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Living after the first psychotic episode:
an anthropological perspective

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INTRODUCTION

Background and motivation

As a third-year student of ethnology and cultural anthropology, my interest in issues related to mental health began mostly because a friend of mine was coping with heavy anxiety at the time, which made his life very difficult. When I was about to start research for my bachelor's degree, mental health advocacy captured my attention, so I spent half a year doing fieldwork in a Slovenian NGO in the field of community mental health. I spent most of my time with people with various schizo-diagnoses. When I was writing my bachelor's thesis, the Slovene Hearing Voices initiative group was born and I was fortunate enough to participate in it nearly from the beginning. There, I was introduced to a new perspective which tried to understand *meaning* in psychotic or psychotic-like experiences and wanted to explore them, creating new spaces (for example, peer support groups) of dialogue and sharing ways of coping with one's lived experience. My bachelor's research and involvement in the Hearing Voices group made me rethink notions I had had about 'psychosis' and 'schizophrenia'. In both contexts, I primarily met people with considerable experience of psychiatric services. They were considered chronic patients.

I enrolled in the master's degree programme without any particular research theme in mind. At the end of November 2015, the beginning of my first year of the programme, a new topic grabbed my attention – the first psychotic episode (hereafter, FPE). I was introduced to it by Vítor Santos, a psychiatrist and a professor of the programme. Later, he turned out to be very important in facilitating my first contact with people who had first-hand experience of psychosis, crucial to the ethnographic part of my thesis.

The FPE is an interesting theme for anthropological research since it may help us understand "how cultural referents and interpersonal dynamics may shape experience, and thereby, shape the course of schizophrenia" (Corin, Thara, & Padmavati, 2005, p. 114). Secondly, in contrast with cases of people with long-term psychiatric experiences, seeking the meaning of an FPE experience "is not yet frozen into the familiar blocks of well-established roles" (ibid, ibidem). Thirdly, focusing on FPEs guided me in a very practical sense because it defined the common denominator of all my informants – they have all experienced the first (treated) psychotic episode.[1] As I show in the introduction, anthropology and other social sciences studying so-

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[1] The word 'treated' perhaps should not be put in bracket since it reveals a rather important point (see Hopper, 2004, p. 63).

called psychotic experiences note the importance of the plurality of the social/cultural constructions of these experiences. A person can have such experiences before their first encounter with psychiatric services. However, the first thing that all of the informants in the study have in common is their first contact with psychiatric services. Some studies of the first mental health hospitalization claim that it implies "the recognition of the existence of a disease and the necessity of a treatment" (Hespanha, Portugal, Nogueira, Morgado Pereira, & Hespanha, 2012, p. 211). I would argue, instead, that the existence of psychosis is constructed by the first hospitalization. However, in the case of the first hospitalization, we can speak about the recognition of suffering and not of disease.

The thesis is influenced, both theoretically and methodologically, by my graduate background in social/cultural anthropology. However, its narrative focus makes it difficult to stay within rigid disciplinary barriers. The anthropological perspective is dominant, but it allows room for other disciplinary influences, including (cross-)cultural[2] psychiatry and psychology.

Outline

The thesis begins with a thematic and theoretical introduction to show the intellectual heritage on which the present discussion is based. The research tradition of investigating meaning in psychosis is explored. Various academic disciplines have approached psychosis as a meaningful phenomenon. This view has also been present in the narrative approach to medicine, psychiatry and systemic therapy. It is significant that similar aims are also pursued outside the academic context – the International Hearing Voices Movement is the example given in the thesis, although there are many more. The chapter ends with an overview of the anthropological discussion on experience and narrative, the two concepts with which we approach the fieldwork.

The second chapter is based on ethnographic fieldwork on psychosis and recovery, focusing on the intersubjective aspect. Firstly, we look at how the participants in the study make sense of psychosis, some at the time of acute crisis and some in temporally removed narratives. Secondly, still based on the fieldwork, we approach the subjective experiences of psychosis. Thirdly, the experience of hospitalization is considered. We conclude the chapter by exploring the intersubjective experience of everyday life after the FPE.

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[2] As there is no in-depth discussion of the historical transformation of this field of study, let us briefly summarise it following Kirmayer and Minas. In its first phase, it dealt with transcultural comparisons of the form and prevalence of psychiatric disorders. In the second phase, it explored (principally in migrant populations) cultural variations in the subjective experience of illness. The third phase can be characterised by the cultural critique of contemporary psychiatric theory and practice (Quartilho, 2001, pp. 148–9).

The third chapter continues the debate on narrative and intersubjectivity, now in the form of reflections on the fieldwork experience. These theoretical concepts have important methodological, ethical and epistemological implications, which is why I first discuss the ethical aspects involved. In terms of methodology, I discuss speaking about psychosis as a tool for recovery. Consequently, participation in research as part of one's recovery process is examined. Next, it is argued that in methodological debate on anthropology, reflection on the techniques that are employed is often absent. Therefore, some aspects regarding research techniques are reviewed. The chapter concludes with further reflection on collaborative research.

Anthropology of mental health – cultural/social construction of illness

Cultural/social anthropology, as a discipline researching people's everyday lives (Muršič, 2011), has from the beginning been interested in an important aspect of everyday life – health and illness – and has understood them as *cultural* categories. In this subchapter, the anthropological interest in health and illness is briefly discussed, followed by how it is applied to mental health. The social constructionist agenda is crucial for the present discussion. It argues against scientific realism and objectivism, the objection being that social phenomena are not simply 'there' in the world to be discovered, but are socially constructed. As Gergen argues, objectivity is no more than a rhetorical exercise (Quartilho, 2001, pp. 97–9). The assumption underlying the thesis is that one can talk about culture in (mental) health and illness not as a *variable*, but as something which *constructs* them (Jenkins & Barrett, 2004; Quartilho, 2001, pp. 97–132).

The idea that illness is a cultural construct may sound somewhat contra-intuitive. It often happens that social phenomena seem so self-evident that people simply think they are natural. Kinship systems were the first big anthropological issue: early anthropologists, such as Lewis Henry Morgan, tried to prove the cultural character of the phenomenon. In showing that they are classificatory (and not descriptive), Morgan denaturalised the concept of kinship systems (Good, 1994, pp. 2–3). Peoples around the world do not describe their kinship 'as is', but culturally classify it in distinctive ways, which leads to a great deal of diversity in cultural kinship systems. This also holds true for illnesses: people classify their health problems and there is no such thing as a pure description.

Anthropological interest in health and illness began with cultural evolutionist descriptions of traditional medical knowledge systems. According to evolutionist thought, traditional medical knowledge opened a window into the early phases of the evolution of the most evolved, Western

society. As such, they were compared to Western medical systems and thought of as irrational and underdeveloped (Lipovec Čebron, 2008, pp. 28–9). The school of thought that followed, historical diffusionism, made some important strides in the research of health and illness. William H. R. Rivers considered non-Western medical systems to be an integral part of those societies, emphasising their social nature (Joralemon, 2006, pp. 9–10). One of Rivers' most important contributions was stating that non-Western medical systems were logical and rational in many ways (Lipovec Čebron, 2008, pp. 30–2). However important, Rivers' diffusionism was succeeded by functionalism, which expanded ethnographic accounts and structured its analysis around the local point of view, but still maintained that non-Western medical systems were merely belief systems (Lipovec Čebron, 2008, pp. 34–6). Cultural relativism – the work of Franz Boas, Margaret Mead, Ruth Benedict and others – rejected evolutionist comparisons and empiricist tradition, and inaugurated cultural emphasis in anthropological research on health and illness. Benedict's essay, *Anthropology and the Abnormal,* is still considered one of the most important contributions to the development of transcultural psychiatry and its claims that normality and abnormality are culturally defined concepts (Lipovec Čebron, 2008, pp. 40–3).

The new subdiscipline, medical anthropology, was slowly being formed. Although Schwarz defined it as early as 1924, it started to gain momentum only after the Second World War (Lipovec Čebron, 2008, p. 43). In the early phases of medical anthropology as its own subdiscipline, two approaches can be emphasised. With social epidemiology emerging, medical anthropology started to serve as a bridge between biological and social anthropology. Another important developing area, ethnomedicine, studied traditional medical systems in aspects hardly "translatable" into Western ones. By valuing non-Western systems, it has contributed substantially to relativizing the exclusive role of Western medicine (Lipovec Čebron, 2008, pp. 44–7).

Another important and more contemporary approach is critical medical anthropology. It emerged in the 1970s and highlighted macrosocial factors in health and illness previously overlooked in analysis. It has studied health and illness within the traditions of political economy and neo-Marxism. The critical approach has produced studies on inequality of access to medical services and the medicalisation of society based on Foucault's concept of the genealogy of power and Gramsci's concept of hegemony (Lipovec Čebron, 2008, pp. 54–7).

The constructivist interpretative approach has significantly contributed to the development of medical anthropology. Profoundly shaped by American psychiatrist and anthropologist Arthur Kleinman, it criticises the notion of disease as a natural category and as an entity (Lipovec

Čebron, 2008, pp. 57–8). Since the constructivist interpretative approach is of immense importance for my thesis, we will examine three significant aspects of it in more detail.

Firstly, Kleinman was the first to theorise health care systems as cultural systems. In his book, *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry,* he writes: "In every culture, illness, the responses to it, individuals experiencing it and treating it, and the social institutions relating to it are all systematically interconnected. The totality of these interrelationships is the health care system" (Kleinman, 1980, p. 24). Furthermore, Kleinman conceptualises three overlapping parts of a local cultural system: the popular, professional and folk sector. It appears that the popular sector is the decisive one, since it is there that illness is first defined and health care activities are initiated. It is also the chief source and the most immediate determinant of care. The professional sector is constituted by "organized healing professions": it is mostly represented by contemporary biomedicine and in certain areas also by professionalised "indigenous" medical systems. The folk sector is characterised by local 'traditional' medical knowledge. In each sector, a person is treated differently: as a "sick family member", as a "patient", and as a "client", respectively. Furthermore, the sick person "encounters different medical languages as he moves between the health care system's sectors. He must translate from one language to another" (Kleinman, 1980, pp. 50–4).

Secondly, interpretative medical anthropology makes a distinction between sickness, disease and illness (Kleinman, 1980, p. 72). Disease is a biomedical construction and as such refers to the malfunction of biological and psychological processes, while illness relates to a psychosocial experience of perceived disease (Kleinman, 1980, p. 75; Kleinman, Eisenberg, & Good, 1978, pp. 22–3). In other words, illness "is the shaping of disease into behaviour and experience", so it "is created by personal, social, and cultural reactions to disease" (Kleinman, 1980, p. 72).

Thirdly, building on the distinction between disease and illness, Kleinman (1980) introduced the concept of explanatory models (hereafter, EMs) in the attempt to further explore the subjective experience of illness:

> Explanatory models are the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process. The interaction between the EMs of patients and practitioners is a central component of health care. (Kleinman, 1980, p. 105)

With the concept of EMs, medical anthropology has made an important step away from the positivist orientation in which diseases were seen as an entity (Lipovec Čebron, 2008, p. 58). It also implies the reallocation of analytical focus to the patient perspective. By exploring the latter, an EM seeks to answer five major questions concerning an illness episode: "(1) aetiology; (2) time and mode of onset of symptoms; (3) pathophysiology; (4) course of sickness (including both degree of severity and type of sick role – acute, chronic, impaired, etc.); (5) treatment" (Kleinman, 1980, p. 105).[3]

Psychosis, schizophrenia, psychiatry and anthropology: Mapping the field

The anthropological research of mental health did not fall behind other fields of health and illness research within the discipline. Additionally, psychiatry and anthropology started to become interrelated as early as 1932 with the article "Cultural Anthropology and Psychiatry", written by the anthropologist Edward Sapir. His collaboration with psychiatrist Harry Stack Sullivan was notable and fruitful as it resulted in similar ideas about culture and psychiatric conditions. Sapir saw the true locus of culture in interactions, while Sullivan understood psychiatry as the study of human interactions (Jenkins, 2004, p. 32). From then on, cultural aspects have been an object of interest to both disciplines, resulting in the first reflection on transcultural research in the 1950s (Hopper, 2004, p. 62). In the following pages, two examples are presented to illustrate the dynamics between the two disciplines and their own distinctive approaches to psychosis and schizophrenia. Two main themes emerge from the discussion: the anthropological critique of the biomedical construction of disease and the anthropological research into the different constructions of what medicine calls psychotic experience.

We might say that culture really started to matter with the paradigmatic "International Pilot Study in Schizophrenia", conducted by the World Health Organisation (hereafter WHO). Starting in 1966, the study included 9 countries around the world with the overall number of 1202 individuals diagnosed with schizophrenia. The first results were published in 1973, followed by the 2-year follow-up results in 1979 and 5-year follow-up results in 1992.

The study found individuals with schizophrenia in all 9 countries, but there was a considerable difference between them when it came to so-called 'recovery rates'. In India, Colombia and Nigeria (referred to as 'developing countries') 2- and 5-year follow-up results showed significantly greater outcome rates than in other countries, referred to as being 'developed' (Leff, Sartorius, Jablensky, Korten, & Ernberg, 1992, pp. 131–2). The dichotomy of

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[3] For further discussion, see the chapter "Doctor-patient interactions" in the seminal book *Culture, Health and Illness* (Helman, 2007).

'developing/developed' countries remained the most significant variable despite many cross-variable analyses (including age, gender, etc.), which led to the conclusion that social and cultural factors do have some influence on different outcomes in schizophrenia-diagnosed individuals.

Some anthropologists commented that in this pilot study, the term 'culture' is referred to as "a black box of variables: the exotic stuff of beliefs, practices, and accountings enveloped by ruder exigencies of poverty, environmental degradation, resource scarcity, and badly stretched treatment facilities" (Hopper, 2004, p. 65). A deeper rethinking of 'culture' is found to be absent, which leads the study to create such dichotomies as urban/agrarian, developing/developed countries, etc. In conclusion, Kim Hopper argues that by understanding 'culture' as being 'there' and not 'here' (therefore as a domain of the distant Other), the WHO study holds a very archaic position (Hopper, 2004).[4]

The Culture and Diagnosis Committee on schizophrenia was founded in 1991 by the National Institute of Mental Health to facilitate a cultural perspective in the then-forthcoming fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (hereafter DSM). The 1991 Conference on Cultural Issues and Psychiatric Diagnosis included over 50 cultural psychiatrists and anthropologists, and thus presents the most significant attempt to stimulate dialogue between the sociocultural and psychiatric perspectives on this mental illness to date (Littlewood, 1992, pp. 258–9). The work of the Committee resulted in the thin inclusion of some cultural aspects in the diagnostic manual, perhaps the most notable part being the glossary of 'culture-bound syndromes'. At the same time, as we saw previously in the case of the WHO study, 'culture' remains the domain of the Other. DSM-IV contains "no statement on the cultural construction of DSM-IV itself" (Aggarwal, 2013, p. 171). As shown by Janis Jenkins, DSM-IV did not include the proposed cultural perspective; instead, culture was referred to as "the generalized context for schizophrenic experience", "a source of structure for schizophrenic symptomatology", or as "a source for substantial variation across societies" (Jenkins, 1998, p. 362). Furthermore, the DSM-IV case serves as a brilliant case-study for the sociology of

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[4] It is crucial to reflect on the term 'culture'. In early psychological and psychiatric (and we might add, early anthropological) research, "the term culture was taken as synonymous with ethnocultural group" (Kirmayer & Ban, 2013, p. 98). Nowadays, anthropology (marked by poststructuralist and postcolonial criticism) supports the idea that well-bounded and cohesive cultures were a result of anthropological construction (Corin, 2007, p. 301). Although there are some cognitive-oriented definitions of culture, it can be said that culture is not just in the head of an individual but in the world – in social institutions, relations, bodies, etc. (Kirmayer & Ban, 2013, p. 98). Culture does not belong only to 'Them', distant 'Others' – it is also what 'We' have in the West.

knowledge since it shows how a hegemonic biomedical discourse dominates the sociocultural discourse on mental illness (ibid, ibidem: 373).

