self perceives itself in relation to its own immediate environment; it is cognizant of its spatio-temporal locatedness. Coupled with this notion of the ecological self is the interpersonal self, an entity which engages in face to face interactions with other selves. Neisser states, "these interactions are perceived too, just as positions and movements are. We can see and hear and feel what we are doing, both ecologically and interpersonally" (1993: 4). Perception and cognition are not processes restricted to the brain where exteroceptors transmit stimuli in the form of impulses having their origin in the outside world. Inversely, thought, perception, language and semiosis

---

[11] For an interesting presentation of the existentialist doctrine (cf. subjective absolutism) 'existence precedes essence' (*existence* of the self not as a *factum brutum*, but as a being placed in a contingent/turbulent world, precedes its *essence* or 'core', which is understood to be a product of intersubjectivity) see Sartre, 1946.

[12] Applying Jopling's (1997) notion of the "self-concept" to insight, we can see that there is no direct "mirror" into the self. Self-concepts, based on the multi-layered model, provide not direct access to the self. Access to the self and self knowledge is mediated via the other in dialogic interactions. Like the rest of reality, there are many aspects of the self that are just not conducive to full analysis: the self, in its complexity, exceeds first-person totalization. "There is always more to the self than can be represented, described, and understood from the first-person point of view, and the self-concepts by means of which people represent themselves, do not always pick out the most salient aspects....there is no privileged access" (Jopling, 255: 1997).

[13] Some degree of integration and singularity is imposed upon the self owing to corporeal embodiment.

occur within the world of entities located outside of our bodies (objects, persons)—through this interaction between self and entities, things reveal themselves in the form of meanings to the self. According to Weiner (1999), in a phenomenological sense, the world of external entities (perception of an object or dialogue with a person) 'draws out' the body's cognitive abilities and capacities. Much in line with the forementioned conception of self and environment, Richard Polt, coming from an existential perspective writes that

> ...the process of human *existence* does not take place merely inside the skull. It occurs when the human body interacts with the beings [other selves and material objects] around it in such a way that those beings reveal themselves in their depths of meaning. If our connections to other beings were cut, we would not end up inside our mind—*we would end up without a mind at all* (1999: 57, original emphasis).

From this perspective, one can come to an understanding that the self, as embodied agent, is in the world with other entities—a theme I shall allude to later in this chapter. We can appreciate that the self is a genuine product of interactions with its social and material environment. As such, it is a result of the 'stock experience' gained through the navigation of the social and material world, that the self can be understood to build and maintain certain consistent characteristics or traits across time while maintaining the ability to shift and modify core-characteristics and peripheral traits.

Now that I have provided an outline for a more plausible model of the self that accounts for certain diachronic consistencies such as 'personality' or 'character', I will turn to a framework of the self/other relation that situates the self within a reciprocal, ethical relation to other selves. In opposition to Cartesian metaphysics of mind, the framework outlined below locates the self in a relation *with* others where self-knowledge, more specifically, insight, is understood as a non-intuitive, non-atomistic socio-cultural and epistemic process predicated on *intersubjectivity*.

Between Selves and Others: Toward a Relational Ontology Based upon Intersubjectvity

When situating the self within the context of an interpersonal relation—instead of an intrapersonal relation where the other is understood as a simulacrum or externalized replica of the self—it behooves us to understand the other as a second *person*, a dialogically responsive agent. It is significant to understand the other as a person who is responsive and attuned to evocative effects of address and response: dialogue frames the experience of the

other as a second-person nominative pronoun, a *you* awaiting response from an *I* (Jopling, 2000).

An approach that obviates the problematic of 'the other mind' in Cartesian rationalism outlined above is what can be glossed as the philosophy of intersubjectivity. The philosophy of intersubjectivity understands the encounter between two persons as between *two persons*, not between two bodies or two minds. Here, interpersonal relations count as a pre-reflective, spontaneous and reciprocal space where two interlocuters enter; the self (*ipseity*[14])/other (*alterity*) encounter should not be framed as an *a priori* cognitive achievement between two bodies which infer, after the fact, that there are two minds exchanging information. Patterns of sociality, interpersonal relations, and interlocution are ontologically and epistemologically prior (Jopling, 1997) to any sort of theory-building or conceptualization of the other. In this way, the self is always and already with the other: set within a cultural and dialogic matrix, this relation is immediate, direct and attuned to the other.

The philosophy of intersubjectivity can trace its antecedents to seminal work of the philosopher Martin Heidegger (1889-1976). Heidegger's understanding of human existence, conceptualized by what he terms *Dasein*[15] is to be understood as an ontological whole—*Dasein* is a being that is always in relation to the entities that subtend it. Heidegger escapes Descartes' solipsism with his notions of *mitwelt* or 'with-world' and *mitsein* or 'Being-with'. Heidegger, in reaction to solipsism, states that "in clarifying Being-in-the-world we have shown that a bare subject without a world never "is" proximally [*zunächst*, from the beginning], nor is it ever given. And so as in the end an isolated "I" without Others is just as far from being proximally given" (Heidegger, 1962: 116).

---

[14] Here, 'ipseity' is to connote what Levinas understands as the 'forgetful', precognitive, preconative self: "'Ipseity' is the dynamic of the "other-in-the-same" or the "onself that does not bear its identity as entities...thematized and appear{ing} to consciousness" (Levinas, 1991: 99-113, quoted in Levinas, 1993b, 250). Alterity, here, may simply be understood as the inverse of ipseity, namely, pre-reflective, pre-theoretical/categorical 'otherness'.

[15] *Dasein*, in German literally translates to "here-being/there-being". It is to be understood as the kind of being that each one of us is. Roughly, it is a term that designates human existence. According to Polt, "Dasein denotes that being from whom Being itself is at issue, from whom Being is in question. For the most part, in Heidegger, this being is us, the human being, although Dasein is not equivalent to human beings; Heidegger insists that Dasein is not an anthropological, psychological, or biological concept. We can think of Dasein as a condition into which human beings enter, either individually or collectively, at a historical juncture when Being becomes an issue for them..." (xii, 2000).

Dasein is always as-a-whole, and is always located in the world along-side or with others: this locatedness is not only in a spatial sense, but also in an existential one. *Dasein* as a being-in-the-world, along-side other entities-in-the-world, exists in the world[16] as a whole. According to Heidegger,

> the compound expression 'Being-in-the world' indicates in the very way we have coined it, that it stands for a unitary phenomenon. This primary datum must be seen as a whole. But while Being-in-the-world cannot be broken up into contents which may be pieced together... (1962: 78).

Dasein, or in a very loose sense, the embodiment of human existence, i.e. the self, is always already positioned toward another *Dasein* in the world. Being-in-the-world, for *Dasein*, is a dwelling along-side entities within a specific context. Being-in-the-world, then, can be understood as a mode of being where *Dasein* is bound and entangled within a certain context or world[17] (Polt, 1999: 46). Hence, persons can only be explained with regard to social relationality and intersubjective mutuality. A self does not encounter another mind, it encounters another self via what Taylor (1989) has termed "webs of interlocution". Here we are presented with an ontology of the social ('I' *and* 'Thou', cf. Buber, 1959), instead of an ontology of the atomistic, theorizing, and cognizing subject ('I' *versus* body, then mind, then person, then 'You') (Jopling, 1997: 299).

In contradistinction to Descartes' intellectualism—where self and world are understood in terms of knowing—Heidegger's approach to the self and world gives precedence to ontology over epistemology. Knowing, according to Heidegger, is a derivative feature of being-in-the-world: *Dasein* is in the world along-side other entities that matter to it; through its day-to-day existence, *Dasein* dwells in a world in which it is engaged and concerned. This dwelling is not centrally cognitive—it is not comprised of the accretion of observations, judgments, beliefs or knowledge; conversely, it may be understood as a relational web based on involvement, familiarity and concern (Polt, 1999: 47).

---

[16] *Dasein*, whose existential and ontological constitution is understood as "being-in-the-world", is a unitary phenomenon. The world, with regard to its relation to *Dasein* is a constituent of *Dasein's* being: it is the horizon of *Dasein's* futural projection and its ultimate existential possibilities. Since Heidegger's thought is far too complex for the scope of this thesis, I will keep this discussion limited to the themes of 'relation' and 'unity'—this is to be taken in direct contrast to Cartesian ontology.

[17] 'World' in Heidegger's sense means that social/material sphere where things matter to a specific *Dasein*. Simply, world is a significant whole where one dwells (Polt, 1999: 49).

In reaction to the philosophy of atomistic subjectivity of Descartes, some major proponents of an ontology of the social [cf. Buber (1959); Heidegger (1927); Mead (1934); Wittgenstein (1953); Schutz (1967); Schutz and Luckmann (1973); Levinas (1961, 1989, 1993a, 1993b, 1999); Jopling (1993, 1997, 2000); Habermas (2001)] propose an understanding that language and communication play a constitutive role in the formation and configuration of the self. The configuration of the self always takes place within a context of meaning. Meaning, in a broad sense, according to the proponents of the philosophy of intersubjectivity is a function of *culture*, or the complex networks of social practices that make up our shared and tacit backdrop for social praxis.

Mediation characterizes the relationship between self and the social world: although the self is 'in' the world, it understands its world via cultural filters and symbols. According to Weiner (1999), though our identities, in most cases, are concealed from us in our every day, pre-reflective lives, it is dependent on the confirming presence of others, the inflection and reflection of our values, understandings and perceptions of others. Best expressed by Jacques Lacan's dictum, 'the unconscious is the discourse of the other', we can see that when engaged in dialogue, we position and direct our wants, wishes, fears, desires and expectations to the other. "It is thus the answering, responding speech of the interlocutor, whether analyst or other, that constitutes us as subjects" (Weiner, 1999: 246).

The Socio-Cultural and Epistemic Configuration of Insight as Self-Knowledge in Psychosis: Of the Phenomenology of Self (*Ipseity*) and Other (*Alerity*)

Having considered the above-mentioned conceptions of intersubjectivity, I will now turn to the reflection on the context under which insight is formed, and the participation of the interviewer in that very process of knowledge production. The broader frame opened up through the consideration of the ideas provided by proponents of the philosophy of intersubjectivity allows us to see that insight, as a form of knowledge of the self, is in part produced through the clinical research encounter with the interviewer. I will develop this conception considerably below.

I argue that insight is the product of *two* temporal/dialogic points of juncture: These points of juncture share somewhat of a fuzzy dialectical tension (*Spannung*, see G. Marcel,

1968) to one another other, although no totality[18] is formed, insofar as self-knowledge at any one time (especially in psychotic patients) manifests itself as provisional, fragmentary, and inchoate. The two points of juncture in the construction and configuration of insight in the research setting are as follows: 1) a precipitating, synchronic 'trigger point' based on the notion of interpellation[19], and 2) a mnemonic 'reaction', which is reflexive and diachronic in nature and is based on a narrative reconstruction or re-authoring of dialogic encounters. With respect to the construction of insight in the context of this study, the key actors involved in this constructive process are the interviewer, the patient, family member/consociate, and health care professional involved (who reconstructs his/her individual account): each actor plays a key role in the patients' construction and formulation of an account of insight, albeit at varying levels in the construction process.

To explain more clearly, the first juncture or trigger point rests on the role of the interviewer to question and interpellate (via the questions featured on the interview grid) the patient into a dialogic space. I base this understanding of interpellation on Emmanuel Levinas' (1961, 1999) notion of the ethics of the self/other encounter. It is appropriate for a distinction to be made regarding Levinas' terminology: Although in some cases Levinas is fairly inconsistent, I understand that his use of the term 'Other' [*l'Autre*] must be distinguished from 'other' [*Autrui*]. My reading of Levinas accords that the self (or what Levinas often refers to as the 'Same' or 'ipseity') may encounter the Other in manifold ways that do not fully evoke the Otherness found within the essence of God (these encounters where the self feels 'at home' with the other are based on what Levinas terms *jouissance*, enjoyment), it is through the *dialogic relation* that the other's 'Otherness[20]' may be

---

[18] Perhaps the word 'totality' is not the most fitting term here. According to Laing and Cooper (1964) and Cooper (1967), a totality is something that is complete and absolute—it is something that can be grasped as a whole, an accomplished unity. The term totalization, based on the Sartrean understanding of the dialectic of interpersonal relations (a process summed up as *dépasser*, a term similar to Hegel's notion of *aufheben*), seems much more fitting as it is more conducive to explaining human reality. Cooper explains that "...a totalization...is a perpetual movement, throughout the life of a subject—a movement of progressive synthetic self-definition, and this cannot in principle be grasped by a method that would arrest it" (Cooper, 1967: 20).

[19] In this instance, the word 'interpellation' is to be understood as a hailing or a calling of a person into a subject position. Although Levinas uses the term to signify the calling of the Other, infinity, to the Same (self), I use the term in a much more immediate sense. Here, I relate the transcendental nature of the Other to the nature of a dialogue between self and other in the clinical context.

[20] Otherness is something that defies full comprehension and constitution by the intending subject. Otherness, to Levinas, is likened to the transcendental, ineffable essence of the One or God (*l'à-Dieu*), the infiniteness of time, and the persistent and fleeting nature of the future and the ineluctable death of self. In sum, it is the 'face' of the other (or, in this case, the engaged interlocutor) that "...denotes the way in which the presentation of the other to me exceeds all idea of the other in me" (Hand, 1989: 5). Hence, in the context of my project,

encountered as a purely immediate, non-containable essence, or what may be summed up simply as the 'ineffable'—the other's Otherness or alterity, exists in the space opened up by dialogicity. Otherness as such is not an apprehension of the other by an *I*, it is an event that takes place in the ontological realm of the *occurrence* (Levinas, 1989: 65). Otherness as alterity exists as an uncontainable fog that neither arises nor sets from any known source; it simply 'comes into being' in the very uncertainty and unknowable relation—set forth via interpellation—characterized by the tension between ipseity and alterity.