In the 'general considerations' section, DSM-IV claims 1) that schizophrenia varies cross-culturally in its presentation, course, and outcome; 2) that it is hard to judge the bizarreness of delusions cross-culturally; and 3) that hallucinations may sometimes be a normal part of a religious experience (ibid, ibidem: 361–2). DSM-IV operationalises culture, according to Janis Jenkins, as primarily pertaining to 'beliefs', and by doing so "runs the risk of trivializing or minimizing the relevance of cultural theory and data for our understanding of schizophrenia" (ibid, ibidem: 372). What is more, DSM-IV tends to be used all around the world, but at the same time, resists a full inclusion of the cross-cultural data in its text and is principally founded on Western clinical data (ibid, ibidem: 372–3).[5]

The dominant construction of psychosis is shaped by the dominant psychiatric knowledge. It is part of a wider biomedical discourse and from an anthropological perspective, constructs its knowledge in a culturally distinctive way – as a science of diseases (see Luz 2007). For biomedicine, the "ultimacy resides in depth, downward to levels that generate surface phenomena. And such deeper structures are not social or divine but ever more fundamental orders of material reality" (Good, 1994, p. 75). This biomedical knowledge constructs the image of diseases as residing in an individual's body and having a natural course (ibid, ibidem: 83).

Schizophrenia is defined by positive symptoms (delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behaviour) and negative symptoms (e.g., diminished emotional expression or avolition) (American Psychiatric Association, 2013, p. 99). There are various aetiological psychiatric theories and each of them reflects a different biological aspect of the psychotic condition (for a detailed discussion, see McCarthy-Jones, 2012, pp. 189–312). As summarised by Jablensky:

> Research has identified a number of putative biological markers associated with the disorder, including neurocognitive dysfunction, brain dysmorphology, and neurochemical abnormalities. Yet none of these variables has to date been definitively proven to possess the sensitivity and specificity expected of a diagnostic test. /…/ Thus, the existence of a specific brain disease underlying schizophrenia remains a hypothesis. (Jablensky, 2010, p. 283)

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[5] Jenkins' article was published in an issue of *Transcultural Psychiatry* (September 1998, 35(3)) dedicated to critical accounts of DSM-IV. At the time of writing this thesis, DSM-V is already in use.

Anthropology has criticised the Western psychiatric and other biomedical constructions of diseases. A good example of this can be found in Robert Barrett's critique of the construction of first rank symptoms (FRS). These were introduced into psychiatry by Kurt Schneider in 1959 and became an important part of DSM and its WHO version, the International Classification of Diseases (ICD). Barrett was interested in understanding how they could or could not be translated into the life-world of the Iban community in Sarawak, Malaysia. Barrett translated the Present State Examination used to ascertain diagnoses according to the ICD-10 criteria into the local language (Barrett, 2004, pp. 88–9). As has been shown, language (including the language of the Present State Examination) includes the social context in which it is produced. For example, the Iban community's concept of thinking is embodied and interactional, which in practice means that they understand thinking as being closely connected with emotions, desire and will, and originating from the heart-liver region of the body. Therefore, the Iban people found it hard to understand the 'Thought Disorder' part of the Present State Examination. Barrett states: "Iban found the idea of thoughts being 'read' nonsensical. And by what stretch of imagination could thoughts be taken from the head?" (Barrett, 2004, p. 95)

Negative symptoms have also been an object of cultural criticism. In psychiatry, they are thought to be a mere psychological manifestation of the 'basic defect' or 'deficiency' (of the brain), which implies that negative symptoms cannot be an effect of medication or a social and cultural context (Sass, 2004, p. 304).

<p style="text-align:center">*</p>

Anthropology has contributed to the debate on psychosis and schizophrenia with a vast amount of research on various, non-Western constructions of what one can call psychotic experiences. Having studied 'symptoms of depression' in Sri Lanka, anthropologist Gananath Obeyesekere observed that in that particular context, there is a "process whereby painful motives and affects such as those occurring in depression are transformed into publicly accepted sets of meanings and symbols", without any reference to medicine, as frequently happens in the West (Obeyerekere, 1985, p. 147). He called this process the *work of culture*. This theory can also be applied to 'psychotic-like' experiences. There are many 'madness labels' which differ from the Western one. In Bangladesh and the West Bengal region, *pāgalāmi* has been identified as being considered both norm-deviant and a divine gift (Wilce, 2004, p. 199). In a part of Borneo, a phenomenon called *ruden rupan* has been observed, where if a person "comes into contact with the water, he will hear voices and have visions of people who want to catch him" (Schmidt in McCarthy-Jones, 2012, p. 163). The *Gila kena hantu* illness in a Malay community in West

Malaysia also includes the experience of hearing voices. The cause of it "is thought to be *hantu* (evil spirits) who can enter an individual and whisper in his head" (Chen in ibid, ibidem).

From a non-clinical point of view, we can see that 'psychosis' is just one of the many patterns of 'hallucinations'. Apart from experiences clinically referred to as 'psychotic', according to Tanya Luhrmann, the most studied ones are so-called 'sensory overrides'. They frequently include similar experiences, namely hearing voices, but the frequency of hearing voices experiences in the case of sensory overrides is not as high as in the case of psychosis. Briefly put, people "who report them [sensory overrides] usually report one such moment, maybe two, perhaps a few a year. They are brief. People hear a word, a phrase, even a sentence or two, but not a paragraph. They are also not distressing." (Luhrmann, 2011, p. 74) This pattern is often found in religious contexts and the voice that is heard is frequently attributed to a god. In such cases, we can say that contact with non-material entities (principally hallucination experiences, in biomedical language) is culturally accepted in certain religious contexts (Larøi et al., 2014, p. S214).

The third pattern of hallucinations according to Luhrmann is the "Joan of Arc pattern", where an individual undergoes a similar experience as in psychosis but with positive and non-distressing voices (Luhrmann, 2011, p. 75). This pattern can be read in line with certain epidemiological studies of hallucination prevalence in the general population which show that there are higher prevalence rates of hallucinations than schizo-diagnoses (Johns & Van Os, 2001): "the extensive overlap in the phenomenology across the groups [clinical and non-clinical] suggests that such experiences alone do not indicate the presence of a clinical disorder" (Brett, Peters, & McGuire, 2015). A study of a non-clinical population with auditory verbal hallucinations has suggested that "emotional content constitutes an important difference between more benign hallucinations and psychopathology" (Sommer et al., 2010).

One possible way to think about the cultural construction of 'psychotic experiences' is by using the cultural invitation hypothesis (suggested by Luhrmann, Padmavati, Tharoor, & Osei, 2015). Diverse cultures 'invite' individuals to think differently about minds, persons, spirits, individuality, personality, etc. (about the cultural construction of the self and its relation to mental health, see also Kirmayer & Ban, 2013, p. 106). Additionally, different cultures have different views on what constitutes veridical reality and this may affect how 'psychotic-like' experiences are reported (Boyer in Larøi et al., 2014, pp. S213-4). Since "people pay attention in culturally varied ways, there are small but important cognitive biases in the way that they identify, respond to, and remember auditory experiences" (Luhrmann, Padmavati, Tharoor, &

Osei, 2015b, p. 649). The Western mind is 'bounded' and the personality individualised, therefore it is likely that voices will be understood as something bad. Luhrmann's cross-cultural study showed that in Ghana (a context marked by notions of witchcraft and demonic power), "hearing a voice spoken by an invisible person was not the sign of a violated mind" and that in India, "it is an evident part of this social world that invisible spirits can speak" (ibid, ibidem: 11–2).

It is safe to say that one can find a variety of cultural constructions of experiences of extreme distress, caused by hearing voices, having visions, feeling prosecuted, and alike (for the first collection of essays about this topic, see Jenkins & Barrett, 2004b; for a more recent one, see Luhrmann & Marrow, 2016). In the case of a hearing voices experience (or auditory hallucination), we can say that as *an experience* (with diverse phenomenology and explanatory models), it can be found across both time and space (McCarthy-Jones, 2012, p. 167). Psychiatry would say that this is due to its biological basis. However, there is a possible anthropological alternative:

> A symptom that holds true cross-culturally is not necessarily a window onto the underlying biological processes of illness. /…/ PAH [persisting auditory hallucinations] may in fact represent a transculturally similar mode of response to the social alienation that stems from psychotic illness. (Barrett, 2004, p. 105)

Anthropological studies of psychosis and schizophrenia are not restricted to "non-Western" contexts only. What all of them have in common is a focus on people's experiences in their everyday lives (Corin, 1990; Estroff, 1981; Larsen, 2002). Some of them emphasise the marginality of people diagnosed with schizophrenia and by doing so raise wider questions about social abandonment, an area where mental health, homelessness and other forms of marginality overlap (Biehl, 2005; Desjarlais, 1997; Luhrmann, 2008). Furthermore, the social context of psychiatric patients has been analysed both in research concerning the community (Scheper-Hughes, 2001) and psychiatric services (Barrett, 1996; Brodwin, 2013; Luhrmann, 2000). As these studies significantly concern my research, we are going to return to them in more detail in certain subsequent chapters of the thesis. Let us now introduce and discuss the two decisive anthropological concepts of the study, experience and narrative.

Finding meaning in psychosis

Schizophrenia has been widely presented as the "essence of incomprehensibility itself" (Lucas, 2004, p. 146).[6] However, more and more claims have been made that psychosis could be called

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[6] Angela Woods provides a brief overview of the reasons why this has happened (Woods, 2013, pp. 38–9). One of the reasons, Barrett argues, lies within psychiatry, which is still affected by the legacy of deterioration and

a meaning-making process. This term has been used both in anthropological (see Jenkins & Barrett, 2004; Larsen, 2004) and in psychological (Cooke, 2014; Roe & Davidson, 2005) accounts of psychosis. From a social constructionist perspective, psychosis is "a temporary, radical, and terrifying alienation from shared, communicative practices: a 'no-man's land' where unbearable experience has no words and, thus, the patient has no voice and no genuine agency" (Seikkula & Olson, 2003, p. 409). Several academic disciplines have studied meaning in psychosis. Some of the most important approaches are discussed in the following pages.

Medical humanities

Social psychiatry and medical humanities have explored the meaning of 'delirium', 'hallucinations', etc., by analysing patient life histories (Jenner, Monteiro, Zagalo-Cardoso, & Cunha-Oliveira, 1992; Romme, Escher, Zagalo-Cardoso, Monteiro, & Cunha-Oliveira, 1997). By doing so, they have put into question nearly all the basis of psychiatric knowledge by assuming a different epistemological position. One of their biggest claims, connected with the meaning of psychosis, is revealed by extensive research into trauma and psychosis.

We would like to focus mainly on the most common psychotic symptom, the hearing voices experience (hereafter referred to also as auditory verbal hallucinations, AVHs), which has also received the most academic interest.[7] AVHs are a diagnostic criterion for several psychiatric diagnoses.[8] It has been shown that the links between AVHs and traumatic experiences generally hold – irrespective of a person's psychiatric diagnosis (PTSD, schizophrenia, bipolar), AVHs may be the result of traumatic events (McCarthy-Jones, 2012, p. 286). Furthermore, a person may have AVHs but not a psychiatric diagnosis (Beavan, Read, & Cartwright, 2011; Johns & Van Os, 2001). As shown in a survey conducted by Romme and Escher, existential traumas were correlated with AVHs in 80% of individuals without a psychiatric diagnosis (Romme et al., 1997, p. 366).

Biological psychiatric investigation has been researching vulnerability genes for specific psychiatric disorders but it has not yielded consistent findings. Thus, it is likely that the genes

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degeneration theories. The other can be found in neuropsychology studies, "investigating schizophrenia's assault on the cognitive and affective underpinnings of narrative capacity" (Woods, 2013, p. 39). The philosophy of psychopathology has contributed to this view with theories about the breakdown of narrative identity and the dialogical self in schizophrenia. In the aesthetic realm, narratives of schizophrenia failed to meet the humanistic criteria of realism or autobiography of the 19th century. By silencing narratives of schizophrenia, stigma and discrimination severely contributed to the idea of the anti-narrativity of such experiences (Woods, 2013, pp. 38–9).

[7] The relation between traumatic events and other positive psychotic symptoms has also been established (for a narrative account of the connection between childhood abuse and paranoia, see Bullimore, 2012).

[8] Prevalence in schizophrenia is around 70%, in post-traumatic stress disorder around 50%, and in bipolar disorder around 7%. For an overview on AVH in different psychiatric diagnoses, see McCarthy-Jones, 2012, pp. 101–33.

interact with what in psychiatric literature is referred to as 'environmental factors' (Bentall & Fernyhough, 2008, p. 1012). Given the often destructive, abusive and threatening character of AVHs, it is not to be expected that the individual's life will be without any problems (McCarthy-Jones, 2012, p. 286). There is a large body of quantitative investigation that has shown the importance of (especially childhood) traumatic experiences in relation to psychosis (Larkin & Read, 2012). Definitions of traumatic events vary considerably (including but not limited to psychiatric[9], psychosocial[10], and social-psychiatric[11] views). Whichever conception of traumatic experiences we apply, we have to know that what is traumatic for someone is not necessarily traumatic for someone else (McCarthy-Jones, 2012, p. 286). The most investigated traumatic life event in connection to AVHs is childhood sexual abuse (hereafter CSA). According to an extensive literature review compiled by McCarthy-Jones, 36 per cent of psychiatric patients with AVHs report CSA, and 56 per cent of psychiatric patients who have experienced CSA report AVHs. Additionally, 22 per cent of 'healthy voice-hearers' (people with AVHs without a psychiatric diagnosis) have experienced CSA (ibid, ibidem: 292).

Besides the considerable link between traumatic events and AVHs established in quantitative research, qualitative research findings provide different, phenomenological evidence. There is a variety of possible links: the content of AVHs may be directly linked to a memory of a traumatic event. There may also be an indirect link in which the voice of the abuser is heard but it keeps saying something new. Trauma can also be a trigger for AVHs, or there may be no connection between trauma and AVHs (McCarthy-Jones, 2012, pp. 294–5).[12] Finally, apart from the first traumatic experience, many find it traumatic to never have been asked about it, even in a clinical context (Read, 2012, pp. 132–3).