According to this understanding, a dialogue between self and other is an ethical relation between interlocutors: a relation between two people responding to each other, and at the deepest level, being responsible for each other. Levinas (1961, 1989, 1993a, 1993b) likens this self/other relation to a relation that cannot be arrested or captured as a totality: the synergy between self and other, like the self's relation to God, is something that we cannot fully grasp or fully comprehend. Accordingly, the self's relation to the other is fundamentally asymmetrical:

> The Other as *Other* is not only an alter ego; the Other is what I myself am not. The Other is this, not because of the Other's character, or physiognomy, or psychology, but because of the Other's very alterity....The Other is, for example, the weak, the poor, 'the widow and the orphan', whereas I am the rich or the powerful. It can be said that *intersubjective space is not symmetrical* (Levinas, 1989: 48, emphasis, mine).

Dialogue, then, according to Levinas, is a communicative modality that frames the self/other encounters directly and immediately. To engage in dialogue is to listen, to answer, and to be open to the other; it is to be involved in responsiveness, responsibility, desire and interest where the self is to not remain silent when face to face with the other (Jopling, 1997: 301). Understood from this view, the Other (and in my sense, applying this experience to the dialogic relation to the other) is not a simulacrum of the *I*, it is beyond objectification and alienation. Levinas, in likening the self/other relation to a relationship with God, provides a *précis* of the foresaid understanding of the dialogic relation:

> [The Same/ Other, or self/other relation]...demands me, requires me, summons me. Should we not call this demand for this interpellation or this summons to responsibility the word of God? Does not God come to the mind precisely in that summons, rather than in the themetization of the thinkable, rather

---

the self/other relation is a *relation* that defies totalization—the ultimate meaning of the relation is not to be grasped as a truth but as *sociality*, a modality of being which is irreducible to epistemology (Levinas, 1993a: 23).

> even than in some invitation to dialogue? Does not the summons to responsibility destroy the forms of generality in which my store of knowledge, my knowledge of the other man, represents the latter to me as similar to me, designating instead in the face of the other as responsible with no possible denial, and thus, as the unique and chosen one? (Levinas, 1999: 27).

Applying the spirit of this foresaid sentiment to the context of the interviews conducted, one can see that the interviewer represents a subject who issues a summons to another subject, the patient: the interlocutive injunction of the interviewer acts as a provocative force on the patient; it calls the patient into question and disrupts or decenters his/her conventional self-understanding at that specific moment in time. This, in a sense, forces the patient to confront the otherness of the interviewer's alienating and solicitious quality of his/her *questions* and, inversely, the interviewer must thus confront the patient's *response*—this response consists of the ordering and putting into words the inner-world of the patient, in order to 'offer it to the other' (Wild, 1969: 3). The 'otherness' invoked in the clinical context, then, consists *not* of the interviewer in relation to the patient (as opposing, individual subject positions occupied by respective spatial, perspectival coordinates), but precisely in the dialogic, futural interval (*zwischen*) *between* two interlocutors.

The lacuna disclosed by the clinical encounter is not merely an instrumental means to insights the patient would have acquired by other non-interlocutive means (Jopling, 2000: 162). Thus, the very presence and mode of interpellation of the interviewer as interlocutor—as subject *vis-à-vis* subject (self *vis-à-vis* other, or vice versa)—acts as a 'trigger point' which opens up, out of the tension of co-presence (*co-esse*), a discursive space in which the patient may construct an insightful account of his/her illness. The patient's reflective and retrodictive (see Kirmayer, 1994) self-inquiry and self-evaluation is thus triggered by the other's solicitous call.

Jopling expounds,

> Not only does dialogue open the self to itself by opening it to the other person; it is by means of reflective dialogue that persons "are talked into" knowing who they are. Interlocution is a constitutive feature of self-knowing; it is not built up from the contingent interactions of pre-social atoms (2000: 157).

Rousseau (1995), much in the same fashion as Jopling, states that self-perception or, more specifically, self-knowledge is the knowledge of one's participation and interaction as 'trans-individual' subjects. In the context of this project, the patient needs a second person

to bear witness to his/her reflective self-inquiries so as to underwrite the meaningfulness of their account as a narrative reconstruction. As such, it is precisely otherness or alterity, then, that sets the stage for the possibility for the construction of insight as self-knowledge.

The second juncture in the process of insight reconstruction consists of an opening up of a mnemonic[21] frame. This frame is a diachronic, reflexive construction of past dialogic encounters with significant actors in the patients' social world. At this juncture, the patient, after having been interpellated or positioned by the interviewer, reconstructs an autobiographical narrative account—this account synthesizes the major/minor nodes[22] within the patients' narrative repertoire[23] so as to author an explanation of his/her illness (which is subsequently crystallized into an insightful account). The type of memory involved at this stage is an autobiographical memory based on *intersubjectivity*. Following this chain of logic, Strathern states, speaking of the type of memory where the human body itself becomes the instrument of remembering: "[t]he remembering involved is always a reenactment, *a restatement of relationships* rather than a straightforward cognitive act that can take place in the mind of the individual" (1996: 32, emphasis mine). Insight, then, emerges as a meaningful, albeit provisional, diachronic narrative account[24]

---

[21] The word mnemonic is to refer here to the patient's recounting of key events in his/her illness experience. The content imparted may consist of purely descriptive/symbolic content (psychological/interpersonal) centering on events associated with the illness and or/ subjective descriptions of symptomatology (depending on the patient). This should not be conflated with the content of a formal anamnesis which usually centres on the medical and developmental history of a patient. A formal anamnesis, according to Oliver Sacks "[is] a form of natural history—but…[it tells us]…nothing about the individual and his history; [it]…conveys nothing of the person, and the experience of the person, as he faces, and struggles to survive, his disease. There is no "subject" in a narrow case history; modern case histories allude to the subject in a cursory phrase ("a trisomic albino female of 21") which could as well apply to rat as a human being (1987, viii, quoted in Garro and Mattingly, 1997: 8).

[22] According to Young (1982), drawing upon D.W. Blumhagen's (1981) approach to semantic illness networks, "nodes" represent patients' reports of symptoms (i.e. "buzzing in my head"), social interaction (family communication), physiological functions (such as "ballooning veins), body states (i.e. overweight), pathogenic agencies (i.e. acute stress), and social/physical activities (smoking, drinking, eating, etc.). I deploy the term somewhat more loosely: nodes, in the context of the analysis of the interviews featured here, are meant to signify common/consistent themes that the patient draws upon (regarding insight) and that can be located in conjunction with certain accounts of experiences throughout the patient's narrative.

[23] When constructing and authoring/re-authoring a narrative account of insight, one must make use of symbolic, cognitive and epistemic frames found within their cultural matrix. Self-knowing/insight takes place within a meaningful social and cultural frame mediated and/or contested by a community of peoples who share that culture. One comes to know themselves in a social and cultural matrix in which basic metaphysical and epistemological beliefs are at least implicitly shared. With the onset of psychosis, this basic metaphysical/epistemological grounding is shaken and often questioned. This questioning—a line of inquiry that takes place via the dynamic between self and other—precipitates the search for meaning and a search for some form of causal attribution, i.e. the process of one's insight into their illness.

[24] This account, often fragmentary and precarious, is comprised of a 'tapestry' or narrative inter-weaving of both the patients' and the significant actors' interpretations of the illness experience (cf. Kirmayer, 1994, 2000;

whose very structure is configured from past dialogic encounters and relations between two persons, a self and an other[25].

Corin, 1998; Corin *et al*, 2003). This inter-weaving of the two or more perspectival narrative strands (patient/significant actor/practitioner) forms the 'discursive yoke' which, figuratively speaking, 'holds together' (however fragmentary or subjunctive) patients' accounts of insight.

[25] The process of authorship (reconstruction of the narrative) can be understood as a process of weaving and re-weaving significant narrative strands. The 'denouement', in this case, an insightful account however provisional, should never be taken as a totality; on the contrary, it is an aleatoric construction voiced in the subjunctive mood where contingency and possibility is always present (cf. Good, 1994; Kirmayer, 1994; Corin *et al*, 2003).

Chapter Four

From Interpellation to the Dialogic Relation: The Reconstruction of the Illness Event and the Construction and Configuration of Insight

After the patient has been positioned (interpellated) and called upon as a speaking subject by the interviewer, the patient enters a mnemonic frame where the authoring of his/her insightful account of illness experience may begin. Upon entering this frame, opened up by the first juncture of insight—the interpellation—the patient draws upon, from memory, salient intersubjective interactions with others where a provisional understanding of the illness event emerges.

I found that the nodes located within patients' and family members' responses to the questions posed by the interviewer while following the grid of the TPI, could be ordered into three distinct, but not necessarily mutually exclusive stages—each emerging out of what I have termed the mnemonic frame. It is out of the specific stages that I was able to specify nodes which signified a component or strand of the insightful account. It is when the nodes, drawn from each distinct stage, and situated along a temporal (diachronic) axis that an insightful account, authored in the subjunctive mode, emerges.

The three stages of insight construction and configuration are as follows: 1) *Detection of alteration of lived experience*: Here, the patient/family member narrates a detection of change in lived experience and atmospheric quality of lifeworld brought on by psychosis—questions raised during this stage are: '*what* is happening to me', or '*what* is happening to our son/daughter'? 2) *Causal attribution*: Concomitant to the onset of psychosis, the patient and family partake in a quest for meaning. Here, the search for etiology is of utmost concern—this stage may be understood as the 'how?' of the illness. Questions such as 'how did this happen to me'? or 'was it something I did to myself'? are of paramount significance. 3) *Global construction of meaning*: Here, the patient and family situate their experiences of/with the illness within a global frame of meaning, one that encompasses the greater social/cosmological/temporal sphere of all actors involved in the illness event—this stage may be understood as the 'why?' of the illness experience. Questions such as 'why did this have to happen to *me*?' or 'why did this happen to *our* family', or, simply, 'why *now*'? are of utmost importance.

Detection of Change in Lived Experience: Approaching the Limits of Understanding

With the onset of psychosis comes a restructuring of the patients' lifeworld—their previous relation to themselves, others, and the world around them undergoes a drastic shift. The patients, in response to this undermining shift in the lifeworld, experience a feeling that hostility infuses the outside world; a pervasive sense of porosity of personal boundaries and limits; a restriction of freedom, and a general sense of confusion and uncertainty (Sass, 1992; Marková and Berrios, 1992; Corin *et al*, 2003). The patient's natural standpoint or pre-reflective orientation to the world shifts such that the world and its taken-for-grantedness becomes highly problematic and unfamiliar (cf. Sass, 1992). Speaking in Heideggarian terms, we can say that in its very facticity, its unquestionable locatedness in the lifeworld, the onset of psychosis 'deracinates' *Dasein* from its existential moorings such that the *Da* (here) may be said to separate from the *sein* (being), leaving the patient with a sense of having been uprooted from his/her previous sense of presence[1].

[1] From a purely philosophical point of view (phenomenological), this separation ('*Da*' from '*sein*') precipitated by the onset of psychosis introduces the patient to a vacuum opened up by the implosion of the lifeworld. Where the patient was previously able to experience the world and its distractions from a pre-reflective stance, a position where the self is able to 'forget' the implications of its own existence and become absorbed in the world of objects and people, the onset of psychosis rends the existential fabric comprising the self causing both a separation and a confrontation with *being* itself. The breaching of the limits of understanding concomitant with the onset of psychosis represents an ineffable confusion; an estrangement and baffling of all the qualities and readings of the senses. The pain and suffering that ensue as a result of this destabilization force the person to confront existence and being in their very persistence through the silent duration of time, unassisted by the amnesias and sweet evasions of the pre-reflective lifeworld (the world of people, objects, commitments, desires, fascinations and other-oriented sorrows). More clearly, according to Levinas, the pre-reflective lifeworld consists of a 'transcendence of need' based in the very essence of materiality, a sphere where the self disregards the burden of existence and the vacuity of time: "So in the very instant of the transcendence of need, placing the subject in front of nourishments, in front of the world as nourishment, this transcendence offers the subject a liberation from itself. The world offers the subject participation in existing in the form of enjoyment, and consequently permits it to exist at a distance from itself. The subject is absorbed in the object it absorbs, and nevertheless keeps a distance with regard to that object...It is not just the disappearance of the self, but the self-forgetfulness, as a first abnegation" (Levinas, 1989, 38-39). Here, unlike the Heideggarian analytic which places *Dasein's* relation (comportment) with tools and the ready-to-hand as prior to theory and praxis, Levinas claims that cathexis and absorption, *a la* enjoyment *(jouissance)* and nourishment in everyday existence are the prime antecedents to theory and praxis—it is through the forgetfulness that accompanies need and desire that the self becomes neglectful of the yoke of its own existence. In applying this sentiment to psychosis, one can see that the onset of the condition brings with it an unspeakable level of suffering and solitude. Psychosis, then, unalloyed by the forgetful, distracting substances (*plurality*) of the lifeworld, represents the highest purity (*singularity*, existential) of suffering. In concordance with the foresaid sentiments of Levinas, psychosis may be said to represent, metaphorically, an unrelenting, pulsing light that is cast on the forgetful, half-shadowed realm of the pre-reflective world, serving as an intense, almost "chimerical" (Levinas, 1989) suppressor of distances, where the self is condemned to confront itself without assistance provided by the 'shade' of residual *otherness*. Levinas adds, "While in moral pain one can preserve an attitude of dignity and compunction, and consequently already be free; physical suffering in all its degrees entails the impossibility of detaching oneself from the instant of *existence*. It is the very irremissibility of being. The content merges with the impossibility of detaching oneself from suffering...In suffering there is an absence of all refuge. It is the fact of being directly exposed to *being*...The whole acuity of suffering lies in this *impossibility of retreat*" (1989: 39, 40,

Case 1., an Anglophone patient residing in Montréal, states at the outset of the interview, "Well, I didn't really notice until it was too late. Basically I notice [*sic*] when I had trouble speaking and trouble thinking....things started happening in my life". The patient goes on to explain that shortly after having noticed that elements of his world were different, he received a disturbing telephone call from a friend:

> I was like (?) you know (?), he sounded scared, and he woke me up (?) and... hang up the phone, woke up the next morning, it seemed now everything was going crazy, you know, far as I can remember it, it seemed like the t.v. got... changed, you know, like, people on the news were more stressed or... shows, seemed to me like people on the news were more stressed or... shows, seemed to me like they were trying to convey a message...

The patient expands by stating,

> Like that morning after the phone call that I received, I started watching the t.v. and things were different in an instant, you know, the moment I woke up, the moment I looked at the t.v., it was like "instant change", it's like "snap!".

It is clear from this patient's narrative excerpt that the structure of his lifeworld transformed noticeably after he received the said telephone call from his friend. One can sense that he was experiencing feelings of anxiety, fear and confusion. It is readily apparent, too, that the patient, although confused and destabilized, was able to detect some form of transformation and drift from his previously unreflective, quotidian existence. Here, the meaning the patient imputed to the changes bears the stamp of feelings of persecution and intense trepidation. Case 1. states,

> ... look, at that point, I was so hyped up, like my shoulders were up to here—it was like... intense like, right, and at that point, I knew... absolutely, that there was something going on and... I also thought that, look, if I was to go to the hospital , it would be a safe place for me... I was just... like hyper stressed, you know, like looking at cars, I thought there was people in cars following us, just a bunch of craziness.

What becomes apparent in the passage above is that the patient is reconstructing an account of the salient transformations (objects, people, relations) in his pre-reflective world. From a traditional psychiatric perspective, one may say that the patient's judgment was clouded as a

---

emphasis mine). Thus, in its persistence and disruption, the onset of psychosis generates something of an ontological 'vacuum' where the self is condemned to confront itself in the nakedness and purity of raw existence—characterized by the enveloping swell of anonymity of Levinas' ontological theme of the *there is*. Returning to Hamlet's famous utterance 'to be or not to be' (which connotes pure possibility, in either direction), one can see that in psychosis, as illustrated in the foresaid description, the self is given no such choice—it simply *is* in the coldness and singularity of alienation.

result of the construction and maintenance (stereotypy[2]) of a delusional framework, or as a result of paranoid and persecutory ideation. From a phenomenological perspective, it can be understood that the patient was cognizant that there was a qualitative alteration of his day to day lived experience, a noticeable 'break' with his existing relation to the world and to others around him[3].

We can see, according to the mother of Case 1., that the first behavioural changes she detected in her son followed the death of her husband. She states, "he was always very quiet and I guess, after my husband died... he came to me and told me that he heard voices". In another response, she states,

> [he was just thinking] more and more that the FBI were after him, the CIA was after him, he couldn't go outside without thinking somebody was watching him; he would be watching television, like he watched [the news] all the time, he felt that they would keep putting his name on the broadcast...

The mother expands,

> Yes, yes, and plus, I didn't see... you know, I mean now I know what's going on, you can that kind of [*sic*]... you know, shows me that and... this type of thing. He was... the self-esteem was not there, looking back and this type of thing, whereas now it's much better.

It is here where we can see the beginning of the construction of insight: First, the patient detects, owing to the presence of an underlying abnormality, a change or transformation in his lifeworld. Second, the resonation of these changes (manifested by a marked change in disposition or behaviour) was witnessed and experienced by the significant actors within the patient's social sphere—in this instance, the patient's mother. As such, the mother, after having detected a change in her son's disposition and relation to the outside world (through repeated observations and dialogic interactions) came to the realization that there was something wrong with her son, something that was in dire need of explanation.

---

[2] Excessive repetition or lack of variation of ideas or patterns of speech, especially when viewed as a symptom of schizophrenia.

[3] This is somewhat reminiscent of Binswanger's concept of 'disequilibrium' of man/woman's anthropological proportion. Binswanger claimed that man/woman's anthropological proportion was specified by a vertical axis: that which corresponds to self-realization and to the actuality of *Dasein* in psychological and empirical terms, and a horizontal axis: that which corresponds to being-with-the-other. Man/woman's *verstiegenheit* (eccentricity) results in a marked disproportion of the dialectical relation between self-fulfillment (existential height, moving upwards to reach one's ownmost possibility [*Eigentlichkeit*]) and world-fulfillment (existential breadth, moving outwards to reach more developed relations with others), a disproportion which ultimately leads to what Binswanger termed a 'miscarried *Dasein*'. (Blankenburg, 1990: 40).

In a much different tone, Case 2., a patient from Bangladesh now residing in Montréal, states that the first changes she remembers were centered in her mind. Speaking about the way she felt upon first noticing that something had changed, the interpreter, speaking for the patient states that "she got (sick?). She was feeling at that time bad and...she doesn't know...bad things, bad feelings. She got sick, she had feelings in her mind, in her head, and it was bad, no good". When asked to describe these bad feelings, the patient adds that "[it was] like there is a person in my brain and I had too much pain". In this instance, as outlined in the previous case, we can see that the patient experienced marked changes in her relation both to the external world and to herself.

Themes in this patient's narrative which indicate a major shift or alteration in the pre-reflective lifeworld consist of troubles eating, sleeping, and feeling "pressure in her mind". She claims that, although her relations with family members and her husband have not changed negatively, she still feels that she was suffering terribly as she was not able to live how she used to. We are able to see that the woman is cognizant of a change in her overall atmospheric quality of life, as she imputes her loss of appetite and insomnia to a basic decline in overall health.

The patient's husband recalls the first change he noticed in his wife's behaviour occurred when she started to speak to herself when alone. He states that "things...that time she thinks too much and talks sometimes alone, alone and bad situation...". The patient, echoing her husband's observations, describes via the interpreter that "[she was] talking alone. She was talking alone. And my health is not good". Due to the relative scarcity of descriptive excerpts from this patient's narrative, we can only infer from this point that the suite of qualitative changes alluded to—those being pain, distress, loss of appetite, insomnia, thinking too much and talking alone—represented a significant rupture within the lifeworld, forcing the patient to modify or completely abandon certain previously taken for granted quotidian routines. When describing how pervasive the changes were, the patient explains that she had to abandon certain activities such as clothing design and house cleaning. Case 2., through her interpreter, explains that, at the beginning of the changes, she had started to design and knit *saris* to lessen the difficulties she was experiencing by engaging in a creative activity. As time passed, she explains that she had to curtail her clothing design because it was becoming too difficult for her to concentrate. The interpreter states that the patient had

to partake in "less activities... [when]... she's having the problem (?). It's not good, not good, she stopped".

Describing the maladaptive changes precipitated by the onset of psychosis, Case 2. explains that along with her creative activities, she could not partake in the household chores that she had participated in prior to her condition. She describes via her interpreter, "that time, she could not (understand?) things, but slow, she was slow, he [husband] was helping to do and... but, she says she wasn't able to cook".

Case 2.'s husband explains that at one point he had to leave her alone for one month so he could attend his sister-in-law's mother's funeral. The husband claims that upon returning, he noticed that the stove had caught fire. The husband describes,

> ... open fire... (?), one month, my sister-in-law... when was this... her mother died, one months, two months alone, one months I be in my work place and I... one months, my brother, I (?) my brother (home?) to live and my work finish, I bring him back home.

Speaking on behalf of the husband, the interpreter adds, "He explain that at that time she had problem in cooking because sometimes she turned... she forgot to turn the oven off...".
It is apparent in the foresaid excerpt that the husband was quick to detect the alterations in his wife's behaviour—in this case her forgetfulness, something she may have not realized right away herself. In this case we can see that daily routines—such as cooking—that would have otherwise been taken for granted, turn into potentially hazardous accidents. Again, instances such as those evidenced by the patient, indicate a profound alteration of the lifeworld however inchoate or inexplicable.

Moving on to Case 3., a patient from Ghana now residing in Montréal, we can see a similar feeling of confusion and uncertainty about the initial changes he experienced as a result of his psychosis. When asked to describe what he felt when he first noticed something was wrong, he replies, "... when one of my brothers passed away then I started to have this problem over here [in Montréal], nightmares, I can't sleep and I am still having it". The patient goes on to describe his initial experiences: "[it] is the nightmare and the voices... in the night! That's what I remember. I was having big problem...".

He explains further,

> This is... Not all of it, but it [*sic*] scary! It's like they whisper, they say they are coming, they are coming, they have swords... and you see them flying, like they are coming to attack you like... I see different, different, different things. Some of them

> I see lot of snakes! Snakes! I am laying in this earth and the snakes...some of them I see like a layout coming and attack me. And I tried to escape.

When asked about the context in which these nightmares were occurring, the patient responds by stating, "During the day sometime it happened...and sometimes I felt. When it happened like nobody...I am gone fell on the floor, I am gone be shaking, shaking, shaking...".

In this patient's case, we see that he uses the term 'nightmare' to describe the state and quality of the changes he was undergoing at the onset of his psychosis. Whether hallucinations and/or delusions, the patient glosses these distinctions by explaining that the quality of his sleep was compromised by invasive images and voices, and that he was unable to seek respite from their persistence.

In another section of the interview, the patient explains in a reflective tone that he was able to detect his current behaviour, modified as a result of the onset of psychosis, deviated radically from his normal or previous relation to world and others around him. He explains, "sometime I do something! I do stupid thing! That I don't know! You know... because...Hey, Yesterday, like this, this guy my friend (?) eh said: "Ah, X.! Why are you acting like a child? Now right there I wake up".

In another passage, the patient explains that he cannot account for the reasons/motivations behind his behaviour as they defy categorical reasoning, and are resistant to any form of concrete explanation. He states, "Yes, I did...lot of things! This stuff I am telling you! It is the stuff when they...When it is like...I am doing it then I realize "Hey!" That's why I don't know why I have done that".

A member of case 3.'s social entourage (a consociate) states that he noticed a marked shift in case 3.'s behaviour shortly after the death of Case 3.'s brother. He recounts,

> Well...he is always very...easy going, easy...very happy, smiling and things like that...and when his brother died and he started to talk, the strange [*sic*] that...he started mentioning...there is voices...being kept up at night...he started talking about peoples coming after him.

He goes on to describe that he noticed not only psychological changes, but also physical changes. When asked to describe these changes, Case 3.'s consociate states:

> Differences...(inaudible) his hair [sic] very long he used to keep it nice and short. And I said: "Hey! What happening with you there you know, you stopped taking care of yourself? (laughter)", but not much no. It is very difficult because I see once and a while you know. But...definitely the initial change is the staggering

and the...you know and his catatonic behaviour...so definitely there.

Such statements reveal that a sudden shift or rupture occurred within the patient's immediate lifeworld. The rupture, for Case 3., as well as for the other featured cases, precipitated a hemorrhaging effect in the social dynamic between patient and the immediate members of the patient's social entourage—as a corollary, the members of the patients' social entourage were able to experience the resonations concomitant with the alteration and re-structuring of the patients' lifeworld.

As for the unifying theme among the featured cases, the patient often feels a sense of helplessness and loss of control in the face of the ontological modifications precipitated by the onset of psychosis. Apropos of the multilayered self model mentioned in chapter three, we can see that, as evidenced in Cases 1. and 2., Case 3. is also able to enjoy a relative degree of self-reflexivity—a stance that grants him the ability to detect, albeit not fully comprehend, a deviation from the normal atmospheric quality of his lifeworld. When approached from a phenomenological perspective, it becomes apparent that—when understood according to this patient's subjective frame of reference—he is able to locate and explain, as a temporally isolable event, the point at which his behaviour underwent a drastic shift from a state of intelligibility to a state of non-intelligibility. It appears here as though there are layers of the self, such as traces of biographical memory, that are recalcitrant in the face of mentally destabilizing psychopathology. In the next narrative excerpt, we are given the sense that, although Case 3. is aware of ego-dystonic[4] modifications in his daily routine, there remains a subjective standard of normalcy (accessed via biographical memory) against which he is able to measure his current behaviour. He describes:

> I want...with the medication sometimes it helps me, sometime it doesn't help me. I want go back to when I came to Canada first, I was...I want that brain to...working normally like then. I was doing everything. Right now, sometime I sit here and I pick a knife and stand outside and...because you know...this is not normal...I don't want do stuff like this, I need help.

In another statement echoing the excerpt above, Case 3. intimates pulses of awareness of the modifications in his behaviour where he is able to formulate a value judgment (based on his own, subjective frame of reference), deeming his current behaviour in need of a change of state or a reversion to a previous, normal level of functioning. Says Case 3,

[4] What I mean by this term is behaviour which is at variance with the aims of the ego and related psychological needs of the individual.

> Yes, sometime I feel like it... But you see... what the thing is doing to me, when it started... it started... I don't talk to nobody, I don't talk to nobody. I just do what the thing told me to do. But sometime I tried to calm myself. You know it (inaudible 8.3) then my mind will come back then I realize that "Hey! What I am [*sic*] doing this is not good?" I have to stop this.

This excerpt indicates that patient is sentient that his psychosis is having a systemically negative effect on his daily functioning, yet he leaves open a space where normalcy is a certain possibility by externalizing and objectifying his illness and referring to it as a 'thing[5]'.

The next section deals with the modes which the patient and his/her social entourage incorporate the illness event within a fluid and provisional system of meanings and explanations: we will see how the second stage of insight configuration (causal attribution) is based upon dialogic relations rooted in significant *historical* (diachrony) interactions and events—the narrated products of which are recounted in the immediacy (synchrony) of the clinical encounter and woven into a subjunctive, albeit meaningful, insightful account.

Causal Attribution: Imputing Meaning to the Experience of Psychosis

Following the destabilizing effects that accompany the onset of psychosis, both patient and social entourage feel left in a void of confusion and anxiety. Consequently, it becomes vital for the patient and social entourage to search for and tender meaningful and valid explanations of the illness event: attributions[6] in this sense are sought so as to confer

---

[5] As a brief aside, we can see that the patient is instantiating his own condition as an 'it', as a separate, external entity or 'thing'. Through this process of externalization, it seems that the patient is able to attain a level of comprehension of the modifications/alterations concomitant with the onset of psychosis. By approaching psychosis as a phenomenon 'that happens' from the outside or something that forces one to do something or to act a certain way, it seems that the Case 3. is sometimes able to maintain a more hopeful stance regarding the cause, course and prognosis of his illness—since its influence on the mind is possible to recognize and stop. It may be said that to some patients, psychosis signifies a weakness, a moral dint to the self that one must 'beat' or 'suppress' by way of inner strength or other intra-psychic means. For an interesting discussion of selfhood and self-conception in light of the diagnosis of schizophrenia, see Estroff (1989).