Given the statistical correlation and phenomenological links provided above, how can we understand AVHs in relation to trauma? Recently, an interesting claim has been made by many

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[9] The APA defines traumatic experience "as directly experiencing military combat, personal assault (physical, sexual, robbery, mugging), torture, severe automobile accidents, as well as witnessing, or simply hearing of, unexpected deaths of close others" (cited in McCarthy-Jones, 2012, p. 286).

[10] John Read has shown that such traumatic experiences include the following: mothers' well-being during pregnancy, insecure attachment in childhood; early loss of parents; witnessing inter-parental violence; dysfunctional parenting (often intergenerational); childhood sexual, physical and emotional abuse; childhood emotional or physical neglect; bullying; war trauma; rape or physical assault as an adult; high level of racist or other forms of discrimination; and heavy marijuana use in early adolescence (Read, 2012, p. 127).

[11] The book *50 stories of recovery* presents 50 stories of successful recovery from schizo-spectrum diagnoses. Of these,24 people had suffered sexual abuse, 14 had suffered emotional abuse, 6 had experienced adolescent problems, 5 had suffered physical abuse, 4 had had high levels of stress and 2 had been bullied (McCarthy-Jones, 2012, p. 287).

[12] Marius Romme frames the possible links between AVHs and trauma, based on his book *50 stories of recovery* as follows: identity links, characteristics of the voices, the voices' content (direct or metaphorical), or situational links (Romme, 2012b, pp. 95–6).

researchers and 'voice-hearers': we cannot see AVHs as a simple and passive response to stressful life events, but as active, quasi-adaptive attempts to solve a problem (McCarthy-Jones, 2012, p. 310). While this surely does not hold true for every voice-hearer, traumatic life events in relation to psychosis indicate the importance of interpersonal experiences that lie at the socially-aetiological roots of psychosis.

Narrative psychiatry and psychology

Narrative-oriented psychology and psychiatry do not differ much from medical anthropology's claims about narrative. According to Geekie and Read, by narrating their story, patients become its protagonists, which in turn enables therapists to learn about and validate their lived experiences (Roe & Lysaker, 2012, p. 8). The birth of narrative medicine can be understood as an effect of the influence of the narrative turn in social sciences and humanities, which started in the late 1970s as an alternative to a medical evidence-based approach. Regardless of the supposed difficulties in finding narrative coherence in psychotic patients, narrative medicine emerged with the normative premise that "*self-expression through narrative is fundamentally healthy and desirable, particularly in the case of illness*" (emphasis in original; Woods, 2011, p. 10). Narrative psychiatry adopts a person-centred approach and assumes that stories told by patients are not just stories about their own lives, but stories with which they construct their lives (Lewis, 2011, p. 491). Furthermore, paying attention to the narrative implies changes in the doctor-patient relationship: "The doctor's contribution to the story is valuable not as a truth which has prior and superior validity to the patient's truth but only if the patient finds the doctor's contributions to the plot useful" (Launer, 1999, p. 19). What is more, from a narrative point of view, the process of understanding the patient's narrative is more important than the patient in terms of understanding narrated events through stories where the meanings are already determined (as happens with diagnosis) (Holma & Aaltonen, 1998, p. 261). In psychotherapy, the narrative orientation has stressed that "the aim of therapy is to create stories that are not yet told or are held in subjugation. These new stories offer possibilities for a new kind of meaning construction and thus enable personal experiences to become storied" (ibid, ibidem: 254).

Interest in the meaning of psychotic narratives has not been present just in academic and therapeutic fields. Several users' movements are also of immense importance, among which I would like to call attention to the International Hearing Voices Movement (hereafter HVM), which has created three valuable tools for exploring the subjective experience of so-called psychotic symptoms.

The HVM is the result of the collaboration between a psychiatrist, Marius Romme, a patient, Patsy Hage, and a journalist, Sandra Escher. They wanted to explore the hearing voices experience and its meaning rather than just labelling it as a symptom of a disease. Hage and Romme went on a television programme in the Netherlands to talk about the experience of hearing voices and invited people to send them testimonies of how they were or were not able to cope with the experience. It turned out that there were a lot of people who were coping with their voices and were functioning well in their everyday lives. This gave birth to an international movement of initially small groups of people exploring the hearing voices experience in safe places of sharing and listening. From the late 1980s until the present day, groups have been founded in more than 26 countries worldwide. The movement has been given institutional support by the International Hearing Voices Network (Intervoice) charity. Starting in 2009, Intervoice has also organised the World Hearing Voices Congress.

The HVM embodies the position of social psychiatry by understanding "schizophrenia" as a kind of being-in-the-world. The life history and social context of the person experiencing psychotic symptoms are principally taken into account. At the same time, there is strong scepticism towards classic psychiatric labels, resulting in the rejection of terms like "auditory hallucinations" and the creation of the term "hearing voices" (and "voice-hearer").[13] As some epidemiological studies show (for example, Beavan et al., 2011), a hearing voices experience is far more prevalent than a diagnosis of schizophrenia. Therefore, it's possible to speak about the continuity of psychotic experiences in the general population (Johns & Van Os, 2001). It follows that we can interpret as something pathological only the voices the individual is not able to cope with and not voices in themselves (Cunha-Oliveira & Zagalo-Cardoso, 1997, p. 23).

In practice, the HVM aims to validate lived experiences and voice-hearers' perceptions, and implement them in strategies of peer-support (Cunha-Oliveira & Zagalo-Cardoso, 1997, p. 21). Accepting the voices, integrating them into everyday life, and developing a compassionate relationship with them are the key concepts underlying the theory and practice of the HVM approach. By doing so, the HVM has developed a series of techniques and methods to facilitate the recovery process in close collaboration with voice-hearers ("professionals by experience"),

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[13] Like every term, *voice-hearer* encompasses just some of the key aspects of these phenomenologically very rich and diverse experiences. This is why not everybody who "hears voices" identifies themselves as a voice-hearer. For a critical discussion of the term, see Woods (2013b).

some of whom also participate as "professionals by profession" (Eleanor Longden, Rufus May, and Jacqui Dillon, to name only a few).

The Maastricht Interview (MI)

The Maastricht Interview is one of the tools that enables us to explore hearing voices experiences. Its aim is to generate *a construct*, which in practice proposes to answer two questions: who and what problems do the voices represent in the voice-hearer's life (Corstens, Escher, & Romme, 2008; Escher, 2012; Romme, 2012a). In other words, it is "a dynamic, psychosocial formulation that explores possible interpretations of the original situation that prompted voice emergence" (Longden, Corstens, Escher, & Romme, 2012, p. 226).

It has been shown that people who are able to make sense of the voices normally show higher levels of recovery from their symptoms. It has similarly been argued that approaches which acknowledge and assist the voice-hearer in making sense of the voices within their life history may have better long-term outcomes in comparison with approaches that see symptoms as a meaningless, "causally independent disruption" in people's lives. (Longden et al., 2012, pp. 224–5)

The MI centres around five principal aspects of the voice hearing experience: the identity of the voices, their content and characteristics, voice triggers, the personal history of voice hearing, and the life (principally childhood) history of the voice-hearer (ibid, ibidem: 227). Longden et al. give the example of 30-year-old Maureen, who hears three voices, two of which are aggressive and the third helpful. The first appeared in Maureen's life when she was sexually abused by her uncle, the second when the report as withdrawn by her parents and the third while Maureen was receiving psychotherapy. The first voice wants to talk to Maureen about the abuse and is very angry when she refuses to listen. The second accuses Maureen of not being strong and persistent with other people. It also tells her to kill herself. The third gives Maureen advice on how to cope with the first two voices. Their triggers are congruent with their content. Her childhood history is explored and Maureen's upbringing is shown to have been very sheltered, and that she was not encouraged her to stand up for herself.

To conclude, the MI offers a promising starting point for studying the phenomenology of the hearing voices experience. It has, to a certain extent, inspired my exploration of the hearing voices experience in the ethnographic part of the thesis.

Voice dialogue

Voice dialogue is a structured tool to talk *to* the voices (and not *about* them, as in the MI approach) with the aim to facilitate a more productive dialogue between the voices and the voice-hearer (Corstens, May, & Longden, 2012, pp. 166–9). According to Marius Romme, the structure of the dialogue is as follows: the facilitator in the dialogue process asks for the permission of the voice-hearer to talk to the voices. This is done to determine whether the voice-hearer and the voices feel comfortable with this or not. The consent of all the parties in the dialogue is of crucial importance: if one of the three parties in the dialogue does not agree or feel safe, they do not go ahead with the session. The voice-hearer's role is to consistently repeat what the voices say. Dialogue is held with just one voice at a time. While delivering messages from the voice chosen by the voice-hearer, different chairs are used by the voice-hearer to mark the distinct positions, using one for the voice and the other when they speak for themselves. As in the beginning, the dialogue must end with the consent of all three parties. The facilitator then says goodbye to the voice. Next, the individual is encouraged to reflect on what has just happened (now using their own chair). The facilitator concludes the session by summarizing what they saw (the voice-hearer can also write it down so that they can keep their own notes) (Romme, 2012a, pp. 170–2).

Peer-support groups

Peer-support groups are the third way of an individual's integration of voices. These groups encourage the emancipation and self-organisation of their members. Politically speaking, this means the construction of an alternative approach (to that of the dominant psychiatry; see Dillon & Longden, 2012, p. 131). These groups pretend neither to be therapeutic nor to be part of the dominant psychiatric system. Their goal is to create safe spaces for sharing experiences and are not necessarily led by mental health professionals (ibid, ibidem: 131–2). In fact, hearing voices groups only have 'facilitators', who nourish the dynamics of the group and to ensure that everybody can be heard, which increases the collaborative character of these groups. As a member of a hearing voices group from the US puts it: "No one tells you what to do. They don't assume they know you better than you know yourself" (Dillon & Hornstein, 2013, p. 292).

Hearing voices groups may facilitate the following: recognizing patterns for coping with voices (for example, negative emotions in relation to negative voices), changing the attitude towards the voices, ending the isolation generally implied by a hearing voices experience, and accepting the experiential reality the voices impose (Dillon & Longden, 2012, p. 132). Accepting and validating subjective experience appear to be crucial points in many stories of recovery.

Anthropology and experience

Subjective experience has also been the subject of anthropological study. Subjectivity, as a 19th century concept, referred to essential individuality (Biehl, Good, & Kleinman, 2007, p. 5). The concept of subjectivity is nowadays the counterpart of objective and objectifying scientific worldviews, as it also suggests artistic creativity and could be thought of in relation to "inner life processes and affective states" (ibid, ibidem: 6). Contemporary anthropological examinations of subjectivity are greatly indebted to Clifford Geertz. He explored this theme from the 1950s to the 1970s, when anthropology was marked by various theoretical schools (the French structuralism of Lévi-Strauss and Lacan, Foucault's theory of discourse and power, and Bourdieu's debate on habitus and agency) that diminished the role of the subject (ibid, ibidem: 6–7). Geertz introduced the distinction between 'experience-near' and 'experience-distant' concepts. An experience-near concept is one which an informant uses to define "what he or his fellows see, feel, think, imagine, and so on, and which he would readily understand when similarly applied by others" (cited in Jenkins & Barrett, 2004a, p. 8). An experience-distant concept would be one which specialists employ "to forward their scientific, philosophical, or practical aims" (ibid, ibidem). Anthropology has started to be interested in something that "is *at stake* for all of us in the daily round of happenings and transactions" (emphasis mine; Kleinman & Kleinman, 1995, p. 277). In investigating subjectivity, anthropology has emphasised personal agency and active engagement in the processes of cultural construction (Jenkins & Barrett, 2004a, pp. 8–9) – something that had been lacking in structuralist and other approaches prior to the 1980s.[14]

Medical anthropology has greatly adopted a phenomenological perspective in its accounts of subjective experiences of ill health. Human conditions such as suffering "offer a resistance in the flow of life to the elaboration of life plans" (Kleinman & Kleinman, 1991, p. 278). Furthermore, illness unmakes common-sense reality, as described by phenomenologist Alfred Schutz (Good, 1994, pp. 124–7): an illness experience alters the forms of experiencing the self; forms of sociality are reduced to a person's experience of bodily pain; a common time perspective is altered; general wide-awakeness is reduced by the pain, etc. Phenomenological studies of health and illness have refuted the duality between body and soul, and pointed to a holistic perspective of "the mindful body" (Scheper-Hughes & Lock, 1987). The body has been

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[14] However, explorations of experience always run into a host of problems. Desjarlais points to a common tendency to see experience as a truer aspect of life, rich enough to defy conceptual models. It is argued that experience is just one form of life among many and that it is a process built by cultural, historical, political, and pragmatic forces (for a further critical discussion on the concept of experience, see Desjarlais, 1997, pp. 10–7).

emphasised in anthropological studies of pain (Šimenc, 2008), where the body has been regarded, according to Merleau-Ponty, as a "setting in relation to the world" (Csordas, 1990, p. 8). The embodiment paradigm has shown that "the body is not an *object* to be studied in relation to culture, but is to be considered as the *subject* of culture, or in other words as the existential ground of culture" (emphasis in original; Csordas, 1990).

The anthropological emphasis on lived experience has to be considered within the context of its cultural critique of the biomedical model of health and illness. Lived experience is ignored by biomedicine since it is something hardly observable by its positivist methodological standards (Roe & Lysaker, 2012, pp. 6–7). However, there has been considerable interest in lived experience in other traditionally more positivist disciplines. Psychosis research in phenomenological psychiatry and clinical psychology has long been intrigued by the subjective dimension (Jenkins & Barrett, 2004a, p. 7; see Strauss, 1989 for one of the first psychiatric articles on subjective experience and schizophrenia). Phenomenology, applied to mental health, suggests that mental distress has to be understood as distress in one's being-in-the-world and not as a disorder of a person *qua* isolated entity (Lamovec, 1994, pp. 204–5). Furthermore, symptoms point to the subject's temporal incapacity for intersubjectivity (Corin, 1990, p. 160). One of the most important contributions made by the phenomenological study of psychosis is the focus on lived experience and not on diagnoses, which made it possible to study what it is like to "hear voices" without paying too much attention to the various psychiatric categories in which it can be included (McCarthy-Jones, 2012, p. 101).

How do we approach lived experience? Although not the only, narrative has been recognized as a privileged way of accessing it. Let us continue by examining the anthropological discussion on (illness) narratives.

Anthropology and narrative

The interest in narratives related to health or 'ill health' had already been broadly discussed in medical anthropology before a similar interest arose in medicine and psychiatry (Martínez-Hernáez, Masana, & DiGiacomo, 2013, p. 9). Of all the subdisciplines of social and cultural anthropology, medical anthropology was the most receptive to the narrative-focused approach. Medical anthropology has put forward, as shown in the previous section, strong criticism of the biomedical model. At the same time, by using a narrative orientation, it has been paying special attention to people's lived experience (Riessman, 2003, p. 6) deemed to be lacking from contemporary healthcare (Woods, 2011a).

Of course anthropology has been dealing with narratives from its very beginnings due to its ethnographic methodology. However, narratives started to matter only after the 'narrative turn' at the end of the 1970s. Until that point, anthropology had never explicitly heeded the narrative form of its data. What has changed with the narrative turn? Anthropologists have become more aware of narratives and have started to treat them not as the incidental form their data happened to come in – they have taken stories seriously (Garro & Mattingly, 2000, pp. 3–4). The narrative turn emerged in anthropology and other disciplines, it therefore does not make any sense to distinguish between the disciplinary tribes (ibid, ibidem: 6).