[6] Here, attributions may be understood as part of Arthur Kleinman's (1980) notion of the explanatory model in that they consist of patients' understandings of the causes, symptoms and signs of the illness event. The exchange of practitioner, patient and family EM's may constitute a diverse set of illness beliefs and understandings. For instance, the patient might maintain one illness interpretation; the patient's family (who may or may not share the beliefs of the patient) might maintain another interpretation; and the practitioner may hold yet another, entirely different interpretation. In essence, we can see that each actor possesses diverse frames of reference from which to construct an EM, or as is sometimes the case, maintain several EM's at once. In this case, the patient or family member is constantly trying to seek a valid explanation to an ever-shifting and changing phenomenon that defies totalization. By maintaining several EM's at once, the patient or family member can maintain an open interpretive space marked by contingency or subjunctivity. Likewise, the physician's EM is configured by various factors such as medical knowledge acquired and favoured; previous

meaning and intelligibility, however instable, on the inchoate distress and confusion caused by the psychotic episode (Kirmayer *et al*, 1994). When constructing a viable, working meaning to assign to their illness, patients may sometimes act in the capacity of a *bricoleur*[7], drawing from various themes and symbolic/semantic systems within the patient's own local sphere and the greater cultural repertoire available to him/her. To illustrate how the patient and social entourage form a social dynamic through which meanings are sought, formulated and crystallized, I shall start with Case 1.

Case 1. seemingly attributes his psychosis directly to the possibility of drug abuse. We can see from his response to the interviewer that Case 1. attributes his psychotic behaviour to the fact that, at one point in his past, he abused drugs, such as marijuana, cocaine and alcohol. This excerpt, narrated in the subjunctive mode[8], illustrates that the patient is constantly in the midst of constructing a stable, workable story out of the sequence of disruptive experiences triggered by the onset of psychosis.

> ...I talked to Dr. M. and he told me that...probably due to smoking too much drugs, because, apparently...I think it's over 70% of all emergencies [*sic*] psychotic cases was due to common weed smoking and 30% of which wind up with schizophrenia, so I don't know if what I have is genetic or if it's due to smoking drugs. I don't know.

Case 1., describing the social and emotional antecedents to his abuse of drugs, states:

> ...basically, I started smoking pot when my dad got sick...it's...like I was

---

clinical cases encountered and the latent biases produced by them; and lastly, the physician's own personal experiences both in and outside the clinic. These features can include personal disposition, social/economic background, upbringing, *et cetera* (Kleinman, 1980). Like patients' whose EM's are the narrative products of circumstantial factors of ethnic origin, lifestyle, clinical anamnesis, and personal history (Martínez-Hernáez, 2000), physicians' modes of explanation, too, are based on experiences and knowledge which transcend the limits of medical epistemology. Due to constrictions of space, I can only centre on the social dynamic between the patient and the patient's social entourage.

[7] The term *Bricoleur* refers to the particular modes in which patients utilize cultural repertoire (Corin, personal communication, 2002). For the psychotic patient, object cathexes may be severed or distorted and perhaps only a few meaningful fragments remain from the pre-psychotic experience: a few memories, names, sounds, or some objects that retain a certain element of propinquity with a world since left behind. The interpretation of experience in the capacity of insight and the available semantic frameworks from which to work from are, for the patient diagnosed with psychosis, often highly incommensurate. Inasmuch as psychosis is a destabilizing experience, the cultural-symbolic frameworks the patient must navigate, negotiate and appropriate in order to make these destabilizations of self coherent, are interpreted in an inconsistent and sometimes illogical manner.

[8] Subjunctivization or the subjunctive mode refers to the manner in which patients and their families maintain multiple and sometimes disparate idioms of reference, all of which represent aspects of the patient's illness experience, and the possibility of multiple readings and interpretations of what happened. According to Bruner (1986), the subjunctive mode within a narrative refers to the way in which a text stimulates a readers' entry into the subjunctive world of the actors involved in the narrative; how the text draws the reader into the diverse and potentially conflicting perspectives of the actors and the interpretation of experience. From this perspective, illness narratives often incorporate multiple lines of evidence and multiple interpretive accounts simply because they maintain the essence of 'subjunctivity' and a potential openness to change (Good, 1994).

> smoking a lot, and I wind up smoking so much drugs in the first little while that I started selling drugs to pay for it and then I started getting good at that, so... I was smoking even more, like some nights I would smoke like 12 grams of weed, Which is obviously too much.

Introducing Good's (1994) concept of the semantic network[9], we can see how Case 1. was able to arrive at his conclusion that it was the abuse of drugs that led to the onset of his psychotic episode. By taking into account the fluid and multiple perspectives of the various actors involved in Case 1's social sphere, we can understand how various perspectives—whether conflicting or non-conflicting—are synthesized and crystallized into an object of personal and social awareness (Good, 1994), or in this case, insight as self-knowledge.

When asked about the potential causal factors involved in her son's illness, Case 1.'s mother states:

> And my understanding of his problem is, that it usually occurs in young adults where there is a death or a tragedy within the family... type of thing. And he had also experimented with drugs, so... yes, earlier from what I understand, I mean... marijuana, I mean, everyone tries that at some point, but he did try some... starts with an E, he tried it and it really messed him up and I think that's another factor that (?).

We can see here, and in other segments throughout the patient's and mother's interview, that the theme of drug abuse was quite prevalent. We can also see that this theme took on such salience that it was able to weave its way into the narrative of Case 1. It becomes clear that Case 1. was able to arrive at the conclusion that drug abuse played a causal role in his illness in that two of the major sources of meaning in his social sphere at the time of his illness, i.e. his mother and his psychiatrist, were able to provide and buttress such a causal possibility.

The major dialogic sources in Case 1.'s lifeworld (mother and psychiatrist) served as separate points of inflection against which the intersubjective, socio-cultural, and epistemic foundations of Case 1.'s insight as self-knowledge were based. Thus, whether through overt references to the connection between drug abuse and psychosis, between mother and physician, latent references mentioned in passing with friends, or the navigation through the available symbolic order (culture), we can see how such a theme such as drug use can assume importance as an attribution for the patient. As well, we must take into account the

[9] According to Good, "Semantic network analysis was thus developed as a means for analyzing illness as a 'network of perspectives' and a 'product of interconnections', as a form of synthesis that condenses multiple and often conflicting social and semantic domains to produce 'the meaning' of a complaint or an illness" (1994: 172).

possibility of the 'folk conception' of the consequences of drug abuse in North American society: according to this conception, if one uses so-called recreational (marijuana, LSD) drugs for a prolonged period of time, it is usually understood that that person may get 'burned out', have a 'bad-trip', or 'go insane'. If we can take this into account, it becomes apparent that the semantic network involved in the construction of Case 1.'s attribution involves a dialogic interface between the major actors within his social sphere and possibly some commonly held cultural stereotypes about drug abuse.

Although the interview excerpts are scant for Case 2. we can see that this patient currently attributes her psychotic illness to an argument she had had with her brother-in-law. The translator for Case 2. states: "His [husband's] brother... comes sometimes and they talk and... some (he starts to make?) misbehaviour and (?). Complicated (situation?)". When asked what happened after this interaction with her brother-in-law, Case 2.'s translator explains:

> something bad, (feeling?) (?) inside (me?)?...She was feeling at that time bad and... she doesn't know... bad things, bad feelings. She got sick, she had some feelings in her mind, in her head, and it was bad, no good... she was talking alone. (?) bad feelings.

In another segment of the interview Case 2. states, via her interpreter, that her troubles are caused by two arguments she had gotten into in her past: the first with school boys in college, the second with her brother. Case 2., through her interpreter, states:

> She was bothered by the small boys, like (?), they did some times excessive, too much, you know, and that time, whenever she had that type of problem, she got sick. And she wanted to know that from Dr. R., why... what is the reason why she get... she got sick at this time.

When asked why exactly she thinks this is so, the patient responds through her interpreter that her illness is due to "foolishness and weakness... physically, physical weakness... mental weakness".

Since the husband's narrative excerpts are quite scarce throughout interview, it is difficult to deduce what role he played in the configuration of his wife's illness attribution. One can surmise that he was agreeing with her and her extended family that she was of weak physical and mental constitution; as such, the opinions of her husband and extended family must have acted as a coercive force on her interpretation that her weakness played a major causal role in her illness.

Regarding Case 2.'s attribution of her illness to the argument with her brother-in-law, we can see that there are some conflicting perspectives regarding the legitimacy of this claim. Case 2.'s husband states that both he and his brother-in-law and sister-in-law think that the argument played no role in his wife's illness. The husband, through the translator states,

> ...because (?) understanding, my sister-in-law she says: 'she's okay, no problem'. Let's live together me, now have [*sic*] feelings problem. And my other brother live together, they're going to (fix?) the problem. Other sister-in-law, my sister-in-law, my brother's wife, and...my brother's think she's okay.

In another segment of the interview, it becomes apparent that the husband and some members of Case 2.'s extended family do not even believe that she is ill. Her husband's explanation is that his wife is just physically and mentally weak, and because of this she is prone to making mistakes. One must also take into account the traditional familial dynamic between husband and wife in Bangladesh. As Guzder and Krishna (1991) state, the relationship between men and women is framed by a rigid cultural paradigm that idealizes the mythic role of the feminine, a role that devalues and demotes the position of women in the familial context.[10] As such, maternal figures are prototypically viewed as devoted to the religious-mythical order, constantly fearful of patriarchal authority, actively working to maintain family boundaries of purity against symbolically polluting elements. For Case 2., it seems that her husband is actively maintaining a suppressive stance against any counter-authoritative interpretation his wife may hold. The socio-political motive embedded in this tendency of the husband to override his wife's interpretations is to maintain the Dharmic[11] principle of family order. This leads to a conflict of interpretation, an instance where the

---

[10] According to traditional Indian (Hindu) narratives, the central matriarchal mythology centers on a central, powerful maternal goddess referred to as Shakti, Mahadevi, Paravati, Durga, Kali or Mahakali (Guzder and Krishna, 1991: 259). The power that these symbolic entities evince stands in sharp contrast to the more prosaic, daily Hindu social reality where women are often precariously positioned in social webs dominated by their male counterparts. In traditional cases, from childhood on, females are subordinated to their male siblings (ibid). As such, traditional Bangladeshi culture is based on stable social hierarchies and family cohesion based on socio-historic and cultural norms. These cultural ideals reinforce a feminine identity which is subservient to male presence and must serve family and social ends. As a result, women are understood to maintain the purity of generational blood lines through their role as mother/wife of the household—this sentiment is expressed in the saying, *grahini graham uchyate* ('the housewife is the house personified') (Guzder and Krishna, 1991: 260).

[11] Dharma is the central Hindu concept meaning 'law' or 'a sense of moral duty' (Guzder and Krishna, 1991: 293). In the case featured above, the husband was actively suppressing his wife's counter-authoritative illness interpretation, *viz.* that it was an argument with her brother-in-law that was the direct cause of her illness. In this instance, the husband's objective was to protect family order and cohesion (through the maintenance of solid family relationships) at all costs, even at his wife's expense.

two social actors are talking at cross purposes. Here we can see that the husband is attempting to minimize the fact that there was a conflict with a male relative toward whom Case 2. owed deference and respect.

Here we can see an example of the conflict of multiple voices, or what the Russian literary critic, Mikhail Bakhtin (1981), refers to as 'polyphony[12]', the dialogic interplay between a multiplicity of voices in a text or narrative. In this narrative, we can see that Case 2. and her husband (and extended family) hold different, conflicting understandings of the cause of Case 2.'s strange behaviour. Case 2.'s husband seems to be resisting the idea that his wife has a psychotic illness, and as such, attributes her 'mistakes' to weak mental and physical constitution. In this sense, Case 2's narrative, like the other case studies, is unfinished and open ended: due to the different positions the members of her family have taken regarding the cause of her strange behaviour, it seems any final attributions must be held in abeyance so to keep open possibilities of resolution.

Near the close of the interview, Case 2. appears steadfast in her stance that the cause of her illness is the argument with her brother. Her interpreter comments on her behalf and states: "She asked her brother-in-law... not to go bothering (her?), you know, but he didn't do". She adds that Case 2. would "like to... feel light inside, she could ask like some... to ask so that she is treated nicely, being treated nicely". The fact that Case 2. attributes past arguments to the cause of her condition reveals that she is possibly associating social and familial conflicts (arguments with boys from school and her brother-in-law) with a putative inability to remain mentally and physically strong. Since it is her husband, and possibly other members of her family, who are telling her through repeated interactions that she is weak and foolish, it seems likely that Case 2. would associate inner distress and confusion with an inability to save face or maintain composure in the event of a domestic dispute.

The semantic network for Case 3. consisted of interactions with the ethno-psychiatrist, friends and co-workers. When asked what his co-workers thought of his behaviour at work, Case 3. explains:

---

[12] According to Bakhtin, polyphony (*полифония*) refers to "several contesting voices representing a variety of ideological positions [that] can engage equally in dialogue, free from authorial judgment or constraint" (Paryas, 1993: 610). In this case, each actor speaks with his/her own voice, i.e., Case 2. and her husband, yet the conversation between interviewer and patient/family member must be understood as not only an exchange between just two interlocutors, but, on behalf of the patient/husband, a conversation with a *multiplicity* of the sometimes muffled antiphony of voices rooted in personal, historical experience, which are then narrated in the immediacy of the clinical context (Kirmayer, 2000: 169).