The narrative turn emphasises the agents of culture who are no longer hypothetical or average natives, but real individuals (Garro & Mattingly, 2000, pp. 19–20). This brings us to the end of 'grand narratives', the core argument of the postmodern turn in the 1980s. It was first presented in the famous work, *Writing Culture* (Clifford & Marcus, 1986), which is intimately connected with the question of narrative. Anthropological written accounts have been subjected to considerable criticism. The researcher no longer occupies the privileged point of view – their story is only one of many in the postmodern polyvocal and cacophonic ethnographic field (Lipovec Čebron, 2008, p. 51). It has to be noted that the debate on the epistemological status of anthropological knowledge has transformed narrative from a specialised interest into the "central construct within the discipline" (Garro & Mattingly, 2000, p. 23).

There has been lively and lengthy discussion on whether speaking about 'narrative' either illuminates or masks. After four decades, a high number of studies on narrative has been accumulated and many definitions of narrative have been made. Narrative can be, in the least defined case, a synonym to any kind of 'self-expression'. Using 'narrative' as an 'umbrella-term' can be quite confusing and can lead to a situation in which various genres of narratives disappear within the chaotic field of narrative (Cohen, 2015, pp. 55–8; Woods, 2011b, pp. 5–6). Although many schools of thought distinguish between 'narrative' and 'story', we use these two terms interchangeably (for a more extensive discussion on terminology and its theoretical background, see Garro & Mattingly, 2000, pp. 12–6). The numerous definitions of narrative have resulted in a multitude of analytical strategies within narrative-oriented medical anthropology, some of which are summarised below. They all belong to the interpretative, meaning-centred tradition, but it is important to keep in mind that "sense-making may be focused on face-to-face interactions, on cultural activities of entire social groups, or on the interface between personal experience and cultural models of thought and action" (Mattingly, 1998, p. 9).

Firstly, illness stories can be viewed as life histories. This approach resulted in researching life histories as a method, which tends to facilitate a processual rather than static view of life (and illness). It often requires collaborative research (Lechner, 2015) and shows people's need for coherence and continuity in life, previously disrupted by an illness experience (Mattingly, 1998, p. 13).

Secondly, one of the most common strategies points out the cultural construction of narrative. Learning how to remember and tell stories is a cultural matter (Garro & Mattingly, 2000, p. 25). Stories can be viewed as cultural scripts (see Langdon, 2001) – they can communicate cultural knowledge and provide material "in which an illness is represented at a societal level" (Mattingly, 1998, p. 13).

Thirdly, performative traditions have stressed that narrative is a social act, "something constructed 'between' text and reader (or teller and audience)" (Mattingly, 1998, p. 16). Some scholars in the anthropology of rituals, such as Barbara Myerhoff, use the term 'story' as something 'enacted' (Mattingly, 1998, pp. 162–3). As proposed by the performative tradition, when one focuses merely on personal stories, "it is possible to miss the fundamentally social and action-oriented nature of both experience and storytelling" (ibid, ibidem: 167). What matters instead "is the experience and action created by telling the story"; meaning lies in the context, in social interaction and is not just the domain of the narrator (ibid, ibidem: 43). This is the most interesting analytical strategy for our present discussion, and will frame the analysis of the ethnographic material in the thesis.

As I have already mentioned, there is a correlation between (pre- or non-narrative) experience and a narrative account of it. However, this can occur in different ways. For example, a realist, adopting the mimetic stance, indicates a natural correspondence between life as lived and life as narrated. This stance sees narrative as a window to either past observable events or to personal experience (Mattingly, 1998, pp. 25–6). Long before the narrative turn, a few 'narrative' sceptics, such as Franz Boas, returned to the Malinowskian methodological maxim of participant observation. Meanwhile, the postmodern school of thought dismissed the mimetic stance as 'naïve realism', 'empiricism' and 'positivism', but it was precisely this criticism which gave narrative its theoretical appeal (ibid, ibidem: 26–31). The anti-mimetic stance sees narrative as the transformation and distortion of experience. It has been widely adopted by medical anthropologists (ibid, ibidem: 25). There is a strong consensus in medical anthropology that the narrative process is an active attempt to understand and recover such unmade common-sense reality. This view therefore implies an ontological difference between life-as-lived (pre-

or non-narrated experience), which lacks coherence, and narrative, which is used for making experience coherent (Mattingly, 1998, p. 32).

Last but not least, narrative and experience are scrutinized by Cheryl Mattingly in her theory of the narrative structure of experience. Analysing interactions between occupational therapists and patients with chronic physical conditions, Mattingly introduces the concept of 'clinical plots'/'emplotment'. The main point of her theoretical work on narrative and experience is that life is structured by narrative seeds: it is "not experienced as one thing after another because actors work to create a story-like quality to their actions" (Mattingly, 1998, p. 47). She also suggests, based on Ricoeur's theory of narrative, that "action can be understood as an as yet untold story" (ibid, ibidem: 46). This aspect will be explored later in the thesis, especially in the last part of the second chapter, "Facing future: (inter)subjective experience of everyday life after the first psychotic episode".

NARRATIVE IN PSYCHOSIS AND RECOVERY: AN ETHNOGRAPHICAL INVESTIGATION

Exploring intersubjectivity in psychosis and recovery

In this chapter, the ethnographic material is "read" through a narrative lens, using the story metaphor to explore the social dynamics of psychosis and recovery. Narratives of psychosis and recovery have been extensively analysed and the vast majority of narrative studies have approached narratives as a separate, individual domain. This thesis is an attempt to overcome this view. It tries to grasp narratives as a social domain, since they are produced and enacted in the field of *interpersonal relations*. Let us briefly sum up some of the key influences on the construction of the study.

Firstly, following Heidegger and Merleau-Ponty, some anthropologists pointed to people's "being-in-the-world" as a domain that lies *between* people, which implied inter-existence being given analytical precedence over individual essence. Subjectivity has been re-approached by some in the context of the intersubjective turn (inspired by Buber's concept of the dialogical, Schutz's social phenomenology, etc.), in which selfhood and other social phenomena are understood as "arising from and shaped by ever-altering modalities of embodied social interaction and dialogue" (Jackson, 1998, p. 6). In short, for some anthropologists (as for the present study), reality is primarily *relational*.[15] In a similar way, contemporary anthropology writing considers subjectivity and the subject "not as original forms but as dynamically formed and transformed entities" (Biehl, Good, & Kleinman, 2007, p. 10). Experience is, therefore, "the intersubjective medium of social transactions in local moral worlds" (Kleinman & Kleinman, 1991, p. 277).

The second influence comes from narrative theory in psychology and psychotherapy. It states that a "narrative through which meanings are constructed is always socially created and maintained in dialogue with others" (Holma & Aaltonen, 1998, p. 253). The dialogical character of narrative is a particularly important aspect, inspired by the social constructionist and

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[15] In the beginning, anthropology's scientific and objective agenda was based on colonial power relations which made it possible to study "the natives". Later, critical reflection on its colonial context meant thinking about its epistemology – how anthropology produces its knowledge –, and this is where the concept of intersubjectivity played an important role (Fabian, 2014, p. 201). This phenomenological concept, intersubjectivity, was received quite differently in anthropology and in sociology. The latter tackled the issue simultaneously with a broader intellectual and political countermovement against the discipline's positivist heritage (ibid, ibidem). Overcoming its quantitative bias, however, was not the issue in anthropology, generally a qualitative discipline. Linguistic anthropology was the most receptive anthropological subdiscipline for intersubjectivity. The subdiscipline was at the time trying to argue against the Saussurian and Lévi-Straussian structuralist notion of language as a system of signs. In the view of Dell Hymes, the most notable scholar to adopt the idea of intersubjectivity, language was thought of as "interpersonal acts and modes of communication" (ibid, ibidem: 202).

Bakhtinian concept of dialogue as "something that is constructed in the area between interlocutors" (Seikkula, Alakare, & Aaltonen, 2001, p. 25). From the relational/dialogical point of view, mental health is about "our experience of being able to move–or not–in relation to others", or put differently: "Both ways into, and out of, psychosocial difficulties are explored in terms of ways of being in the world together with others" (Bøe et al., 2014, p. 475).

The emphasis on social interactions in psychiatric and psychological studies is not at all new. Freud wrote about family influences on schizophrenia in his account of Dr. Schreber in 1911 (Nichols & Schwartz, 1998, p. 26). Furthermore, the already mentioned psychiatrist Harry Stack Sullivan theorised interpersonal relations in psychiatry. He coined the term 'problems in living' to describe the experiences of people diagnosed with schizophrenia. The evolution of placing emphasis on interactions in mental health brings us to systemic thinking in psychotherapy. The work of biologist and anthropologist Gregory Bateson and his schizophrenia team in Palo Alto, California, was one of the starting points for family therapy. Bateson's concept of the 'double-bind' introduced the idea that schizophrenia could be an adaptive response to a larger system of relations that generates paradoxes (Seikkula & Olson, 2003, pp. 404–5).[16] Some systemic therapists have adopted the narrative view (M. White & Epston, 1990), which is another influence on my thesis. The proposed narrative point of view is characterised by the main metaphor of the text, through which psychosis and recovery are analysed. Problems (say, a psychotic crisis) are thought to be constructed as a performance of an oppressive, dominant story or knowledge. The recovery process is thought to be constructed in terms of the social dynamics of opening up (or not) space for the authoring of alternative stories (White & Epston, 1990, p. 6). According to Foucault, power is a 'productive' force in that it is constitutive in shaping people's lives (ibid, ibidem: 19). Therefore, power does not repress but subjugates, and consequently, we can speak of dominant and subjugated stories.

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[16] The double-bind theory was subsequently anthropologically used in the famous book *Saints, Scholars, and Schizophrenics*, where it was applied not on the family but on the community level (Scheper-Hughes, 2001). Meanwhile, the narrative and dialogical orientation in psychosis was intensively adopted in Finland. The Open Dialogue Approach, now an already quite well-known approach for working with people experiencing their first psychotic episode, has been developed on the basis of the Turcu Project, and subsequently the Finnish Integrated Approach to the Treatment of Acute Psychosis Project (for a more detailed account, see Seikkula, 2011). Open Dialogue stresses immediate service response in acute psychosis (within 24 hours of referral) and includes the patient's family and social network throughout treatment (for its basic principles, see Seikkula et al., 2001, pp. 249–50). It has been shown that while only 33% of patients in acute psychosis received antipsychotic medication, in the two-years follow-up, 81% of patients did not have any residual psychotic symptoms, and 84% had returned to fulltime employment or studies (Seikkula, Alakare, & Aaltonen, 2011). These findings also resonated in the USA and support Whitaker's claims about the questionable long-term effects of antipsychotic medication (Whitaker, 2010).

Participants in the study

I have carried out ethnographical fieldwork with three individuals. They all differ in many respects, however, a unifying theme remains: they all passed through the first acute psychotic episode which led to their first hospitalization in a psychiatric hospital.

The initial idea[17] of the fieldwork was to meet people during the last phase of their first psychiatric admission and then collaborate with them in their transition to the community. In the study, the story of the fieldwork is also the story of the challenges I faced in conducting it.

The first possibility to conduct fieldwork emerged when I met Paulo, a man in his mid-twenties, for the first time on 11th October 2016. Doctor Santos wanted to introduce us but it turned out that there was no need to do so since Paulo and I had already known each other before. Following the first ambiguities, we succeeded in constructing a warm relationship which went beyond traditional academic research, or as he once reflected, a relation of companionship. However, it turned out that Paulo did not want to continue the collaboration and on 15th November 2016, he finally withdrew from the study.

On 18th November 2016, I met with 43-year-old Sofia to talk about her story. The conversation was originally not intended as part of the study but I finally chose to include it, in part perhaps because she once suggested I should do so. Sofia and I met for the first time in 2015 in an academic context. In the autumn of 2016, she started to attend a peer-support group organized by the Hearing Voices initiative that I was collaborating with. Once, after a group meeting, she talked quite a lot about her experiences. I wondered whether she would be willing to write something about it for publication on the initiative's web page to send a positive message that recovery from psychosis *is* possible. She said she would find it difficult to write on her own but that would like to speak about it in a more structured form, transcribe the conversation and then eventually publish certain sections. We did so, and a few weeks later, she said she would not mind her story being included in my thesis. In March I considered the idea once more and decided to include Sofia's story. It altered my original research agenda slightly, since the research with her did not start in the FPE unit. However, the focus of the study did not change as she provides rich insight into her FPE experience.

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[17] On 28th November 2015, in the context of the master's degree programme, I attended a lecture by Professor Vítor Santos on public mental health. He gave us some examples from his clinical psychiatric work on the first episode psychosis team. I was immediately interested in the topic and the subsequent conversation with Professor Santos raised the possibility of conducting ethnographic fieldwork in a ward at the Sobral Cid psychiatric clinic in Coimbra.

Months passed by and it appeared that there were not as many possibilities to carry out the fieldwork as it had been proposed. Some opportunities did emerge, but for various reasons they all turned out to be too difficult to realise until I met 26-year-old Mário on 24th January 2017. The contact was facilitated by Vítor Santos, Mário's psychiatrist. We met in the outpatient clinic at the university hospital in Coimbra. Doctor Santos talked to Mário during their appointment that day about my research and invited him to participate in it. Mário was accompanied by his mother and his girlfriend. They waited for us in the waiting room during our first conversation, which lasted for much longer than I could have imagined. I immediately felt he was well-inclined to talk about his experiences. I do not know how long we talked that day, but I know that I felt a bit uncomfortable knowing that Mário's mother and girlfriend were waiting for us. However, this was not the case with Mário, so we had a fruitful conversation, resulting in an outline which I wrote and sent to him. He corrected it so that it could – and finally did – facilitate our first interview.

All three participants contributed significantly yet differently to this study. The different phases of psychotic experiences and recovery they were in at the time opened up possibilities for different levels of analysis. The fieldwork conducted with Paulo gives us an insight into the social dynamics of the last week of the first hospitalization and of the transition back into the community. Furthermore, his refusal to collaborate a month later reflects and is interpreted as a meaningful strategy Paulo employs to be able to live in the community, on the margins of the psychiatric system. Secondly, Sofia's story provides illuminating insight into the importance of interpersonal relationships for recovery and presents a somewhat temporally distanced and more analytical perspective on her own recovery journey. Thirdly, Mário's story enables us to further reflect on the importance of intersubjective dynamics in recovery.

In the analysis, the common thread of interpersonal relations both in acute psychosis and the recovery journey can be identified. The analysis also includes the relationships our participants have with me as a researcher (see the methodology chapter), as I was a part of their lives during the fieldwork, and in some cases also afterwards.

The text is organised chronologically, beginning with the ethnographic account of the participants' first psychotic crises. It is followed by the analysis of the participants' experiences of hospitalization, and a discussion of their individual coping processes. In all of the cases it can be noted that the first acute psychotic episode means a kind of biographical disruption in people's lives (Bury, 1982), an initial Aristotelian *peripeteia* – a "breach" of life plan (Myers, 2016, p. 430).