> Oh!...I think... when my friend makes me realize that something is not right! Then I go to work... I don't see... I see people like... (inaudible 29.5) and what I am doing, me, myself I do the thing, then I wake up and I say "Hey!" And I started having problem with supervisor, I am not good and then right! Then I realized something is wrong... They know!...They keep asking me: "X.! What's the matter?" I am gone sit over there and they... sometime they say things to me I don't realize it... they say I sit down... I can sit down and I start laughing! Laughing loud! Then sometime I start clapping my hands... and probably like I am mad.

It becomes apparent that the members of Case 3's social entourage (consociates, co-workers) were able to provide him with the reflexive incentive to realize that something was different about his behaviour. Again, it is in such an instance where we can see the beginnings of the construction and configuration of insight: observations of and dialogic interactions with significant actors in the lifeworld, which provide, in this case specifically, an observational standard for error-checking of cognitive, ideational and behavioural idiosyncrasies.

In terms of causal attribution, Case 3. claims it was the death of his parents and brother and the social/economic climate in which these deaths occurred, that was the cause of his illness. Case 3. explains:

> And my family passed away first and then later I come here [Montréal] then my older brother too died. That's why I started having this problem.... Yes. And like ...the mental... I was physically... everything was ok for me before. Yes, before and when I came to Montréal I was ok, but one of my brothers passed away then I started to have this problem over here, nightmares, I can't sleep and I am still having it.

Speaking of the current political climate of his country or origin, Case 3. explains that his family was involved in some form of socio-political entanglement, and that his family had been murdered as a consequence of this state of affairs. When asked how he thought this contributed to the cause of his illness and what he thought was the apparent cause of his illness, Case 3. responds:

> Me I think it is because of my family. Because this peoples... me I believe they killed my brother too. They... can put something like powder on the floor, you walk on it, it is over! That's why I believe they did that to my brother. And if they can find me they would do anything... like they spell something on me to make me mad, no more person any more, like... walking... That's what they did... I believe they did that to me.

In this instance we can see that the patient is drawing upon symbols specific to Ghanaian culture to explain certain events for weaving together incidents constituting the context

wherein his problems began. We can also see that an excerpt taken from another point in the interview reveals that Case 3. had brief interactions with a Haitian ethno-psychiatrist. In response to a question asking what the foresaid psychiatrist thought of his illness, Case 3. responds: "...he said: 'this is spell...this is not good...for this boy is not...they did something Vaudoo [*sic*] on him'". A member of Case 3.'s social entourage states, in corroboration:

> I think he has the ethno-psychiatrist which is good to. I think who happens if I not mistaking to be Haitian and who comes from a country that vaudoo is part very much...I think if you are going to meet something like that, somebody who comes from some African country and you [*sic*] discussing vaudoo, I think you definitely need to have someone who knows all the culture definitely.

For Case 3., the dominant theme found throughout his interview pertains to thaumaturgical (magical) elements such as spells and voodoo. This dominant theme seems to be the product of the interweaving of seemingly different causal mechanisms: 1) the death of Case 3.'s family and 2) the casting of spells from a magical agent. Case 3., as evinced throughout his narrative, relates the onset of his illness to the totality of events following the death of his family. In this case, the different causal agents alluded to in Case 3.'s narrative are closely associated with one another. Case 3.'s illness interpretation incorporates the melding of *prima facie* unconnected causal mechanisms (death of family and subsequent casting of spells) into a subjectively coherent causal framework based on the unfolding of harmful events in close propinquity—particular to the traditional African world-view[13] (Corin: 2003, personal communication). Case 3. confirms this by mentioning that he was able to meet with an ethno-psychiatrist from Haiti who understood the causal role of the thaumaturgical, i.e. voodoo, magic and spells. One may speculate that the dominance of the magical theme was substantiated and buttressed after the dialogic interaction with the ethno-psychiatrist.

The next and final section deals with the ways in which the patients and members of the patients' social entourage manage to situate the illness into a meta or global semantic frame. By situating potential reasons for the cause of the illness within a more global, inclusive semantic frame of meaning (as opposed to the immediate frames in which causal

[13] Unlike explanations of causality in the West which stress the purely contingent or aleatoric nature of events, Case 3.'s explanation (particular to most traditional African cultures which usually lack a sense of pure chance) stresses the interconnection of potentially harmful social events and the precipitative role that these events may play, especially regarding the onset of illness (cf. Lienhardt, 1964 on the role of witchcraft, sorcery and magic in some African cultures).

attributions are made), patients and their family members seek to find tentative answers to the *larger*, more *generalized* questions which follow the illness event. Examples of such questions patients and family members are desperate to have answered are, 'what did I do to bring such tragedy upon myself'? 'Can I attribute this illness to a series of poor choices or wrong directions in my life'? Or, 'What exactly were the social, economic or political conditions that lead up to our son/daughter's illness, was there something we could have done to have prevented such a thing from happening—will this thing ever go away'? We can see that after patients and their family members have attributed the illness to a provisional cause, the next stage of meaning ascription seeks to focus on finding answers to the conditions leading up to the illness by drawing upon larger themes, such as morality, religion, personal worth, ability, strength and self-affliction. I now turn to the last section of the featured case studies.

Global Construction of Meaning: Situating Illness within a Greater Semantic Frame

Starting again with Case 1., it seems that the dominant themes attributed to the reason behind his illness lay in the recent loss of his father, a dashed romance, drug use, and a disintegrating familial structure. Near the beginning of the interview, the patient speaks of a recent break up with his live-in girlfriend; his inability to get along with his younger brother, and his turning to drugs as a coping mechanism to help ease the reality of his father's ensuing death. The patient talks about the pressure, sadness and anxiety he experienced following the death of his father who had suffered from chronic diabetes. Case 1. also explains that his father was in a rapidly declining state of health during the prodromal stages of his illness. The patient also explains that, following his father's death, he turned to small scale crime in order to distract himself from the sadness of his father's passing. The patient, in response to a question regarding the period of time he first started to notice profound changes in himself, states:

> ...my dad was...his health was failing, he was dying. So...I had a lot of things happening at that time, you know, it was love, it was trauma, it was drugs, it was me and my brother with...we were really not getting along.

He goes on to explain,

> I was going to the bar quite a lot, drinking quite a lot, doing quite a bit of drugs and...things started happening in myself. I met the girlfriend that I [*sic*] living with previously,...and then we split up...and that's when I started taking speed,

> and... I took maybe 3 or 4 pills of speed, like one or two every week for two consecutive weeks with alcohol and smoking a bunch of pot... I was getting into crime and stupid things like that, and it was just... my whole life was getting more and more complicated by the day, you know.

In a latter section of the interview, the patient reconstructs an account of the global context in which his illness occurred such that, by way of drawing upon cultural conceptions and stereotypes of youth culture, social pressures, and drugs abuse, he understands his experiences as a *chaîne opératoire* that culminated in the onset of psychosis. Case 1. explains:

> I don't know, it's like... it was... from the time when my dad got sick to about a year ago, not even, 6 or 7 months ago, it was like a movie, it was like something that was not out of a reality that I had known in my entire life, from when I was a kid up until when it started happening, you know. But... if you take a look at the perspective of young people in the culture of our society, and you look at what they've been exposed to, in a way like media and peer pressure, it like, it was bound to happen, you know. So, if you want to know... I can't say what to do, but... I can say, you know, there's a lot that needs to be... no necessarily fixed, but changed in a little bit [*sic*] (respected?) you know.

Drawing upon much of the same themes alluded to in the forementioned excerpt, the mother of Case 1. states, "I felt he was withdrawing more probably because of the loss of his father, he had to go through a lot with H. too because he was home with H. at this time". When asked if she had any theories regarding one of the potential causes of her son's illness, she states, "again, I attributed most of it, I think, to my husband's death and the ordeals that we had gone through as a family". She expands,

> So, I think everything came to a heads because... and it probably was the best thing [son's hospitalization] that happened because then we knew (like to get him out?). Like this didn't happen over night type of thing, it... happened over a period of time and... they brought it to a (halt?) so that we could get the help that he needed.

With empathic understanding, we can see that this patient and his family experienced a harrowing ordeal through the chronic illness and subsequent death of the father. Insofar as this was a highly traumatic and recent event in relation to the onset of the illness event, it appears—by using the patient and the family as a subjective frame of reference—quite logical that the family would impute Case 1.'s psychosis to the emotional exigencies and suffering associated with this period.

Case 2., drawing upon moral themes, explains that her illness is the result of physical and mental weakness. We can see in her narrative excerpts that she directly correlates the distress caused by her illness to moral flaws in her disposition and sense of self. She explains through her interpreter:

> I feel that I'm a good girl and because of my foolishness, my disease has increased because of my foolishness. This is why I was like an idiot, foolish, that is why I have got this disease, otherwise I'm a good girl.

The interpreter expands,

> She says that she said like foolishness, she's (Bengali...), that means now she's telling my foolishness or my weakness. Part of my weakness, according to her husband, she says she's a good girl, she talks to everybody, other men or women, it doesn't matter, but inside she's good, that's why she talks...with her...in front of her, but other people, they take the (?), they misunderstand her and they (heated?) the problem...Yes, like too much...simplicity, open (like door?), simple minded, but she says, too much (maybe?) and people misunderstand me, I talk and...you understand?

It becomes apparent throughout the interview that Case 2.'s husband agrees with his wife's attribution: that she is weak and that she is too open and talks too much to other people. We can see that the cultural matrix in which these actors are set plays a major constitutive role in the configuration of insight. In this instance, by apparently 'talking too much' to people she does not know, Case 2. (according to the content of some of her husband's narrative excerpts) seems to be breaching implicit cultural limits and norms regarding proper Bengali social comportment. The individual actors within the patient's lifeworld, i.e., husband, and members of her extended family, serve as salient intersubjective and dialogical points of inflection from which the major social, cultural and epistemic correlates of self-knowledge may be refracted, and thus synthesized and crystallized at the local level within the patient. More clearly, it is Case 2.'s husband and extended family that provide her with the epistemic data issued, via dialogic interactions, used (in a latent or non-reflexive sense) to formulate the understanding that her mistakes (talking too much) and suffering (troubles eating, sleeping, and pressures within the brain), must be attributed *not* to an illness and *not* to emotionally disruptive arguments, but to some sort of *flaw* in her moral constitution—again, an instance of polyphony within the illness narrative where multiple voices hold contradictory views about the putative *proper* attribution (relative to whose voice is apparently more dominant) to the illness event. We can see that the perspectival

concordance and/or dissonance of the views maintained between the patient and family members plays a salient role in the economy of attributions and, thus, remains the basis for subjunctivity in illness narratives.

In response to her husband's opinion, Case 2., in some of her responses to the interviewer, attempts to qualify her actions and strange behaviour by making such statements as, 'otherwise I'm a good girl', or 'but inside she's good'. Here we can see that she is qualifying her position in the family, explaining that, from her perspective, she is suffering from troubled social relations with her brother-in-law. Thus, for Case 2., we can see that the co-mingling of narrative threads (the patient's, her husbands, and family member's) constitute a 'pending' narrative where no one opinion or account takes precedence. Regarding insight, we can observe the narrative threads woven by each of the actors into the greater narrative (which situates the reason for the illness within a greater semantic frame) is still in process. Although Case 2. believes firmly that her illness is the result of physical and mental weakness, we see that the denouement of her story remains open-ended due to the subjunctive nature and *unfinalizability*[14] of her multi-vocal narrative.

For Case 3., we can understand that the global frame in which he situates the meaning of his illness lies in the events following the deaths of his mother, father and brother. From the interview, we can gather that Case 3.'s mother, father and brother were involved in some form of socio-political entanglement where they were killed as a result. Case 3. clearly attributes his illness to the entanglements his family were involved in. Says Case 3.:

> Ya and they know it is from my family, they will know why right away. they will know. But I don't (inaudible 27.8) because what my family did, sometime I believe it, sometime I don't believe it. So it is like what goes around comes around. I think [I am] the one taking the punishment for them, because what they did...

In various segments throughout his interview, Case 3. claimed that someone had cast spells on him as an act of retribution for his family's actions. When asked if he believed that someone put a spell on him, Case 3. responds, "exactly, me I believe what they did to me it cannot never touch me too much in here [Montréal]. I can... but if I am down there [Ghana],

[14] The term unfinalizability (*законченность*) comes from Bakhtin (1984). This rather clumsy term connotes the impossibility to 'sum up' or, in my own words, echoing those of Levinas, 'totalize' an individual via dialogue. Here, a person *qua* interlocutor (and the stories they tell) can never be finalized or totalized as the very nature of dialogicity, according to Bakhtin, is open-ended and indeterminate.

I won't be like this, I will be like... walking in the street mad...". We can see Case 3.'s existence in Montréal provides him some protective distance and respite from the totality of events that unfolded in Ghana.

By the end of the interview, the interdigitation of causal themes becomes readily apparent. i.e. the fear of being caught by his family's murderous assailants and the fear of falling under the power of the putative spell cast upon him. As such, these two apparently distinct events are two facets of the same causal attribution—an attribution that explains his illness as part of a series of negative events involving his family. Case 3.'s consociate describes,

> I don't remember the order ok, but I do know his parents primarily passed away, his sister... I think he didn't know where she was or if she also passed away? His brother was involved in some sort of (inaudible 5.0). And he... if I remember correctly, I think he started to talk to me about how his parents died. His parents... were [of X origin]... He is from a family that was [X], and that he started to tell me that is... There is some kind of vaudoo [*sic*] or caiman involved in the way that they died and the reason they died.

Case 3.'s consociate elaborates,

> I am not... I am not sure if he... he said that this family was [X], and I think (inaudible 23.3) before and they had this caiman or whoever it is put a spell on them to become (inaudible 23.5) and then someone else put a spell on his family so that they could lose all the money... it is very complicated...