However, I must emphasise that two of the three participants wanted to talk more about their recovery journey then about their psychotic experience. The organisation of the text is, therefore, more influenced by my attempts to give a temporally comprehensive account of people's experiences, than by the participants' narrative construction of them. Although the psychotic episode in all three cases *is* a biographical disruption, and the organisation of the text may endorse this view, the participants' narratives are predominantly characterised by their attempts to live their everyday lives after the crisis.

Before proceeding to the ethnographic part, we have to dedicate a few words to terminology. The emphasis on lived experience on the one hand and the use of psychiatric terminology on the other may appear somewhat strange. Predominantly, terms like 'psychosis' and 'psychotic episode' are used to refer to experiences of persecution, hearing voices, having visions, and the like. These psychiatric 'experience-far' concepts are used in order to emphasise the social construction of these experiences in the context of the participants of the study. Some of them hear voices, some had feelings of persecution, etc. – these subjective experiences are validated and analysed. However, all three participants have had experiences with psychiatric services. I would argue that these experiences – because of psychiatric hegemony – shape the subjective experiences of 'psychosis'. By opting for the use of psychiatric terminology, therefore, I do not necessarily agree with it (on the contrary, there are many occasions in which I critically reflect on it), but it is important to recognise the social construction of these experiences because they affect the participants' lives.

Short life stories

Paulo has been enrolled in two different university courses in Coimbra. Engaging in the arts, however, has been of greater importance to him. When he was younger, he had cancer, which included heavy drug therapy. He no longer receives this therapy as the cancer is considered cured, and from the moment the therapy finished, he started to live what he refers to as "a crazy life":

> P: I was doing everything I wanted to. I was partying hard. Discotheques.
> JŠ: The good life.
> P: The good life. It is true. But it fucked me up. I lived it all. I basically experienced everything I could. Then I had this thing… they say I had a psychotic episode.

Paulo's life has recently also been marked by his spiritual quest. He has been searching for spiritual masters to help him establish well-being in the balance between the spiritual and the everyday world. An important topic present in the narrative about his life before the acute

psychotic episode is, apart from a crazy life, also a spiritual "stagnation". He says he should not spend time with some of his friends since they have taken some further spiritual steps and if he socialised with them, he would slow down their spiritual progress. When asked about his life before the psychotic crisis, his most significant response was "doing nothing" (except working hard on his spirituality and seeking quick spiritual growth), as he found it difficult to provide reasons for his crisis. Finally, he recalls being stronger before the episode and hospitalization.

Sofia offers a temporally more removed view on her psychotic episode. She starts telling her story by emphasising her difficult relationship with her mother, in which she sees a kind of structural predisposition (but not the trigger) that culminated in the crisis. Sofia's undergraduate studies were followed by a few years of work experience in various private firms, subsequent independence and living alone. After four years, she left her company job and enrolled in a master's degree programme, followed by a PhD programme in Lisbon. After two years in Lisbon, she transferred to the University of Coimbra. Furthermore, before the crisis she had been on a trip to India, after which she decided to end her relationship with a partner with whom she had stayed for about six years. She had met someone in India with whom she was maintaining a relationship through social media, which turned out to be a difficult task. Before the crisis she was also experiencing feelings of isolation due to the lonely nature of her academic work.

Mário's dream as a teenager was to become a professional football player. Although he used to practise other sports (swimming and roller hockey), by the age of 12, football turned out to be his favourite sport. He trained until he started his university studies in Coimbra, when he stopped in order "to dedicate everything 100% to [his] studies". Football was one of the main things in his everyday life between the ages of 12 and 18, occupying nearly all of his days, with training sessions during the week and matches on Sundays.

Apart from football, Mário's time was also occupied by his drug use. He had started smoking marijuana by the time he was 12. Reflecting on it now, Mário recognises that the period between 12 and 15 was a period of self-searching, of finding his own way of living, also of his first intimate involvements. Additionally, he was quite easily influenced by his peers. He understands his first experiments with drugs also within the context of his family structure, because he is an only child and his father used to be quite absent: "I missed the presence of my father a bit".

He was not satisfied with the first university course he enrolled in, so he transferred to another. Mário did not finish the first academic year in his new course, so he decided to work to financially help his parents in paying the tuitions. He found a job in a bar near his home. His next job was in Belgium, where he stayed for a few months. When he came back, he already had the bad reputation of a cannabis user (*fumador*). This period of his life is also marked by a busy intimate life, as he was involved with several girls.

By chance he met someone on Facebook who offered him a job in Germany, which he accepted. He returned from Germany to take an entry-exam for sports education studies in Chaves. The conflictive duality of sports vs. drugs continued in this period: on the one hand, he was studying sports, and on the other, he was consuming drugs. The situation changed in the final stages of his last, third year of studies, when his drug use and his psychosocial crisis reached their peak, resulting in three weeks of very disorganised experiences and a great deal of suffering.

Making sense of psychosis
Confusion and unemplotted subjective experience

Paulo's story brings us to his last week in the inpatient context. It points to the fluid process of the emplotment of various "explanatory models" (Kleinman, 1980) as enacted at the ward, principally between him and the medical professionals. Kleinman's notion of the explanatory model has undergone considerable criticism. Firstly, it was suggested that medical anthropology has produced theories and models that portray patients as rational people, which leads scholars "to bracket out the non-cognitive and non-rational determinants of the statements they study" (Young, 1981, p. 317). Secondly, performance-oriented narrative studies would suggest that narrative (explanatory model included) is a co-construction, a social act, "something constructed 'between' text and reader (or teller and audience)" (Mattingly, 1998, p. 16). It is therefore by no means something that waits for a researcher's voice recorder to be registered, or something that does not change in time. The next paragraphs attempt to show the temporality of the explanatory model change and the interpersonal realm of its creation. Temporality should be a key aspect of the text since it is also a very important aspect of Paulo's experience. His process is a very fluid one and that is why the dates accompany the ethnographic data where necessary. This story-like writing is believed to be a helpful way to grasp the temporality of the process.

Paulo's explanations of his "psychotic episode" are embedded in his current way of understanding the world. The predominant theme in his narratives about life is related to his own agency. He says that "life is the consequence of our choices". When asked what he was

doing before the crisis, his response was, "nothing", which he saw as a problem somehow related to the crisis (25th October). At the time, he did not make any decision about his life, he let the situation be as it was, and so the crisis occurred: "I could have grabbed my things and gone somewhere, to work abroad" (31th October).

Despite mentioning some connection with the world of spirits in the first days of our conversations (from 11th October onwards), Paulo did not expand substantially on how he explained what was happening to him. Everything was more focused on his discomfort with being a psychiatric patient: "I've had my fill of psychiatry" (25th October). Even if he found the psychiatric explanation of his condition strange to him, he felt something had happened, or in his own words: "I really went crazy".[18]

A week later he talked to the staff in the ward and they explained to him that he had an acute psychotic episode because of, as he puts it, "the excess of information in my head and the pressure from my family". I wondered if that made sense to him and he told me it did. A week later we talked about psychosis again and he told me that he would check out what psychosis was on the internet when he went home. The next passage is illustrative of the way he was facing his own and the psychiatric explanatory models:

> Here it is as if you had a broken machine. Here. Sometimes the problem is not in the machine but in the abstract problems within you, you know? Or there is confusion about other things and you need to go somewhere else. And then it starts to get complicated… I do not know, I came here and now I have to accept it, I have to accept the medication. I have to beat it into my head that I had a psychosis. Probably psychosis was just what they called it and maybe my problem did not have anything to do with it. (2nd November)

Biomedical models[19] are brain-centred – in explaining psychiatric conditions, psychiatry focuses on alterations in the brain. This model does not seem to be very serviceable if one does not see any considerable alterations but still feels confused and is hospitalised in a psychiatric unit. What is more, a routine TC (computed tomography) brain scan did not show any significant data to support the psychiatric explanatory model, which contributed to Paolo's confusion, the main dimension of his lived world in the phase of acute crisis and hospitalization. On the other hand, spirituality – another important aspect of his lived world – is not something

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[18] 'Going crazy' for Paulo here does not imply 'being mentally ill' (for an analysis on the normal and the pathological in early psychosis, see Tranulis, Park, Delano, & Good, 2009).
[19] There are many biomedical models. Simon McCarthy-Jones offers an extensive review of how various models interpret the aetiology of the hearing voices experience (McCarthy-Jones, 2012, pp. 189–312).

often addressed in psychiatry, which also holds true in Paulo's case. He tried to talk to his psychiatrists about spirituality but "they do not understand it":

> P: Maybe my problem is not psychiatric at all, maybe it is not in my brain. They did a TC but they did not find anything in the brain.
> JŠ: A TC?
> P: They did a brain scan, like a picture, but they did not find anything. Maybe I do not have anything. But do you see what I mean? Maybe my problem isn't medical, it could just be spiritual.

One can view evidence-based psychiatry as a mythic world. Through diagnoses and psychoeducation practices, it creates its own distinguished kind of symbolic healing (Larsen, 2007, p. 301). What is put into question here is not the empirical truth of this scientific psychiatric perspective, but the fact that this truth is "presented and manipulated to be accepted by the clients as an *experiential truth* – a perspective they used to make sense of their experiences and life situation" (emphasis in original; ibid, ibidem: 294). Psychosis is generally approached according to the dominant psychiatric practice based on positivist clinical rationality. It's possible to say that this was also what happened in Paulo's case. It diminished the possibility for Paulo to be understood through dialogue and not according to pre-fabricated theoretical or diagnostic stories (Holma & Aaltonen, 1998, p. 254).

Ethnography seems to be a useful way to grasp the temporal changes in explanatory models. In this case, I witnessed the process of changes in the explanatory model, a very spiritually-oriented one, accompanied by great scepticism about the mental illness explanation. On 11th October, Paulo told me he was tired of his psychiatrist and the ward. Additionally, he tried to make sense of his experiences in a different register, related to "doing nothing" before the crisis and his spiritual quest. On 2nd November, I heard him say: "I have to beat it into my head that I had a psychosis". At the same time, he wondered what it meant, asked me if I knew anything about it and said he would look it up on the internet when he returned home.

His other meaning-making attempts appear throughout his biographical data. When he was younger, he had cancer. He no longer receives drug therapy for cancer and from the moment the therapy finished he embarked on what he called a crazy life (already referred to in this chapter), which can be seen as a free self-narrative, full of Paulo's agency.

Paulo explains his quest for spirituality as another possible factor that led to the crisis. He perceives that there is something beyond material reality – a spiritual word that he wants to explore. In the time leading up to the psychotic crisis, he tried to "illuminate himself by force". Again, confusion (mess) is a key element of the narrative:

P: I was searching for a lot of spiritual information. Loads of different things. It caused a big confusion in my head. I wanted to illuminate myself by force. With different types of information.

JŠ: Yeah. Once, you told me that you had experienced confusion because of an excess of information. This is, if I understand it right…

P: Spiritual. It is not necessary to go after things in your life, things will come to us when we are prepared and able to absorb them. I tried to absorb it all at once. I was searching for three spiritual masters at the same time. [He smiles.] /…/ Lots of times it was contradictions and this affected my brain.

JŠ: Wow. Too much information.

P: Yeah. Too much information for my young brain.

The fact that in acute illness, narratives have not yet been constructed or that there are multiple tentative accounts that coexist and compete with each other has been well-documented (Kirmayer, 2000, p. 171). This also holds true in Paulo's case. There are plenty of connections Paulo sees as potentially meaningful and likely to partly frame his episode: his "crazy life" after the cancer therapy, his spiritual quest, the absence of his agency in actively changing his life before the crisis, etc. However, the main theme in his making sense of what was going on is the confusion: "I do not know, this is why everything is so confused. One does not have certainties about anything, and the world becomes confusing". Let us recall an important claim of narrative-oriented studies in psychosis: a psychotic episode can be seen as an ultimate way of maintaining one's agency since another way is not possible due to social circumstances (Holma & Aaltonen, 1997). From the narrative point of view, symptoms are therefore seen as someone's productive (even though sometimes hardly understandable) attempt to live in their experimental world. However, in analysing his hospitalization experience, one cannot say Paulo took part in dialogical meaning-making. Due to his explanatory model that differed substantially from the psychiatric one, he was alone in his personal construction of reality.

Metaphors used in Paulo's narrative to describe his situation may help clarify our claim. Paulo speaks about being stuck in a hole, implying that he perceives his situation as a place without an exit or a place which is difficult to exit. We are going to continue to draw on this in the next subchapters because Paulo's agency has a strong connection not just to his psychotic experience, but also to the way he faces the future.

Loneliness and social isolation

Sofia uses the word episode (*surto*) to describe her experiences. She has had two, the first in 2012 and the second in 2014. She describes them as disconnectedness from a commonly shared reality. In the previous subchapter, we saw the circumstances of her life before her first psychotic episode. She sees them as closely related to both of her psychotic crises. Her

etiological explanation is based on her loneliness and disconnectedness from others, which implies a further disconnectedness from reality. Firstly, she sees her difficult relationship with her parents as a predisposition for the episodes. Secondly, before the first episode, she had ended a long-term romantic relationship, which resulted in going back to living alone in her apartment. Thirdly, she was faced with the challenge of maintaining a long-distance relationship through her computer. Last but not least, her loneliness was increased by the fact that she was transcribing interviews for a PhD thesis for about one year. In short, there is a noticeable absence of dialogical places where Sofia could engage in meaningful relations in her intersubjective world.

As previously mentioned, Sofia calls her crises of diminished contact with a commonly shared reality psychotic episodes. Although she adopts medical terminology, she preserves her own etiological narrative, somehow distinct from the biomedical explanatory model, related to a world of interpersonal relations or, more precisely put, her withdrawal from it. We can conclude that Sofia partly uses medical narrative but constructs her own story.

Drug consumption and the psychotic crisis

Mário's story of psychosis is intimately connected to drug consumption. He sees drug use and the subsequent lack of sleep as the main triggers of his crisis. He started with cannabis. As he recalls, it was difficult towards the end to know what he was taking exactly, because he was using a mixture of heroin and various other drugs at the same time. Narrative theory understands psychosis as a way of escaping from an unbearable situation, caused by the subjugating story. In psychosis, a person frequently expresses themselves in a way that is not easily understood by others: "Thus the psychotic person is left out of dialogue in which the meanings are negotiated with the reference to the immediate context" (Holma & Aaltonen, 1998, p. 254). This was the case in Mário's drug-taking experience, and furthermore (as we will see later), also in his psychotic experience. He considers the drug use as a way out of a difficult situation, as

> a way out of our problems, it is an illusion, because when we are drugged we think that everything is marvellous, that the problems are gone. I felt like this, without drugs I was sad, with drugs I was happy. It was horrible. I never knew how to find balance in this aspect of my life.

Drug consumption was an active attempt to escape from the situation he perceived as difficult. The dominant story is the story of Mário's position, his being-in-the-world of social interactions. He describes the problems he was trying to solve with drugs as follows:

It was the illusion that it made us rise to the next level. Being in a normal state was being still lower than when I was on drugs. The more drugged I was, the more potent, the more cool I would become in relation to the others. Everything in relation to the others. I would see myself as worse in the normal state.

Drug-taking turned out not to be a very productive strategy of coping with his problems. The circle turned out to be a vicious one, and it did not let him escape: "it makes us consume more and more heavy drugs, it makes us inject things, then feel hungover so that we cannot make it stop. It is a vicious circle, it is impossible to leave it". According to him, what made him leave it was the psychotic episode.

In this way, Mário seems to accept the terminology of the biomedical explanatory model. However, it seems that he uses it in his own way. He adopts some parts of the biomedical narrative and not others (for example, he does not speak of any changes in the brain). He recalls the crisis as follows: "At that moment I was wondering if reality was so disturbed or if I was hallucinating and starting to get ill". The recognition of the crisis made him accept the support which seemed to be most at hand, psychiatric hospitalization.

Experiencing psychosis
"Too much information for my young brain": psychosis and spirits
Paulo's father and mother are separated and he is an only child. They are both, as Paulo himself, interested in spirituality, which they practice each in his or her own way. The spiritual is not just one of the strongest plots with which to understand "the episode" but is also a prominent dimension of Paulo's everyday life. He opposes the common perspective of life, on which he ironically comments: "We are hard, rigid, like [in a very low voice]: there is nothing besides this reality". In Paulo's perspective, children see lots of things and feel many other presences beyond the ones of "this world", but are socialised to forget this. "There are presences all around us", and Paulo wants to learn more about this dimension in order to be a channel (a medium) between the two. Contemplating the existence of a spiritual dimension of life implies acknowledging that "sometimes we do not understand anything".

Spirits are an important part of Paulo's experience. This element was not emplotted during his inpatient psychiatric care, which made him try to emplot it as much as possible on his own. He does not read a lot, and the only book he had in the psychiatric unit was a book about spirits. On 31st October, Paulo was able to go home for a day and then came back to the ward the next day. We met when he came back to the unit and I was curious about what he did that day. He told me he had gone to a religious group meeting with his father. He talked to a woman there, a medium. He talked to her a lot and she listened a lot. At one point, she said he could go. I had

a feeling he was not very satisfied with his visit but at the same time recognised that he was talking so much that it was understandable that she should end the session like she did.

We talked about spirits quite a lot but we were limited by Paulo's discomfort about going too far. For Paulo, speaking about the spiritual world entails a great deal of respect and, very importantly, personal strength, which he did not have at the time of our conversations:

> I am not qualified to give you this information. I am not feeling OK, you know, how can I speak about these things? /…/ It [spirituality] is one way. But I do not want to talk about it. That is… Nobody… I have to help myself first.

If one does not have enough strength and knowledge to speak about the spiritual world, in Paulo's view, one should avoid speaking about it. Fear is very much present and is strongly connected to Paulo's experience of the spiritual: "I have to understand… I have lots of fears, you know. I think that it was a part of the episode I had". We talked about his fears a few times but overall, the topic remained nearly untouched. When he was younger, he was afraid of the dark. Once he said this fear was gone and what remained was the fear of living in certain circumstances and the fear of failure.

We will see later how the strategy of 'preferring-not-to-talk' (about spirits) extends also to Paulo's withdrawal from the study. However, the strategy can here be observed as a meaningful mechanism Paulo uses for maintaining control over his experiences, which are strongly characterised by confusion and uncertainty. Paulo's psychotic experiences seem to have been overwhelming to the point where he temporarily lost the ability to engage in the intersubjective world (Corin, 1990, p. 160). As is commonly observed, Paulo was also "no longer a performer, but more like member of an audience *to* his or her performance of a story" (emphasis in original; Holma & Aaltonen, 1997, p. 465).

Experiencing hyper meaning

Sofia felt that she was experiencing "a series of coincidences" which she allowed to guide her to the point where she started to create those coincidences on her own: "I started to see things which, in fact, are coincidences but are not… how can I explain… which others do not see. I saw coincidences that maybe nobody else could see."

Her subjective experience was also characterised by fear. Firstly, it was related to the data in her interviews: she was afraid that a third person might see and expose her data, revealing the identity of the people in her PhD study. Secondly, her fear was related to entering too much

into the flow of coincidences she felt in the world. It made her feel that "there was something much stronger than me that put me on this track, maybe I was connected to something bigger".

Sofia's psychotic episode can actually be seen as experiencing hyper meaning (Os, 2014). She felt that everything in the social world around her had some connection with her:

> If somebody came closer to me, it would not be by chance… I cannot say more than that… for example, at the time of the second episode, it was here in Coimbra, I was at a park, I went for a walk and I saw 'I love you' written on a bridge. It was signed, let's say it was António… I thought it was written for me, you know?

Another experience of connectedness that she felt took place at a fairground in Santa Clara, Coimbra. There she could see "the dynamics of all the people that were circulating around the different stands. It was like a big dance where the synchronicity among 'the dancers' was visible, like a swarm, making their interconnectedness evident." In my opinion, this experience could call into question the assumption that psychotic episodes contain types of "hyper", "extra" experiences.[20] One might ask if they are really "hyper" or "extra", since interconnectedness is included in growing socio-political, mystical, new age and other narratives and worldviews (in the context of mental health, the Icarus Project proposes the idea of psychoses and other mental health issues being "dangerous gifts"; see (Hall, 2012)).

Sofia understands her psychosis as a disorganising yet meaningful reaction. Psychotic episodes had a meaning "that you tell to yourself, about the reality, about what is going on". How can we think of the meaning of her subjective experiences within her intersubjective context? What was the self-narrative that her psychosis offered to her? If we read her experiences during her psychotic crisis along with her previous experiences in her life before the first episode, we might postulate that the psychosis was her self-narrative response (Holma & Aaltonen, 1995) to her solitude and emptiness in her interpersonal world from the time before the crisis. The psychotic crisis made her go out and interact with people, which is something she would not do in her situation immediately preceding the crisis. However, Sofia points out an ambiguous element of the psychotic crisis in terms of connecting with others. The crisis made her interact with others, but she was still not connected to the commonly shared reality. Instead, she was connected to her auto-referential world: "Although I interacted with people during the episodes, these processes were something that was really mine". As it was something ultimately just hers, Sofia finds it hard to talk about it in great detail: "you are on your own journey". Her social

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[20] However, Sofia interprets it differently. She says that in this case, "the interconnectedness of the bigger whole, the large swarm of people, becomes salient in the perceived reality".

isolation made the meaning-making process possible only through idiosyncratic explanations, psychiatrically understood as psychotic symptoms (Roe & Davidson, 2005, p. 91).

Hearing voices and having visions

The phenomenological perspective in mental health has introduced the possibility to research experiences without having to rely on the way they are labelled by psychiatry. As previously mentioned, hearing voices experiences, for instance, are included in various diagnostic clinical pictures and are present also in the so-called "healthy" (psychiatrically undiagnosed) population (McCarthy-Jones, 2012, p. 101). Phenomenological inquiries have contributed to the current body of knowledge on the diversity of hearing voices: people can hear one or multiple voices; around one half of voice-hearers experience literally auditory voices, while the other half has thought-like or mixed experiences; the hearing voices experience can be accompanied by other bodily sensations; usually hearing voices implies fear and anxiety, but it can also provoke positive or neutral emotions (Woods, Jones, Alderson-Day, Callard, & Fernyhough, 2015; see also Jones & Luhrmann, 2016). The hearing voices experience usually implies loss of hope, relationships, homeostasis and/or autonomy (McCarthy-Jones, 2012, pp. 136–40), but as such cannot be thought of exclusively in terms of pathology; instead "the inability to cope with them or dysfunctional coping may result in a state that can be labelled illness" (ibid, ibidem: 145).

Mário's psychotic episode lasted for three weeks, with a peak of three days and nights. Here we will look closely at his experience of it. As Mário describes it, the psychotic episode is the most terrible thing that has happened to him so far. The worst thing about it is that it was not predictable, and as such abnormal; it could not be controlled:

> Our parents and loved ones will pass away, but this is part of our lives, it is normal, we are all prepared for it. I was not prepared to have an episode like this. It was the tipping point for a huge amount of baggage, for all these preoccupations that had already been piling up for a long time.[21]

His episode was marked by a few days without sleeping, which were days of extreme affliction. The main theme in the narrative of the episode appears to be the fact that he could not control his own experiences: "I could have enjoyed myself, I could have done many things, but things went out of control, I was in the middle of a group of people who saw nothing but drugs in their lives and this made me lose control…"

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[21] His thought preoccupations took the form of, as he adds, hypothesising that was parallel to reality. It used to happen when he was under the effect of drugs. The preoccupations might relate to football, his girlfriends, and his friends. Many times he wondered, for example, why a certain person appeared in a certain place at a certain time.

Mário's psychotic experience was characterised mostly by hallucinations, something he had not experienced before: "During those three weeks, I heard voices in my head, I heard something I thought was something superior, but was in fact my head going crazy".

During the psychotic episode, he was seeing and, principally, hearing things others could not. He heard the voices of people he could recognise, voices of his loved ones –his mother, his girlfriend[22], and a friend with whom he was socialising regularly. He continues his narrative by talking about the voice of his girlfriend.

> M: I felt, in fact, that my hallucinations let me see her as if she were there, and hear friends of mine. It showed me how these people were important to me.
>
> JŠ: What did you hear her say?
>
> M: She was crying, telling me not to do the things I was doing, telling me to keep calm and that she loved me.

He heard lots of other voices apart from the one of this girlfriend. It appears the voices also helped him by giving him advice:

> M: They were giving me advice. "Keep calm. Run." On the street, lots of times. Discussions between the voices.
>
> JŠ: About what?
>
> M: About me. I heard my girlfriend cheating on me with others. It was really hard, it caused a lot of suffering.

Like Sofia, Mário understands the voices' company as a result of his feelings of loneliness at the time of the episode: "feeling so alone, I tried to find my loved ones". Despite being alone during the peak of the psychotic crisis, Mário had the constant company of his voices. It seems that with them, he found a dialogical space in which meaning could emerge. In his world of interpersonal relations, he surely could not find it.

The company of his voices is not the only supportive dimension. This is also the case with his visions: he saw people insulting him, people jumping from a bridge, etc. Additionally, he saw people climbing the same stairs, but when he had climbed them to the end, the people he had seen were gone. Nowadays, he reflects that it was somewhat dangerous to have such visions

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[22] He uses this term to refer to a girlfriend with whom his relationship had ended before the episode but he had stayed in contact with. After the episode, as we will see afterwards, they continued their relationship.

since he could have also jumped from a bridge. He could not identify most of the people he saw.

He feels that this content did not contribute a lot to his suffering, as he had been used to hearing negative comments from people since his early childhood. His greatest problem in acute crisis was therefore to distinguish between the reality and the fiction. It was very important for him to keep calm. By calming down, he let himself feel things twice and so check if what he felt was true or not. He wondered how he could hear his mother, father, his girlfriend and her parents all together at the same time while they were in a different city. Verifying with others was one of strategies he used to cope with the strange experience: "I verified things, knocking on doors, calling neighbours, like 'Do you hear that?'. They told me they did not and I told them I did." In the city where he was studying at the time of the episode, Mário was sharing an apartment with some other students. His colleagues from the apartment were the first ones to witness his crisis. They responded to it by withdrawing and offering no support, which Mário remembers as follows:

> It came to the point where they would close the doors to their rooms not to hear me crying or speaking anymore. There were moments of total despair, it was very tough, there were two or three nights in which the hallucinations were at their peak, it was very difficult.

He was also experiencing two or three voices of friends from the city he was living in at the time:

> It was not normal for them to be there and for me to hear their voices. The only possible explanation was that there were some microphones. I was, my brain was always trying to find a possible explanation. Is it my telephone? I looked for something on the walls to explain the situation. Then my psychiatrist explained that it was an episode. It was just my imagination.

This excerpt can further our discussion about how psychiatric narratives colonise people's own explanatory models and ways of making sense of their experiences (as presented in Paulo's case). The psychiatric imposition of its explanatory model in Mário's case cannot be understood as harmful for him - on the contrary, it seems to have had a positive impact since by imposing the explanation on his experiences, it showed him an already existing frame of interpretation. In other words, Mário's suffering had a name.

Continuing the discussion on coping strategies, one of Mário's ways of coping with the voices was also to contact people whose voices he heard. At the peak of the episode, his girlfriend did not answer his phone calls because it was hard for her to deal with Mário's aggression, caused by the profound disturbance. He told her that he had heard her cheating on him and asked her

if it was true. She told him this was not the case. Additionally, Mário called his parents several times, mostly at night when he experienced the peaks of his crisis, and insulted them, trying to make them get out of his head:

> M: I treated the others, my mum, my dad very badly. I insulted them a lot.
>
> JŠ: How come?
>
> M: I would say: 'What are you doing here in my head, go away, leave me alone.' My parents did not understand, they thought I was crazy. I called them names, sons of a bitch…
>
> JŠ: Because they were always [in your head]…
>
> M: Always.

This leads us to a rather important aspect of acute psychosis, one's relationship with others. Mário's life before the episode was full of his strange feelings about himself in comparison to others, which led to a certain social, and (as he emphasises) conscious withdrawal. Before his hospitalization, he felt like the worst person in the world. He withdrew from his girlfriend because he knew his presence would not do her any good: "Because I knew I would have paranoid and abnormal thoughts that would not be any good for anybody. But everything very consciously because I knew I would not be any good for anybody, so I withdrew."

Let us remind ourselves of the relational/dialogical point of view again: mental health is about "our experience of being able to move–or not– in relation to others" (Bøe et al., 2014, p. 475). It seems that Mário could not move, firstly, because he did not want to (due to his perception of himself as the worst person in the world), and secondly, also because his interpersonal world was not supportive of the change he wanted to make. Time, space, and the world in general are, as phenomenology suggests, not something (pre)given, but are an experiential domain. Russian scholar Mikhail Bakhtin uses the term ethical (time and space) to convey the phenomenological emphasis that time and space are experienced and not given (ibid, ibidem: 476). Ethical space can be explained as a space perceived as 'a place for me' or 'no place for me' (Bøe et al., 2014, p. 479). One could argue that Mário's withdrawal from his loved ones was an ethical-relational breakdown (Bøe et al., 2013, p. 26). He rationally refused to participate in social relations since he perceived that his presence would not be positive for others.

The ultimate way of coping with the voices which were constantly present in his head was to leave his apartment and go out, but the voices stayed with him. A friend of his saw him in class and told him that they would go to the hospital together:

I went out on the street because I was fed up with hearing voices, but they persecuted me, I was hallucinating completely. I remember a policeman putting me in a car and taking me to the hospital. There they gave me medication to help me fall asleep. When I woke up, I was a bit calmer, so I went to my classes. I told to my friends what had happened and they told me I had to be hospitalised.

Hospitalization

Paulo: "rising up from the hole"

As previously mentioned, Paulo describes his life before and during the crisis as being stuck in a hole. However, staying in the psychiatric ward was a kind of "rising up from the hole" for Paulo, a call for a new beginning (as has already been observed in the literature, see Hasson-Ohayon, Lerer, Tuval-Mashiach, Shamir, & Roe, 2016, p. 253).

> JŠ: To start again. Tell me if I understood you correctly. The fact that you are here permitted you to start again, is that so?
>
> P: It permitted… there was no other solution. I changed. I changed. There are things that changed, there are things that cannot be how they used to be.