Acting in the capacity of *bricoleur*, Case 3. was able to draw upon symbolic elements from his culture of origin (voodoo, spells, themes of madness) in order to situate the symptoms of his illness within a subjectively meaningful frame. As stated in the previous section on causal attribution, the dialogic relation between Case 3. and his ethno-psychiatrist also played a determining role in confirming his own suspicions, inasmuch as Case 3. places direct emphasis upon the causal role of the thaumaturgical in the development of his illness. Taking these factors into account, we can surmise that there is a correlative relationship between two major traumatic events in Case 3.'s lifeworld: the death of his family, and the subsequent experience of distress, nightmares, and suicidal ideation. In one particular segment of the interview, Case 3. mentions that it was his uncle who had prompted him to leave Gahana immediately for Canada, to avoid any immediate danger to himself as a consequence of his family's socio-political entanglements. We can deduce that the interaction between the salience of cultural symbols (the role of the thaumaturgical), the

propinquity of devastating events (death of his family, the onset of psychosis), and the observations and relations with others (Haitian ethno-psychiatrist) may be understood as constitutive of Case 3.'s positioning of his illness within a global meaningful frame. For Case 3., it was the intersection of macro-social/cultural features (thaumaturgical symbols), micro-social features (dialogic interactions) and self-reflexivity that provided the template upon which he could construct and author a subjectively meaningful insightful account.

It now becomes possible to understand that the synthesis of the narrative content may be subsumed under the three stages of insight construction and configuration, 1) *Detection of alteration of lived experience*, 2) *Causal attribution*, and 3) *Global construction of meaning*. This yields, when viewed from a phenomenological perspective, a subjectively insightful account of the illness event. To recapitulate: the processual configuration of insight may be understood as a dialogic *event* consisting of two distinct points of juncture: 1) the synchronic, clinical context, and 2) the diachronic, retrodictive re-construction and authoring of significant events related to the onset of psychosis. The foresaid points of juncture may be described as such: First, the patient is interpellated by the interviewer within the clinical context. It is here where the patient, after taking up a subject position and having been called upon to recount his/her story, enters a mnemonic space where he/she may re-construct and author a meaningful account of his/her illness. It is at this juncture where the temporal tension arises between the *synchrony* (immediate dialogic interaction within the clinical context) and *diachrony* (recollection of dialogic interactions related to the illness event which occurs across time) of the construction and subsequent authoring of significant events from autobiographical memory, which are in turn issued forth and narrated in response to the interviewer's interpellation—all of which takes place within an immediate, synchronic face-to-face context.

The configuration of insight in psychosis may be said, then, to be wrought also from an ontological tension between two persons: the tension between one person confronting another person's inchoate and de-centered *otherness* produced by psychosis. As Levinas claims, applying this sentiment to the everyday, this tension is what characterizes the essence of metaphysics and thus must be understood as the *first* philosophy[15] (see Levinas, 1961; 1999), a philosophy of ethics based on the inherent asymmetry of the face-to-face *relation* where being *qua* being is understood to manifest itself in the transcendental dialogic

[15] Where priority is given to the exteriority of the other's *otherness*, not his/her *being*.

event. As Jopling (2000) maintains, the process of acquiring self-knowledge, or in this case, insight as self-knowledge, follows a triadic structure: it is for the self, of the self, and before the other. This process involves encountering the other person in a face-to-face dialogue that consists of injunction, attestation, and avowal: here, the self is carried "beyond its narrow first-personal boundaries, and beyond the naïve egoism that places it at the centre of the world, as the measure of all things" (Jopling, 2000: 166).

Chapter Five
Conclusion: Toward a Relational Ontology of Insight as Self-Knowledge in Psychosis

This thesis illustrates that the production of patients' insight is an inherently intersubjective and dialogic phenomenon based on the interaction between the patient, members of the patient's family/consociates, and the available symbolic media provided by each actor's autochthonous socio-cultural matrix. In the clinical context, I have illustrated that the production of insight occurs at two separate temporal points of juncture: a synchronic juncture where the patient is interpellated by the clinician and hence positioned as a speaking subject, and a diachronic juncture where the patient, as a result of having been called into a speaking position by the interviewer, constructs and authors a narrative account of significant events related to his/her psychotic experience—an achievement which occurs as a result of the opening of a mnemonic frame based on biographical memory. This second point of juncture was shown to consist of three distinct, but not necessarily mutually exclusive stages: *Detection of alteration of lived experience*, the patient's ability to sense a distinct change in the atmospheric quality in his/her lifeworld; *Causal attribution*, the patients' and family members' construction of a causal mechanism for the onset of psychosis; and *Global construction of meaning*, the patients' and family members' construction of a general framework of explanation emphasizing the overall reason for which the patient became ill. These stages were shown to form the intersubjective and dialogic basis for the construction and configuration of a subjectively meaningful account of insight. Each stage was shown to be an attempt by both patients and their family members/consociates to explore the meaning of the psychotic experience and situate it within a larger interpretive frame.

Regarding current diagnostic criteria used to diagnose severe mental illnesses such as psychosis, one can see both undeniable advantages and disadvantages. According to Andreasen (1997), diagnostic criteria improve reliability, provide a basis for cross-centre standardization nationally and internationally, improve clinical communication between health care workers and facilitate sounder research. Regarding the disadvantages of diagnostic criteria: they may provide a somewhat oversimplified and oftentimes incomplete view of the clinical picture, discourage clinical sensitivity to individual patients and thorough and complete anamnesis. As Andreasen states, the inflexible adherence to diagnostic criteria could make students and even health care professionals believe that "knowing the criteria is enough which may lead to a tendency to reify an argument that was

only intended to be provisional, and discourage creative or innovative thinking about the psychological and neural mechanisms of schizophrenia" (1997:108).

With regard to the construction and configuration of insight illustrated in this thesis, it becomes apparent that coupling current diagnostic criteria with a broader, interpretive approach, placing emphasis on the patients' and family members' intersubjective and socio-cultural/socio-historic context, may be more beneficial in reducing potential conflict between actors involved in the clinical/therapeutic context. As evinced by each one of the cases featured in this thesis, a broader, more holistic approach suggests that insight in psychosis is the provisional narrative *derivative* of mediational processes dependent on the intersubjective and dialogic positioning of the self in relation to other persons, all within a specific, social and cultural matrix. The illness narratives featured in this thesis illustrate how each patient, albeit in different ways, was aware of a marked shift in the atmospheric quality and content of his/her lifeworld, and was subsequently able to label this experience—through metaphors and insights gleaned from past interactions between other persons and forms of media, all of which were deeply rooted in a specific cultural matrix—as deviant from his/her normal, quotidian existence. In contrast to the traditional notion of insight in clinical psychiatry, i.e. a patient's ability to confirm with the objective clinical standards regarding the proper labeling of pathological mental phenomenon, this thesis calls for a broader understanding of insight, an understanding that stresses the significance of subjective ability to experience, detect and label deviant phenomenon.

Regarding the clinical implications of the research conducted in this thesis, we can appreciate the salience of a relational, contextual and hermeneutic approach to insight in psychosis—an approach that measures the meaning and interpretation of illness against the patient's and social entourage's own frames of reference, rather than the objective and often impersonal clinical standards—and how potential for conflict and discrepancies regarding both help-seeking behaviour and adherence to treatment regimens may be possibly minimized over time. The key element in augmenting the current clinical scope and epistemological basis of insight as a heuristic construct is to widen its interpretive field and centre on the essential roles of the dialogic, epistemic and socio-cultural correlates of subjective meaning and lived experience. Following this line of reasoning, the crux of the therapeutic dialogue is to reduce the destabilizing effects of the chaos and confusion accompanying mental illness; locate and attempt to alleviate the symptoms; and attempt to

make sense—via the hermeneutic enterprise—the source of the patient's and social entourage's distress. According to Kirmayer (1994) and Rousseau (1999), this requires being open to the patient's idioms of distress, or in the case of pervasive confusion/uncertainty, offering the patient (and members of the patient's social entourage) new metaphors for experience that will be intelligible in terms of his/her own pre-existing symbolic/interpretive frameworks.

As such, this thesis has attempted to contribute to the broadening and reconsideration of the conceptual boundaries of insight in psychosis and the establishment of spaces of negotiation between physicians, social workers, patients and their social entourage by putting into place a clinical frame sensitive to the multi-perspectival and intersubjective aspects of human relationships, culture, social circumstance and alternative meaning systems—all of which, to the patient and family members, are in a state of constant interpretative flux.

In chapter one of this thesis, I provided a review of contemporary literature regarding insight as a clinical phenomenon. I also problematized the theoretical notion of insight as a heuristic, meta-analytic construct and situated it within an anthropological and phenomenological framework placing meaning on insight as a direct correlate of the results of perspectival and dialogic relations with other persons.

In chapter two, I outlined the methods of the phenomenological and hermeneutic approach and its application to mental illness. I described here the development and applications of phenomenological psychiatry to mental illness. I introduced a general theory of hermeneutics and the significance of this approach for interpreting the patients' illness narratives. I also presented the methodology of the larger project upon which the data of this thesis are based. In closing, I outlined the specific methods that were employed in the textual analysis of interviews featured in this thesis.

For chapter three, I chose to introduce the reader to the various philosophical issues and debates regarding the notion of self and self-knowledge. My purpose was to begin with the Cartesian model of the self and self-knowledge and use this as a model against which to test and present more plausible approaches to self-knowledge. Arguing for an inclusive, relational ontological framework, I considered and discussed key features of the philosophy of dialogue. I then presented Emmanuel Levinas' understanding of the relation of *otherness* as a descriptive template upon which to delineate the clinical phenomenon of the synchronic

and diachronic production of self-knowledge. Following this paradigm, I showed that the configuration and construction of insight consisted of a *synchronic* juncture where the patient is interpellated by the clinician and hence positioned as a speaking subject, and a *diachronic* juncture where the patient, as a result of having been called into a speaking position, constructs and authors a narrative account of significant events related to his/her illness experience based on biographical memory.

In chapter four, I introduced the reader to the analysis and discussion of the featured case studies. My purpose was to provide and illustrate examples of the intersubjective and dialogic construction and configuration of insight as self-knowledge. By focusing on the three narrative stages of insight production—*detection of alteration of lived experience*, *causal attribution*, and *global construction of meaning*—my intent was to offer a new model with which to approach and understand insight in patients recently diagnosed with psychosis. This model emphasized that in order to understand insight we must shift our attention from models purporting insight as a solitary, introspective act of self-transparency, to one approaching the construction, configuration and narration of insight as a processual and inherently intersubjective and dialogic phenomenon.

McGill

Research Ethics Board Office
McGill University
5 Sherbrooke Street West
James Administration Bldg., rm 429
Montreal. QC H3A 2T5

Tel: (514) 398-6831
Fax: (514) 398-4853
Ethics website: www.mcgill.ca/rgo/ethics/human

Research Ethics Board I
Certificate of Ethical Acceptability of Research Involving Humans

Project Title: Expanding the Epistemological Horizons of Insight in Psychosis: Toward an Anthropological and Phenomenological Reframing

Applicant's Name: Mark S. Dolson **Department:** Anthropology and Social Studies of Medicine

Status: Master's student

Supervisor's Name (if applicable): Dr. E. Corin

Granting Agency and Title (if applicable): N/A

This project was reviewed on Nov 21, 2002 by

Expedited Review ____
Full Review ✓

Lynda McNeil Dec 3, 2002
Signature/Date

John Galaty, Ph.D.
Chair, REB I

Approval Period: Dec. 3, 2002 to Dec 2, 2003

REB File #: 161-1102

CONSENT FORM (patient)

Ethics committee: Board of Professional Services, McGill University Health Center, Royal Victoria Hospital

Research Project : Psychosis and Culture. The role of spaces of negotiation (patient-family-practitioner) during clinical contact.
Primary researcher: Dr. Ellen CORIN - Douglas Hospital, Psychosocial Research Division
Primary practitioner : Dr Marc LAPORTA, Royal Victoria Hospital

This is a study aimed at a better understanding of the relationship between mental health practitioners and patients. We have asked to meet with you to find out about your experiences on this subject :

- We would like to better understand your expectations of practitioners through a better grasp of your difficulties, the role of practitioners and the help that they provide to you
- We would also like to better understand from the perspective of your culture of origin, the types of problems you have had and that you currently experience and know if you have sought help outside of the medical community
- Finally we hope that this research will contribute to facilitate communications between patients and practitioners.

1. I agree to participate in this research.

1.1. The details of my participation in this project have been explained to me. They are two (2) interviews of 2 hours each over a one year period; as well as filling out a short questionnaire evaluating my symptoms.

1.2. This interview will take place in either my mother tongue, English or in French, as per my request.

1.3. If I choose to have the interview done in my mother tongue, I agree to have a professional interpreter present during the interview.

2. I agree that ....., a member of my family or my close friend, may be contacted to participate in this research. The conditions of their participation have been explained to them in detail, and are: two (2) interviews of 2 hours each over a one (1) year period.

3. I agree that my primary mental health care provider will also be contacted to participate in this research, participating in three(3) interviews of one hour each over a one year period. I also agree that one of the members of the research team will be present as an observer during a meeting of the clinical team with whom my practitioner works.

4. I have been assured that the interviews are done one on one and that the information gathered during these interviews is confidential; no personal information will be shared with my health care provider, my family, or anyone else.

5. I know that I can ask for other information about my role in the research or about the research itself.

6. I know that the information from my interview will be recorded with a tape recorder. The interview cassettes will be placed securely in a locked filing cabinet in the places where the research team works. Access to the cassettes is strictly limited to those persons directly

implicated in the research. The information will be rendered anonymous with all personal identifiers being removed. It will be preserved on tape during the period of the study, two (2) years plus one (1) additional year to finish the research reports. That is, for a period of three (3) years, after which they will be destroyed.

7. I understand that as there are no direct risks deriving from the project. However, the recall of certain periods of my life may bring back painful memories and the person interviewing me will take great care to respect the limits and boundaries I decide to keep.

8. I have agreed of my own free will to participate in this research and know that I can discontinue at any moment without effecting my medical treatment and without prejudice.

9. I will be given $20.00 for my participation in this study to compensate for any inconveniences I experience. I can decide where I want the interviews to take place.