Paulo once sketched a drawing for a nurse while trying to explain his life before and during his stay in the unit. He once showed it to me and we talked about it a bit. On the left side of the drawing, there is a straight horizontal line which represents his life before the episode. The line transforms into a big mess, a balloon of lines going in all possible directions, making all possible bends. Paulo explains it represents the crisis. Finally, there is a zig-zag line coming out of the mess, which represents his stay in the unit. As I perceived through our conversations, the confusion was not limited just to the crisis period, but continued also during his stay in the ward: "I have not understood yet how I feel. Something happened." In Paulo's case, the confusion implies an elevated feeling of vulnerability:

> P: No. I don't know... I used to feel OK alone, now I feel better accompanied.
>
> JŠ: Accompanied, how come?
>
> P: Accompanied by somebody to hold on to, you know, you are here, to protect me. For example, my father, listen, dad, come here [he makes the gesture of a hug].

We did not talk about the medication. Paulo mentioned several times that he had "a bad memory" but did not relate this to the effects of the medication. I would not like to risk saying that the two are connected, but it is common for people on antipsychotic drugs to have such experiences regarding their memory. The topic was not explored further, but this is how we talked about it with Carlos., one of his closest peers in the unit:

> P: I forget things, you know. I have a bad memory. From one day to another…

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C: Write it down. I use an organiser.

JŠ: What do you forget?

P: I lose the common thread of things. Afterwards, I may recall it.

The hospitalization period is marked by the considerable presence of dualities. For example, everyday life in the hospital, passing time from one meal to another, made Paulo feel tired and bored. At the same time, the hospital rhythm structured his day: "I am tired of being here, but at the same time, I feel better here than out [outside the hospital]. Outside, it is like, what am I going to do?"

Sofia: the psychiatric ward as a prison

Sofia explains her experience of hospitalization primarily in terms of her perception of the hospital being a strange place. She begins her narrative about hospitalization by describing the ritual aspects of hospital admission: "I entered and they took everything from me, my clothes, my rings, earrings… everything is taken, they give you convict-like clothes, an identification bracelet that you can only take off when you leave the ward. You cannot take it off even when you have a shower."

Sofia's hospitalization experience by no means differs from the experience that the majority of people have. Its characterised by time structured around meals – in between them, waiting for them: "In the morning we would take a shower, then we would have breakfast, then we would go to the common area. Our rooms would be closed so we would be obliged to use the common areas and corridors. /…/ /T/hen a sociocultural animator would come. After that we would have lunch, then a snack, then we would wait for dinner… we would be waiting for meals all the time, it's an empty life." She wanted to write down some of the things that were passing through her mind. She asked her father to bring her some paper, which he did. But as she recalls, she never succeeded in writing anything: "So, I haven't written anything because I didn't have the conditions to write… the ideal place to write would be my room but it used to be closed during the day." Additionally, she also could not write because she never got an idea of what to write about, which she relates to the medication. Considering the first aspect of Sofia's not-writing, it is curious to note that while the psychiatric institution structures one's time, it does not emplot one's necessities. As she recalls, the daily activities in the ward "do not give you the space" to write, since one has to be in the common areas and not in one's own room.

Another element emphasised in her story of hospitalization is associating the hospital with a prison. This aspect of the narrative is rather ambivalent since being 'in a prison' had apparently

contradictory implications for Sofia. On the one hand, the ward limits the liberty to move around. Combined with a lot of time to kill, few activities in the ward and lots of people in acute suffering, her first impression was that "it is a life sentence, potentially traumatising". This idea is very common in narratives about experiences of receiving a psychiatric diagnosis. Patricia Deegan, for example, recalls her third hospitalization (by the age of 18) as follows: "the psychiatrist was telling me that my life, by virtue of being labelled with schizophrenia, was already a closed book. He was saying that my future had already been written" (Deegan, 1996, p. 92). This is similar to how Sofia perceived the dominant narrative she was faced with when she entered the ward: "When I entered the ward and entered my room I thought: my life is finished. I thought immediately: I will not finish my PhD thesis, we will see." Based on Heidegger's view that human life is not about being but about becoming, Mattingly argues that becoming is narratively guided. In the present, a temporal situatedness between the past and the future, one is not passive – desire occupies a central role in narrative construction (Mattingly, 1998, p. 93). In light of this, the hospitalization from Sofia's point of view was determining her future and pointing to a narrowed end, destroying her hope of finishing her PhD thesis, which at the time of hospitalization narratively structured her present and future. Sofia's strategy during her hospitalization was to accept the hospital reality but to deal with it in her own way: "be yourself, just breathe, you are going to get out quickly, interact with others, and participate in the activities". Sofia considers this aspect to be crucial, as what enabled her to "survive" the hospitalization.

Then there is the other side of the coin ('the prison'). After a long conversation about the negative aspects of hospitalization, I felt that the narrative became saturated by it, so I wanted to explore alternative stories. Together, we came to the conclusion that the hospital with all of its security services also permitted Sofia to feel more secure. This turns out to be a crucial aspect when one reads it together with Sofia's psychotic experiences, which are predominantly characterized by feelings of persecution etc.

> JŠ: What did you need at the time, what do you think would have been a more…
>
> S: More adequate?
>
> JŠ: Yeah, what did you need?
>
> S: I felt relieved in the hospital. I needed support and I knew it. The psychiatrist asked me if I felt anxious or relieved by the hospitalization… I felt relieved, I felt safe there, a prison also has this dimension.
>
> JŠ: It is important.

S: Yeah, mostly when you have many fears… feeling safe is important. By the second episode I went to my parents' place, it is also a kind of a prison [she smiles], /…/ but my parents – very aware of what had happened to me – they gave me this safety that I needed to get rid of my fears. So, what did I need? I needed precisely this, to feel safe, I felt very unsafe before, vulnerable, well, I was alone.

What was Sofia's life like during the hospitalization in terms of the interpersonal? She received visits from her parents, friends, an ex-boyfriend, a professor from the master's degree programme with whom she had a good relationship, etc. Remembering it, she emphasises an interesting dimension which is going to become even more meaningful when we talk about her recovery. In spite of the many visits she received, "when one is in a process like this, one doesn't need much help from the outside, one has to reconstruct oneself first. Help from the others may provide some emotional support, human warmth, but the process is yours, the process of reconstruction".

Mário: hospitalization as a lone journey

As we have mentioned, Mário experienced a 3-week-long psychotic episode, which was at its peak for 3 days. During this time, he experienced a great deal of suffering. After these three days of crisis, he came to class and his classmates reacted in the following way:

"Mário, you have to be hospitalised, you have to get out of this life". They phoned my parents and an ambulance, the police, to come and take me to the hospital. I was hospitalised and my parents came to pick me up.

He was initially hospitalised in the city he was living in. His parents went to pick him up. They went to the local health centre where he received the diagnosis of an acute psychotic episode. After, "I was taken to the hospital in Coimbra where I received an injection that made me sleep for two days. I woke up in another hospital in Coimbra."

Mário's narrative about the month-long hospitalization is marked primarily by the fact that he had plenty of time which he used to think about his life. As he emphasises, he did not have enough time neither before nor after hospitalization to reflect on his life. Before the hospitalization, he was busy with football and drugs, and afterwards with his studies and drugs. He adds that he was not at an age where he could reflect well upon where such a life would lead him. Until the ages of 21 or 22, he had taken life lightly, without reflecting on the consequences of his actions. At this age he started to be more conscious about what he was doing. Nowadays, a year after his hospitalization, he reflects clearly on his acts from the perspective of his life now. However, the turning point of this radical change occurred at the time of his hospitalization. It is a decisive factor which changed his life: "to think about my deeds, it was

the best medicine. The best medicine wasn't the one that the doctors used to give me. I spent time alone, I was thinking a lot, I was organising my ideas." Introspection, calm and peace are the main words Mário uses to describe his experience during his hospitalization. When hospitalized, he tried to understand his life before the crisis. In the inpatient context, he felt "like in a prison", far from his everyday social world. It means the opposite of the liberty which is one of the basic values he considers having learned from his parents. The restricted liberty made him, in stark contrast to Sofia's case, look at everyday life from another perspective, "with more joy, will to live".

The inpatient context, therefore, gave him time for himself. In other words, it gave him the space that he used to construct his alternative narrative, different from the subjugating story inherent in his drug taking experience. The latter absorbed him and so did not allow him any space to create his own narrative: "Because until then [the hospitalization] I was asleep, I saw a way out in drugs, I was alive only when I was smoking weed. And I was not able to smoke just one or two, I had to… I only felt alive when I was smoking."

It seems the experience of hospitalization was important not just because it allowed him to reflect on his life, but also on the importance of life as such. He came to the conclusion that you can lose everything in a moment. Additionally, he started to look at drugs as something which "wasn't anything essential, it wasn't what I wanted to do". A different narrative of a preferred life emerged: "I really wanted to feel good, to be OK in the company of others".

Another rather important aspect of Mário's hospitalization experience is that the voices he had been hearing disappeared: "once medicated, I didn't hear any voices. Without drugs, of course, I felt far better". However, it is important to note that medication also had some negative aspects: "Some psychiatric medication has very powerful side effects, it causes irritation, it makes your body want to move, you cannot stand still, it causes some ticks that we do not initiate. It was very difficult."

Mário's hospitalization seems to have been primarily about his solitary journey of reflection and withdrawal from others. However, we cannot overlook the fact that the process of hospitalization does imply contact with other people, such as medical professionals and peers from the ward. Additionally, he received visits from his parents, his uncle and some friends from his town. As he recalls, he had some contact with the other patients with whom he shared a few moments and especially the idea that everybody there had gone through something which resulted in them being hospitalised. However, they did not talk a lot about their problems.

Nowadays, he does not remain in contact with them since he has lost his mobile phone and so also their phone numbers:

> I haven't had any contact with any of them. The other day, a colleague of mine called me to ask how I was doing. I lost my phone and all the contacts along with it. But I would like to know what they are up to, I would like to have a kind word and say: think.

More importantly, Mário received support during his hospitalization from people who had been important to him even before the crisis, principally his parents and his girlfriend. His parents, as he recalls, have always believed in him and can now be calmer since they see his recovery. His girlfriend, who is 9 years his junior, he says in addition, has supported him with her different way of life and values.

Facing the future: (inter)subjective experience of everyday life after the first psychotic episode

In studying everyday life following a psychotic crisis, we cannot overlook the concept of recovery that has recently gained popularity in mental health research and policy. Even though definitions vary from symptom-, function-, and personal-focused definitions of recovery (Snyder, Young, & Schactman, 2016, p. 25), we can broadly distinguish between clinical and personal recovery. Clinically, recovery is defined as the outcome of observable variables, evaluated by mental health professionals. The patient perspective may not be taken into account by contemporary evidence-based psychiatry due to its biological orientation. This can also hold true when it comes to the psychiatric conceptualization of recovery, which is traditionally considered to be a remission of symptoms. This view has been challenged as too categorical (offering just two possibilities: of a patient being in the process of recovery or not) (Liberman & Kopelowicz, 2005, p. 738). On the other hand, the concept of personal recovery emphasises its processual dimensions, therefore varies from person to person and is defined and evaluated by a person with first-hand experience (Slade & Longden, 2015, p. 3).

Furthermore, the notion of recovery as an *outcome* (in the context of the clinical conceptualization of recovery) has been criticized from the first-person perspective. The concept of personal recovery rejects the biomedical preoccupation with the "outcomes" (of recovery). It emphasises the perspective of everyday life and thus maintains that recovery, here equating with life with mental illness itself, is not an outcome: "Being in recovery in this sense has to do with pursuing and participating actively in a meaningful and pleasurable life within the limitations imposed by the disability" (Davidson, Tondora, & Ridgway, 2010, p. 3). Finally,

if one is to speak about an outcome, "the process of recovery is its own outcome" (Jacobson, 2001, p. 254).

From the two presented above, the concept of personal recovery is more relevant for this discussion. One of the first authors to theorise it was William A. Anthony, who defined recovery more broadly than as just a remission of symptoms:

> Recovery from mental illness involves much more than recovery from the illness itself. People with mental illness may have to recover from the stigma they have incorporated into their very being; from the iatrogenic effects of treatment settings; from lack of recent opportunities for self-determination; from the negative side effects of unemployment; and from crushed dreams. (Anthony, 1993, p. 527)

Anthony conceptualizes recovery exclusively in the scope of people with first-hand experience: "Recovery is what people with disabilities do. Treatment, case management, and rehabilitation are what helpers do to facilitate recovery" (ibid, ibidem). This brings us to Kleinman (1980, pp. 50–1), who argues that health is not defined and managed just within the professional sector but primarily within the popular sector of the health care system. This resonates with Anthony's claims about recovery being in the domain of, in Kleinman's terms, 'the popular sector'.

Paulo: emplotting the future, creating an experience one cares about

In analysing Paulo's last week of hospitalization, I will employ Mattingly's concept of "emplotment" and understand stories as an interpersonal domain in which stories are "told" not only in words but also in actions that create an experience which both parties care about (Mattingly, 1998, p. 83).

To make the present analysis more meaningful, let us take a quick cursory look at an uneventful therapeutic session between Donna and Steven, as analysed by Cheryl Mattingly. The session summarised below is a therapeutic encounter between Donna, an occupational therapist, and Steven, who has only just awoken from a coma following a car accident in which he suffered a brainstem contusion. He is twenty years old and cannot talk. This is the first occupational therapy that he receives. The session begins with four medical professionals around Steven's bed. They help him stand up from the bed and move him to a wheelchair. This part of the session is considered to have little narrative integrity, where Steven is treated primarily as an injured body and each professional executes strictly their own tasks. In the next part of the session, Donna and Steven are left alone. She wants him to comb his hair. She first explains the exercise in biomedical terms – by doing it, he is going to improve his balance. Donna says that he missed a few places that the nurses also miss because they cannot reach them when he is lying in bed. After a while, when they finish, he asks for a mirror. At this point, Donna asks him jokingly:

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"Going to make yourself look good for your girlfriend?" Then he asks to go for a ride, to get to know the hospital, since he has only been in his bed until now. Donna explains what he is going to be doing in the rooms they pass. The session ends with them returning to his room. Since it is Friday, and Donna does not work on weekends, they will see each other on Monday. (Mattingly, 1998, pp. 86–9)

The emplotment of the hair combing scene changes from biomedical-sounding rationale (improving balance) to a self-care activity (nurses cannot comb all his hair when he is lying in bed). He seems to accept this altered meaning as he asks for a mirror. She accepts it as she builds on his request with the joke. In the second part of the session, she again builds on his request: they go for a ride, not meant as simply going up and down the hall, but is meant, according to Mattingly, as a chance to see and to be seen. To sum up, Donna reads Steven's requests as requests to move out into the world and does so aloud so that Steven can hear her interpretation: "She 'emplots' his requests with a plausible but strong reading of the desires motivating them" (ibid, ibidem: 90). Additionally, by showing him the therapy rooms in the hospital, she indicates a future story, a story of work and pain.