10. If I have questions about my rights as a patient or participant in a research project I know I can call the Ombudsman's Office at the :
(514) 842 1231 ext. 35655

11. For any information concerning the research study, I know I can contact: Dr. Ellen CORIN:
(514) 761-6131 ext. 4339
Dr Marc LAPORTA : (514) 842 1231 ext. 35328

Signed in Montreal, the .....

Name of participant..... Signature of participant

Name of interviewer..... Signature of interviewer

October 3 2002

CONSENT FORM (family member or member of the entourage)

Ethics committee: Board of Professional Services, McGill University Health Center, Royal Victoria Hospital

Research Project: Psychosis and Culture. The role of spaces of negotiation (patient-family-practitioner) during clinical contact.
Primary researcher: Dr. Ellen CORIN - Douglas Hospital - Psychosocial research unit

Primary practitioner: Dr. Marc LAPORTA, Royal Victoria Hospital

This is a study aimed at a better understanding of the relationship between mental health practitioners and patients. We have asked to meet with you to find out about .....'s experiences as a patient.

- We would like to better understand your expectations of practitioners through a better grasp of the nature of the problems of the patient, the role of practitioners and the kinds of help they provide.

- We would also like to be more aware, from within the perspective of your culture of origin, of the types of problems..... has had and that..... currently experiences and to know whether you have sought help in places or from persons outside the medical community.

- Finally we hope that this research will permit a more stable continuity of treatment for the patient and a better communication between the patient and his or her practitioners, as well as between the practitioners themselves, and between the patient and yourself with regard to medical services.

1. As a member of the family (or a close friend) I agree to participate in this research.

    1.1. The details of my participation in this project have been explained to me. They are two (2) interviews of 2 hours each over a one year period.

    1.2 This interview will take place in either my mother tongue, in English or in French, as per my request.

    1.3 If I choose to have the interview done in my mother tongue, I agree to have a professional interpreter present during the interview.

2. I have been assured that these interviews will be done one on one and that any information gathered during these interviews is confidential; no personal information will be shared with the health care provider, the patient or anyone else.

3. I know that the information from my interview will be recorded with a tape recorder. The interview cassettes will be placed securely in a locked filing cabinet in the places where the research team works. Access to the cassettes is strictly limited to those persons directly implicated in the research. The information will be rendered anonymous with all personal identifiers being removed. They will be securely preserved on tape in order to allow further verification. They will be destroyed after a period of three years.

4. I know that I can ask for other information about my role in the research or about the research itself.

5. I have agreed of my own free will to participate in this research and know that I can discontinue at any time.

6. I will be given $20.00 for my participation in this study to compensate for any inconveniences I experience.

7. If I have questions about my rights as a participant in a research project I know I can call the Ombudsman's Office at the :
(514) 842 1231 ext. 35655

8. For any information concerning the research study, I know I can contact: Dr. Ellen CORIN: (514) 761-6131 ext. 4339
Dr Marc LAPORTA : (514) 842 1231 ext. 35328

Signed in Montreal, the .....

Name of participant. Signature of participant

Name of interviewer Signature of interviewer

October 3 2002

Literature Cited

Abrams, M. H. 1993. *A Glossary of Literary Terms*. Fort Worth: Harcourt Brace College Publishers.

Amador, X. F., Strauss, D. H., Yale, S. A., Flaum, M. H., and Gorman, J. M. 1993. Assessment of Insight in Psychosis. *American Journal of Psychiatry*, 150: 873-879.

Amador, F. and Kronengold, Henry. 1998. The Description and Meaning of Insight in Psychosis. In *Insight and Psychosis*. Xavier F. Amador and Anthony S. David (Eds.), pp.15-32. New York: Oxford University Press.

Andreasen, N. C. 1997. The Evolving Concept of Schizophrenia: From Kraepelin to the Present and Future. *Schizophrenia Research*, 28: 105-109.

Bakhtin, Mikhail, Mikhaĭlovich. 1981. *The Dialogic Imagination: Four Essays*. Caryl Emerson (Trans.). Austin: University of Texas Press.

Bakhtin, Mikhail, Mikhaĭlovich. 1984. *Problems of Dostoevsky's Poetics*. Caryl Emerson (Trans.). Manchester: Manchester University Press.

Battaglia, Debbora. 1995. Problematizing the Self: A Thematic Introduction. In *Rhetorics of Self Making*. Debbora Battaglia (Ed.), pp. 1-15. Berkeley: University of California Press.

Battaglia, Debbora. 1999. Toward an Ethics of the Open Subject: Writing Culture in Good Conscience. In *Anthropological Theory Today*. Henrietta L. Moore (Ed.), pp. 114-150. Massachusetts: Polity Press.

Bebbington, P. E. 1995. The Content and Context of Compliance. *International Clinical Pharmacology*, 9, supplementary, 5: 41-50.

Benner, P. 1985. Quality of Life: A Phenomenological Perspective on Explanation, Prediction, and Understanding in Nursing Science. *Advances in Nursing Science*, 8 (1): 1-14.

Berrios, German, E. and Marková, Ivana, S. 1998. Insight in the Psychoses: A Conceptual History. In *Insight and Psychosis*. Xavier F. Amador and Anthony S. David (Eds.), pp.15-32. New York: Oxford University Press.

Binswanger, Ludwig. 1963. Heidegger's Analytic of Existence and its meaning for Psychiatry. In *Being-In-The-World, Selected Papers of Ludwig Binswanger*. Jacob Needleman (Trans. and Ed.), pp. 206-221. New York: Basic Books.

Blankenburg, Wolfgang. 1982. A Dialectical Conception of Anthropological Proportions. In *Phenomenology and Psychiatry*. A. J. J. de Koning and F. A. Jenner (Eds.), pp. 35-50. New York: Grune & Stratton.

Blankenburg, Wolfgang. 1991. *La Perte de L' Évidence Naturelle*. Paris: Presses Universitaires de France.

Bourdieu, Pierre and Wacquant, Löic, J. D. 1992. *An Invitation to Reflexive Sociology*. Chicago: The University of Chicago Press.

Bruner, Edward. 1986. Experience and its Expression. In *The Anthropology of Experience*. Victor Turner and Edward Bruner (Eds.), pp. 3-30. Urbana: University of Chicago Press.

Buckley, Philip (Personal communication, January 15th, 2002) endorses this view.

Buber, Martin. 1958. *I and Thou*. Translated by Ronald Gregor Smith. New York: Charles Scribner's Sons.

Canguilhem, Georges. 1966/1991. *The Normal and the Pathological*. New York: Zone Books.

Colins, Jeff and Selina, Howard. 1998. *Introducing Heidegger*. New York: Totem Books.

Comer, Ronald, J. 1995. *Abnormal Psychology*. New York: W. H. Freeman and Company.

Cooper, David, G. 1967. *Psychiatry and Anti-Psychiatry*. New York: Ballantine.

Corin, Ellen, E. 1989. Trends and Avenues in Psychiatric Semiology: Towards a Reframing. *Mental Health* 4: 153-168.

Corin, Ellen, E. 1990. Facts and Meaning in Psychiatry: An Anthropological Approach to the Lifeworld of Schizophrenics. *Culture, Medicine and Psychiatry*, 14: 153-158.

Corin, Ellen, E. and Lauzon, Gilles. 1994. From Symptoms to Phenomena: The Articulation of Experience in Schizophrenia. *Journal of Phenomenological Psychiatry*, 25 (1): 3-50.

Corin, Ellen, E (personal communication, February 15th, 2002) endorses this view.

Corin, Ellen, E (personal communication, July 26th, 2003) endorses this view.

Corin, Ellen, E. Thara, R., and Padmavati, R. 2003. Living Through a Staggering World: The Play of Signifiers in Early Psychosis in South India. In *Culture, Subjectivity and Schizophrenia* (In press), J. Jenkins and R. Barett (Eds.), pp. 1-49. New York: Russell Sage Foundation and Cambridge University Press.

David, A. S. 1990. Insight in Psychosis. *British Journal of Psychiatry*, 156: 798-808.

David, A., Buchanan, A., Reed, A., and Almeida, O. 1992. The Assessment of Insight in Psychosis. *British Journal of Psychiatry*, 161: 599-602.

Davies, Bronwyn, and Harré, Rom. 1990. Positioning: The Discursive Production of Selves. *Journal for the Theory of Social Behaviour*, 20 (1): 43-64.

Dennet, Clement, Daniel. 1990. The Myth of Original Intentionality. In *Modelling the Mind*, K. A. Mohyeldin, Said, W. H. Newton-Smith, R. Viale, and K. V. Wilkes (Eds.), p. 48. Clarendon: Oxford University Press.

Descartes, Rene. 1641/1968. Meditations. In *The Philosophical works of Descartes*, E. Haldane and G. Ross (Eds.), Vol. 1 and Vol. 2. Cambridge: Cambridge University Press.

Desjarlais, Robert. 1997. *Shelter Blues: Sanity and Selfhood Among the Homeless.* Philadelphia: University of Pennsylvania Press.

Desjarlais, Robert. 1999. The Markings of Personhood in a Shelter for People Considered Homeless and Mentally Ill. *Ethos*, 27 (4): 466-489.

Dolson, Mark, S. 2002. *On Existential Anxiety and the Differences between Normal and Pathological Being-in-the-world.* Unpublished Paper written for Philosophy (Epistemology and Metaphysics) 720b, McGill University.

Dressler, William, W. 1996. Culture, Stress and Disease. In *Medical Anthropology: Contemporary Theory and Method.* Carolyn F. Sargent and Thomas M. Johnson, (Eds.), pp. 252-271. Westport: Praeger.

Eilan, Naomi. 2000. On Understanding Schizophrenia. In *Exploring the Self: Philosophical and Psychopathological Perspectives on Self-Experience*, Dan Zahavi, (Ed.), pp. 98-100. Philadelphia: J. Benjamins Publishing Company.

Elwell, Walter, A. 2001. *Evangelical Dictionary of Theology.* Grand Rapids, Michigan: Baker Academic.

Estroff, Sue. 1985. *Making it Crazy: An Ethnography of Psychiatric Clients in an American Community.* Berkeley: University of California Press.

Estroff, Sue. 1989. Self, Identity and Subjective Experiences of Schizophrenia: In Search of the Subject. *Schizophrenia Bulletin*, 15 (2): 189-195.

Fabrega, Horacio, Jr. 1974. *Disease and Social Behaviour: An Interdisciplinary Perspective.* Cambridge: MIT Press.

Fabrega, Horacio, Jr. 1989. The Self and Schizophrenia: A Cultural Perspective. *Schizophrenia Bulletin*, 15 (2): 277-290.

Fleshner, Chris, L. 1995. First Person Account: Insight from a Schizophrenia Patient with Depression. *Schizophrenia Bulletin*, 20 (4): 703-707.

Feuerbach, Ludwig. 1843/1966. *Principles of the Philosophy of the Future.* (Trans. M. Vogel). Indianapolis: Bobbs-Merrill.

Foucault, Michel. 1980. *Power/Knowledge: Selected Interviews and other Writings, 1972-1977.* New York: Pantheon.

Gadamer, Hans-Georg. 1975. *Truth and Method.* Garret Barden and John Cumming (Trans. and Eds.). New York: Seabury Press.

Galaty, John G. 1995. Transgression and Transition. In *Beyond Textuality: Asceticism and Violence in Anthropological Interpretation*, Gilles Bibeau and Ellen E. Corin (Eds.), p. 196. New York: Mouton de Gruyter.

Garety, P. A. and Freeman, D. 1999. Cognitive Approaches to Delusions: A Critical Review of Theories and Evidence. *British Journal of Clinical Psychology*, 38: 113-154.

Garro, Linda, C. and Cheryl Mattingly. 2000. Narrative as Construct and Construction. In *Narrative and the Cultural Construction of Illness and Healing.* Cheryl Mattingly and Linda C. Garro (Eds.), pp. 2-39. Berkeley: University of California Press.

Geertz, Clifford. 1973. The *Interpretation of Cultures: Selected Essays.* New York: Basic Books.

Gergen, Kenneth, J. 1977. The Social Construction of Self-Knowledge. In *The Self: Psychological and Philosophical Issues*, Theodore Mischel, (Ed.), pp. 139-169. Oxford: Basil and Blackwell.

Gibson, James. 1979. *The Ecological Approach to Visual Perception.* New Jersey: Erlbaum.

Good, Byron and Mary-Jo DelVecchio-Good. 1981. The Meaning of Symptoms: A Cultural Hermeneutic Model for Clinical Practice. In *The Relevance of Social Science for Medicine.* L Eisenberg and A. Kleinman (Eds.), pp. 165-196. Dordrecht, Holland: D. Reidel Publishing Company.

Good, Byron. 1994. *Medicine, Rationality and Experience: An Anthropological Perspective.* Cambridge: University of Cambridge Press.

Greenfeld, David, Strauss, John, S., Bowers, Malcolm, B., and Mandelkern, Marshal. 1989. Insight and Interpretation of Illness in Recovery from Psychosis. *Schizophrenia Bulletin*, 15 (2): 245-251.

Guzder, J. and Krishna, M. 1991. Sita-Shakti: Cultural Paradigms for Indian Women. *Transcultural Psychiatric Research Review*, 28: 257-301.

Hand, Séan. 1989. Introduction. In *The Levinas Reader.* Séan Hand (Ed.), pp. 1-8. Oxford: Basil Blackwell.

Heelan, Patrick. 2001. The Lifeworld and Scientific Interpretation. In *Handbook of Phenomenology and Medicine*. S. Kay Toombs (Ed.), pp. 45-60. Dordrecht: Kluwer Academic.

Heidegger, Martin. 1927/1962. *Being and Time*. John Macquarrie and Edward Robinson (Trans.). New York: Harper-Colins.

Hughes, Charles, C. 1996. Ethnopsychiatry. In *Medical Anthropology: Contemporary Theory and Method*. Carolyn F. Sargent and Thomas M Johnson (Eds.), pp. 131-149. Westport: Praeger.

Jackson, Michael. 1989. *Paths Toward a Clearing: Radical Empiricism and Ethnographic Enquiry*. Bloomington: Indiana University Press.

Jackson, Michael. 1996. *Things as they are: New Directions in Phenomenological Anthropology*. Michael Jackson, (Ed.), pp. 3-50. Bloomington: Indiana University Press.

Jackson, Michael. 1998. *Minima Ethnographica: Intersubjectivity and the Anthropological Project*. Chicago: University of Chicago Press.

Jaspers, Karl. 1913/1963. *General Psychopathology*. J. Hoenig and Marian W. Hamilton (Trans.). Manchester: Manchester University Press.

Jenkins, Janis and Karno, M. 1994. The Meaning of "Expressed Emotion": Theoretical Issues Raised by Cross-Cultural Research. *American Journal of Psychiatry*, 149: 9-21.

Jenkins, Janis, H. 1996. Culture, Emotion and Psychiatric Disorder. In *Medical Anthropology: Contemporary Theory and Method*. Carolyn F. Sargent and Thomas M. Johnson (Eds.), pp. 71-87. Westport: Praeger.

Johnson, Sonia and Orrell, Martin. 1995. Insight in Psychosis: A Social Perspective. *Psychological Medicine*, 25: 515-520.

Jopling, David. 1993. Cognitive Science, Other Minds, and the Philosophy of Dialogue. In *The Perceived Self: Ecological and Interpersonal Sources of Self-Knowledge*. Ulrich Neisser (Ed.), pp. 209-309. New York: Cambridge University Press.

Jopling, David 1997. A "Self of Selves"? In *The Conceptual Self in Context: Culture, Experience and Self-Understanding*. Ulrich Neisser and David Jopling (Eds.), 249-265. New York: Cambridge University Press.

Jopling, David. 2000. *Self-Knowledge and the Self*. New York: Routledge.

Kirmayer, L. J. 1994. Improvisation and Authority in Illness Meaning. *Culture, Medicine and Psychiatry*, 18 (2): 183-214.

Kirmayer, L. J., Young, Allan and Robbins, J. M. 1994. Symptom Attribution in Cultural Perspective. *Canadian Journal of Psychiatry*, 39 (10): 584-595.

Kirmayer, L. J. 2000. Broken Narratives: Clinical Encounters and the Poetics of Illness Experience. In *Narrative and the Cultural Construction of Illness and Healing*. Cheryl Mattingly and Linda C. Garro (Eds.), pp. 153-180. Berkeley: University of California Press.

Kirmayer, L. J. and Corin, E. 1998. Inside Knowledge: Cultural Constructions of Insight in Psychosis. In *Insight and Psychosis*. X. F. Amador and A. S. David (Eds.), pp. 193-220. New York: Oxford University Press.

Kleinman, Arthur. 1980. *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine and Psychiatry*. Berkeley: University of California Press.

Kleinman, Arthur. 1988. *Rethinking Psychiatry: From Cultural Category to Personal Experience*. London: Collier Macmillan.

Kleinman, Arthur. 1998. Do Psychiatric Disorders Differ in Different Cultures? In *Understanding and Applying Medical Anthropology*. Peter J. Brown (Ed.), pp. 185-196. Mountain View, California: Mayfield Publishing Company.

Kumar, T. Manoj, and Sims, Andrew. 1995. *Insight and its Measurement in Relation to Psychosis: A Review*. Internet Publication: http://www.e-wtc.com/pu/Insight1.html.

Kruger, Dreyer. 1981. *An Introduction to Phenomenological Psychology*. Pittsburgh: Duquesne University Press.

Laing, R. D. and Cooper, David, G. 1964. *Reason and Violence: A Decade of Sartre's Philosophy*. London: Tavistock Publications.

Lanteri-Laura, G. 1982. Phenomenology and a Critique of the Foundations of Psychiatry. In *Phenomenology and Psychiatry*. A. J. J. de Koning and F. A. Jenner (Eds.), pp. 51-70. New York: Grune & Stratton.

Lewis, A. 1934. The Psychopathology of Insight. *British Journal of Medical Psychology*, 13: 332-348.

Levinas, Emmanuel. 1961. *Totality and Infinity: An Essay on Exteriority*. With an Introduction by John Wild. Alphonso Lingis (Trans.). Pittsburgh: Duquesne University.

Levinas, Emmanuel. 1993a. *Outside the Subject*. Michael B. Smith (Trans.). Stanford California: Stanford University Press.

Levinas, Emmanuel. 1993b. *God, Death and Time*. Bettina Bergo (Trans.). Stanford California: Stanford University Press.

Levinas, Emmanuel. 1999. *Alterity and Transcendence*. Michael B. Smith (Trans.). New York: Columbia University Press.

Lienhardt, Godfrey. 1964. *Social Anthropology*. London: Oxford University Press.

Lock, Margaret. 1993. Cultivating the Body: Anthropology and Epistemologies of Bodily Practice and Knowledge. *Annual Review of Anthropology*. 22: 133-155.

Lock, Margaret, and Scheper-Hughes, Nancy. 1996. A Critical-Interpretive Approach to Medical Anthropology: Rituals and Routines of Discipline and Dissent. In *Medical Anthropology: Contemporary Theory and Method*. Carolyn F. Sargent and Thomas M. Johnson (Eds.), pp. 41-70. Westport: Praeger.

Lock, Margaret, and Scheper-Hughes, Nancy. 1998. The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. *In Understanding and Applying Medical Anthropology*. Peter J. Brown (Ed.), pp. 208-224. Mountain View, California: Mayfield Publishing Company.

Lysaker, P. and Bell, M. 1994. Insight and Cognitive Impairment in Schizophrenia. *Journal of Nervous and Mental Disease*, 182: 656-660.

Lysaker, P. and Bell, M. 1995. Work Rehabilitation and Improvements in Insight in Schizophrenia. *Journal of Nervous and Mental Disease*, 183: 103-107.

Marcel, Gabriel. 1968. *Martin Buber: L'homme et le Philosophe*. Introduction by Robert Weltsch. Éditions de L'Institut De Sociologie de L'Université Libre De Bruxelles: Brxuelles.

Marková, I. S. and Berrios, G. E. 1992. The Meaning of Insight in Clinical Psychiatry. *British Journal of Psychiatry*, 160: 850-860.

Marshall, William L. and Firestone, Philip. *Abnormal Psychology: Perspectives*. 1999. Scarborough: Prentice Hall Allyn and Bacon Canada.

Martinez-Hernáez, Angel. 2000. *What's Behind the Symptom? On Psychiatric Observation and Anthropological Understanding*. Susan M. DiGiacomo and John Bates (Trans.). Amsterdam: Harwood Academic.

McEvoy, J.P., Aland, J., Wilson, W. H., Guy, W., and Hawkins, L. 1981. Measuring Chronic Schizophrenic Patients' Attitudes toward their Illness and Treatment. *Hospital and Community Psychiatry*, 32: 856-858.

Mead, George Herbert. 1934. *Mind, Self and Society: From the Standpoint of a Social Behaviourist*. Chicago: University of Chicago Press.

Merleau-Ponty, Maurice. 1962. *Phenomenology of Perception*. James Edie (Trans.). Evanston, Illinois: Northwestern University Press.

Minkowski, Eugène. 1932/1970. *Lived Time: Phenomenological and Psychopathological Studies*. Nancy Metzel (Trans.). Evanston, Illinois: Northwestern University Press.

Moore, Henrietta, L. 1999. Anthropological Theory at the Turn of the Century. In *Anthropological Theory Today*. Henrietta L. Moore (Ed.), pp. 1-23. Massachusetts:Polity Press.

Morris, Brian. 1991. *Western Conceptions of the Individual*. New York: Berg Publishers.

Morris, Brian. 1994. *Anthropology of the Self: The Individual in Cultural Perspective*. London: Pluto Press.

Nanda, Serena, and Warms, Richard, L. 2002. *Cultural Anthropology*. Belmont: Wadsworth.

Neisser, Ulrich. 1988. Five Kinds of Self-Knowledge. *Philosophical Psychology*, 1: 35-59.

Neisser, Ulrich. 1993. The Perceived Self. In *The Perceived Self: Ecological and Interpersonal Sources of Self-Knowledge*. Ulrich Neisser (Ed.), pp. 3-21. New York: Cambridge University Press.

Obeyesekere, Gananath. 1981. *Medusa's Hair: An Essay on Personal Symbols and Religious Experience*. Chicago: University of Chicago Press.

Obeyesekere, Gananath. 1990. *The Work of Culture: Symbolic Transformation in Psychoanalysis and Anthropology*. Chicago: University of Chicago Press.

Osbourne, Grant, R. 1991. *The Hermeneutic Spiral*. Downer's Grove: IVP.

Packer, M. J. and Addison, R. B. 1989. *Entering the Circle: Hermeneutic Investigation in Psychology*. Albany: State University of New York Press.

Polt, Richard. 1999. *Heidegger: An Introduction*. Ithica, New York: Cornell University Press.

Renfrew, Colin and Bahn, Paul. 1996. *Archaeology: Theories, Methods and Practice*. London: Thames and Hudson Limited.

Richfield, J. 1954. An Analysis of the Concept of Insight. *Psychoanalytical Quarterly*, 23: 390-408.

Ricœur, Paul. 1970. *Freud and Philosophy: An Essay on Interpretation*. Denis Savage (Trans.). New Haven: Yale University Press.

Ricœur, Paul. 1992. *Oneself as Another*. Kathleen Blamey (Trans.). Chicago: University of Chicago Press.

Robinson, G. D. 1995. Paul Ricœur and the Hermeneutics of Suspicion: A Brief Overview and Critique. *Premise*, 2 (8): 12-21.

Rorty, Amélie, Oksenberg. 1988. The Deceptive Self: Liars, Layers and Liars. In *Mind in Action: Essays in the Philosophy of Mind.* Amélie Oksenberg Rorty (Ed.), p. 219. Boston: Beacon Press.

Rorty, Amélie, Oksenberg. 1990. Aspects of Identity and Agency. In *Identity, Character and Morality: Essays in Moral Psychology.* Owen Flanagan and Amélie Oksenberg Rorty (Eds.), p. 19. Cambridge: MIT Press.

Rousseau, Cécile. 1999. Playing Around with a Story. *Transcultural Psychiatry*, 36 (4): 447-450.

Rousseau, Jérôme. 1995. The Subject of Knowledge. In *Beyond Textuality: Asceticism and Violence in Anthropological Interpretation*, Gilles Bibeau and Ellen E. Corin (Eds.), pp. 289-302.

Sackeim, Harold. 1998. Introduction: The Meaning of Insight. In *Insight and Psychosis.* Xavier F. Amador and Anthony S. David (Eds.), pp.3-12. New York: Oxford University Press.

Sartre, Jean-Paul. 1946. *Existentialism and Humanism.* Philip Mairet (Trans.). London: Methuen & Company, Limited.

Sartre, Jean-Paul. 1972. *The Transcendence of the Ego: An Existentialist Theory of Consciousness.* Forrest Williams and Robert Kirkpatrick (Trans.). New York: Octagon Books.

Sass, Louis. 1992. Heidegger, Schizophrenia and the Ontological Difference. *Philosophical Psychology*, 5 (2): 109-131.

Schutz, Alfred. 1967. *Phenomenology of the Social World.* George Walsh and Frederick Lehnert (Trans.). Evanston, Illinois: Northwestern University Press.

Schutz, Alfred and Luckmann, Thomas. 1973. *The Structures of the Life-World.* Richard M. Zaner and H. Tristram Engelhardt, Jr. (Trans.). Evanston, Illinois: Northwestern University Press.

Shorter, Edward. 1997. *A History of Psychiatry: From the Era of the Asylum to the Age of Prosac.* New York: John Wiley & Sons, Inc.

Strathern, Marylin. 1991. *Partial Connections.* Savage: Rowman and Littlefield.

Strathern, Andrew, J. 1996. *Body Thoughts.* Ann Arbor: The University of Michigan Press.

Taylor, Charles. 1989. Sources *of the Self: The Making of the Modern Identity.* Cambridge: Harvard University Press.

Taylor, S. and Brown, J. 1988. Illusion and Well-Being: A Social Psychological Perspective on Mental-Health. *Psychological Bulletin*, 103: 193-210.

Tellenbach, Hubertus. 1974. *Melancholie: Problemgeschichte, Endogenität, Typologie, Pathogenese Klinik.* Berlin: Springer-Verlag.

Toombs, S. K. 1987. The Meaning of Illness: A Phenomenological Approach to the Patient-Physician Relationship. *The Journal of Medicine and Philosophy*, 12: 219-240.

Van Manen, M. 1990. *Researching Lived Experience.* London, Ontario: The Althouse Press.

Walton, Jo Ann. 1995. *Schizophrenia: A Way of Being-In-The-World.* Unpublished PhD. Dissertation (Department of Nursing). New Zealand: Massey University.

Waxler, Nancy. 1977. Is the Outcome of Schizophrenia Better in Non-Industrialized Societies? *Journal of Nervous and Mental Disease*, 167: 144-168.

Weiner, James. 1999. Psychoanalysis and Anthropology: On the Temporality of Analysis. In *Anthropological Theory Today.* Henrietta L. Moore (Ed.), pp. 234-261.

White, R., Bebbington, P., Pearson, J., Johnson, S., and Ellis, D. 2000. The Social Context of Insight in Schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, 35: 500-507.

Wittgenstein, Ludwig. 1953. *Philosophical Investigations.* G. E. M. Anscombe (Trans.). Oxford: Basil Blackwell.

World Health Organization. 1973. *The International Pilot Study of Schizophrenia*, Volume 1. Geneva: World Health Organization.

Young, Allan. 1982. The Anthropologies of Illness and Sickness. *Annual Review of Anthropology*, 11: 257-285.

Young, Allan. 1993. A Description of How Ideology Shapes Knowledge of a Mental Disorder (Posttraumatic Stress Disorder). In *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life.* Shirley Lindenbaum and Margaret Lock (Eds.), pp. 108-128.

Young, Allan. 1995. *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder.* Princeton, New Jersey: Princeton University Press.