Analysis of Paulo's everyday life after his first psychotic experience and hospitalization is here restricted to his last week at the unit, since this was the only time of my involvement. Before Paulo's last week in the ward, other things appeared to be at stake; in his last week, our conversations were more and more focused on his facing an uncertain future – life outside the unit. The main feeling I got was that leaving the unit was what Paulo desired, but it was at the same time, according to his uncertainties and hesitations mentioned above, something rather hard for him. By leaving the unit, he was facing an uncertain future.

Alentejo: Paulo's narrative
The crisis demanded some changes in Paulo's life and in Paulo himself. His parents do not live together. Due to the particular situation, going back "home" was a difficult decision. Going to his father's place seemed the best option since his father was on a similar spiritual journey as Paulo himself (together they found a religious group and regarded it as a meaningful response to their problems). In contrast, he considered his mother likely to be an energetically destabilizing influence.

Paulo had lots of options but picking the right one presented a rather difficult task. I felt that he considered making the right decision very important, and what is more, it seemed that there was only one try, implying that he had to make the right choice.

Besides his family members, there was another option he was thinking about (expressed more explicitly on 1st November). Here, again, a strong wish to make a trip, to go somewhere, to move, is repeated. It is important to remember that the very absence of agency partly led him, according to his own explanations, to the crisis. In the place Paulo wanted to go, he had a friend, "a good person", whom he had not met yet, but he had a lot of confidence that that person could help him to stabilise: "Because (s)he is the one who can help me, who can put me on track and make me stronger". In the uncertain situation at the time, Paulo's main idea of recovery was to stabilise.

On 2nd November, Paulo's plans became a bit more concrete: after his discharge, planned for 4th November, he would go to his grandmother's home for the weekend and then he would go to live at his father's place:

> P: There has to be something. It [going to his grandmother's home] is not what I would like to do now. I just want to go somewhere by car, you know. Now, at this precise moment. Just to go away.
>
> JŠ: To go away. What would you search for?
>
> P: Nothing. I would have a good time.

If symptoms can be understood as a way of escaping the dominant narrative in order to maintain at least some sense of agency (Holma & Aaltonen 1997: 476), we could say that the hospitalization experience perpetuated leaving Paulo out of the spaces in which meanings emerge and remain emplotted in dialogue (Holma in Aaltonen 1998: 254). However, at the time, the trip-motif continued in his narrative. The next day (3rd November) was marked by Paulo's calm mood, perhaps interrelated to his strategy to feel good and to survive his last day in the hospital. We were talking when he suddenly changed the topic and said that he would have to go to Alentejo. This desire was not shared by his father (and we will see that this was also the case with his other loved ones) who wanted him to stay in Coimbra.

Maria, grounding and exploring the possibilities
When I was visiting Paulo on 1st November, we were joined by one of his friends, Maria. At the time of his hospitalization, she was moving apartments. One day she rang him to help her and that is how she knew he had been hospitalised. Paulo had told me about Maria's dance workshops when we first met. I went there to try out the workshop and prior to this day in the hospital we had met several times in Coimbra. So we all knew each other and I felt that everybody was alright with going for a walk, all three of us together. This was partly because of this minimal proximity we all had and partly because of Maria's enthusiastic suggestion to

go for a walk, accompanied with a gesture suggesting that she meant all of us. I stayed with them during her visit, intentionally assuming the position of observation rather than intervention. I wanted to make space for them to talk, which turned out to be an interesting opportunity to see how their stories emerged, mixed and coexisted.

When Maria arrived, Paulo and I were sitting in front of the unit. Paulo and Maria shared a big long hug. At the time of her arrival, I was feeling a bit absorbed into the general feeling of the hospital, which made me a little lazy and passive. The enthusiastic Maria seemed to be in the opposite mood and the proposed walk turned out to be a suitable thing to do. We were about to sit on some benches in the garden but we finally sat and lay down in the shadow of a tree. Paulo laid in Maria's arms, receiving a head massage. I sat a bit outside of their space. Paulo gave a deep sigh and said, "oh, my life", but we did not start to talk about it since there was a stronger story to follow: a dance. It was a national holiday, a very sunny and hot day for the time of year, and Sobral Cid hospital was empty. Maria put some relaxing music on and they started to move and dance and at one moment they made some space and gestured for me to join in. We danced in the garden of the psychiatric hospital, surrounded by cypress trees and relaxing music from Maria's phone. She suggested we do some yoga and bioenergetic grounding exercises. When she gave me a ride back home, she told me she usually feels when a person is dissociated and using exercises that make a channel of energy through the legs, tries to ground them.

Than we stretched for some time on the ground until we had stayed there for a while and talked about Paulo's situation. His future was the main and the most spontaneous theme of the conversation.[23] Maria, as a person who has known Paulo from his life "outside", asked him several things regarding his wishes and desires after his discharge from the hospital. It was Tuesday and the discharge was planned for Friday. Paulo's main story was dominated by the observation that he had lots of possible choices – it was hard to pick the right one. The main idea was, as previously mentioned, to pack his things and go on a trip to meet the "good person" in Alentejo, which was not facilitated by Maria's story. Her story was dominated by the idea that Paulo would be fine in Coimbra, mostly because of some well-established ties with people Maria considered were supportive for Paulo. She also mentioned her new yoga classes. At the core of it, Maria's story follows the same lines as Paulo's father's story – they both emplot Paulo's stay in Coimbra as preferable and more supportive. However, Paulo's story is quite different and marked by the motif of a trip, of escaping from his context in Coimbra and

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[23] At the time I did not consider my relationship with Paulo as strong enough to start taping the conversation (which happened the next day), so I'm relying on the data registered in my field notes.

searching for support from an outsider, in the person from Alentejo who remains a mystery to everyone else and maybe even to Paulo himself.

Carlos, yoga and "grounding"

I first met Carlos on 1ˢᵗ November just before Maria came to visit. I came to the unit at lunchtime, so I had to wait for a while. Then I met Paulo with all his unit-peers in the process of going to have a cup of coffee from the coffee machine called "Medusa" in another unit. I accepted Paulo's invitation and joined the group. It seemed that Carlos was Paulo's closest peer from the ward.[24]

Carlos explained to me that he is a medium and illuminated by Jesus. He has helped Paulo in the ward – they have had some therapies that Paulo considered effective. When asked how he gives the therapies, Carlos responded he was born with this gift. I felt Paulo respected Carlos's power and gift. What may additionally connect them is that they speak the same language – one of spirits, powers, presences…

I was sitting in the hospital garden with Paulo on 3ʳᵈ November when Carlos passed by us. As he told Paulo during the conversation, "you are going to leave soon and I am here to help you". By that time we had done some taped conversations so I felt alright in taping this one too. It started like this:

> C: The big boss sent me here.
>
> P: The big boss?
>
> C: Jesus.
>
> P: He sent you here?
>
> C: Yes.
>
> P: What for?
>
> C: To tell you something. To you, Paulo. Firstly, don't be afraid of the scars you have. You have many, haven't you, Paulo? Don't be afraid of them. They will just repeat themselves, you let them happen. You have to look inside yourself. Do yoga, there is yoga at the Academic Association, go there, do yoga, ground yourself. It is very good for you to go to Alentejo, isn't it? It is. It will be a good exercise to guide you.
>
> P: Now?

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[24] The importance of peer-support during hospitalization has been observed also in other studies in Portugal (Hespanha et al., 2012, p. 169).

C: Not now. At least for some time stay in Coimbra and then go there, like your father says. Your father is right.

Here one can see that the Carlos' narrative goes well with Paulo's father's and Maria's – they all emplot Paulo's stay in Coimbra after his discharge from the hospital. However, we can see that Carlos acknowledged Paulo's uncertainties regarding the future. Carlos acknowledged also another important theme in Paulo's narrative, the need for stabilisation. Carlos thought it could be achieved through yoga. It would make Paulo stronger:

The more you cry, the more possibilities you have to come back here [to the hospital]. You have to go away from this life. Take your medication. Accept what the doctors say. It will make you evolve on earth.

Carlos' notion, "to evolve on earth", offers us a way to partially explore his idea about illness that implies a specific interpretation of recovery. A person's self is thought of in different terms than a person's body. A person has a body while being in "this world" and this body *has* the illness. One has to be strong enough to live with it. This idea about illness and recovery accepts the biomedical disease model and includes taking medication as part of the recovery process.

C: It is not you who has the disease, your body has it. Your body isn't yours. Your body belongs to the earth. You have to live with it and with your disease while you are on the earth.

P: OK. But I have to grow stronger?

C: With sports, with yoga. Manta yoga to make you calmer, but don't do it a lot, it has lots of spirit. Do yoga, yoga, you have to do yoga.

P: I will.

C: It helps you establish equilibrium.

Moreover, Carlos seems to be sensible of another very important part of Paulo's experience – doubts. He recognizes that Paulo has a lot of doubts but emplots them as a non-central dimension of human existence, the goal of which he sees primarily in love:

You are full of doubts. You cannot resolve them all. Because we are not on the earth to resolve whys. We are here to be love. To become love.

Even though I was welcome in the conversation between the two, from a certain moment on, there was not enough space there for an anthropologist. This is where my observation of the emplotment between their two narratives ended:

P: OK, I want to hear what you want to say.

C: Alone. And you [to JŠ]?

JŠ: OK.

C: It is just for him.

P: Because I will go away and we will not… But we will talk in a while [to JŠ].

JŠ: Of course.

C: You have a lot of time to talk. You will study the man! [We laugh.]

Psychiatry seems not to have succeeded in emplotting Paulo's narrative. On the other hand, Carlos and Maria have. They seem to have noticed what was at stake in Paulo's life in his last week of hospitalization. It seems constructive to conclude by recognising and reiterating the importance of 'the popular sector' of health care (Kleinman, 1980). It has been recognised by Paulo himself: a week after his release from the hospital, he told me he would like to visit his peers from the ward. He recognised that they had given him support and he wanted to return the favour.

Sofia's narrative of personal recovery: recovery as a reconstruction and reaching out to others
Sofia's case gives us a different kind of insight into the recovery process. She considers herself as being in the process of reconstruction. Here I am going to analyse her personal narrative. As it is the most prominent part of her narrative, we are going to discuss the importance of interpersonal relationships in the journey of recovery. We are going to discuss all of her meaningful relationships except the one constructed in the context of the research, which we discuss further in the chapter on methodology.

As I have already mentioned, personal narrative can be understood both as a crucial part of recovery or as a means to facilitate it (Roe & Lysaker, 2012, pp. 10–2). By engaging in their own personal narrative, a person experiencing psychosis can employ their agency and author a new story (Lysaker, Wickett, Wilke, & Lysaker, 2003, p. 154; Roe & Davidson, 2005, p. 93). In addition, politically speaking, talking about mental health issues in a first-person narrative means interfering in the field of power-relations, dominated by psychiatric discourse alienated from experience. In other words, the authority of medical (and anthropological) discourse is normally challenged by the authenticity of the lived experience constructed through first-hand narratives of psychosis (Estroff, 2004, p. 288) and recovery. However, first-person narratives are also subject to various influences due to the power relations they are embedded in. Based on first-person accounts in the *Schizophrenia Bulletin*, it has been argued that such narratives implicitly or explicitly enter the 'genre of insight'. They emplot it and so seek credibility by

presenting normalised, non-psychotic discourse, emphasising "clarity and consistency of communication" (Woods, 2013, p. 44).

The qualitative examination of personal recovery narratives is a growing field. Jacobson identifies four dimensions in narratives of recovery from mental illness: recognising the problem, transforming the self, reconciling the system, and reaching out to others (Jacobson, 2001). Ridgway finds some recurring motifs in personal stories of recovery from psychiatric disability: reawakening hope after despair; breaking through denial and achieving understanding and acceptance; work and active participation in life; moving from passive adjustment to active coping; reclaiming a positive sense of self; moving from alienation to a sense of meaning and purpose (Ridgway, 2001, pp. 337–40; for a recent systematic review of personal recovery in mental health, see Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).

Sofia's case is, again, quite different from Paulo's, since she is in a different phase of recovery. It likewise implies a different level of analysis: Sofia's recovery process is surely still ongoing, but she can see it with a higher degree of reflection since the crisis is further away in time. With Sofia's narrative, then, we refer to the story of more or less past events. Meaningful interpersonal relations have a strikingly important role in Sofia's narrative. She discloses that they were not very present in the context of the family: "Because I don't have brothers or family close to me, the relationships I have with others are very important to me, friends and so on, they are really important to me."

She sees her process of reconstruction as having started before the psychotic crisis. Her life before the first psychotic crisis was mainly characterised by her loneliness during her PhD work. After the crisis and hospitalization, her scholarship was frozen and she spent a year and three months at home on medical leave. The decision to move to Coimbra was made quickly. It is considered very important in her reconstruction journey: "I didn't have any faith in my work, I wasn't enthusiastic about it anymore, but I thought that I needed to go to Coimbra to integrate myself better. I thought it would give me the energy to finish the thesis." The most important aspect of her move to Coimbra was to create meaningful, significant relationships. She refers to various "families" she started to integrate into. She still goes to the research centre where she completed her PhD almost on a daily basis to work on her own projects; she is involved in voluntary work and other academic and non-academic projects; she now lives with some friends in central Coimbra; she has been involved in the Hearing Voices group in Coimbra, etc.

Maintaining or creating new meaningful relationships has received some attention in the existing literature on recovery. The friends from before people come into contact with psychiatry are important since they constitute "a connection between the individual's present problematic life and the past". On the other hand, the friends people make during the recovery process are also important and are frequently described as company in which "'one could be just oneself', showing both strengths and weaknesses" (Schön, Denhov, & Topor, 2009, pp. 343–4).

Personal success plays a significant role in recovery. An important step for Sofia was to defend her PhD dissertation, which gave her more time to spend with others and engage in other meaningful activities. Another interesting aspect of Sofia's recovery is also the ability to offer support to others. As the recovery process can be seen as the process of reconstructing one's everyday life, the system of support cannot be unilinear (Topor et al., 2006, p. 25). Sofia currently offers support as part of her voluntary project. Additionally, she helps friends by reviewing their theses. She refers to her participation in the peer support group "*As nossas vozes*" (a Hearing Voices project) as something which may simultaneously help her self-recovery and provide support to others with her story. As part of her recovery, then, she considers it important not only to receive but also offer help to others. Therefore, social capital and social inclusion seem to be of great importance in the recovery journey: "It is where people are involved in activities that they regard as meaningful that a sense of personal fulfilment and connection to the outside world can be achieved" (Tew et al., 2012, p. 12).

Sofia explains that her process of reconstruction started before the crisis, which indicates her understanding of reconstruction as a long term personal process in life, which in her case includes a psychotic crisis. She has so far undertaken a series of actions to make her being-in-the-world more meaningful to herself. They are all characterised by Sofia's rejection of the narrative she was embedded in. Firstly, after four years of working in the private sector, she started to feel trapped in an inhuman workplace, so she decided to quit the job and enrolled in a master's degree programme (2000). Secondly, Sofia further sustained her independence by making the decision to live alone (2002). Thirdly, she decided to enrol in a PhD programme out of her primary area of study and transferred to Coimbra, which presented a big challenge to her (2007). Additionally, she went to India, not only out of academic interest but also to make a reflective journey during which she decided to end an intimate relationship of many years (2011). According to Sofia, her path reflects a massive process of reconstruction, which began

at the age of 26 or 27. She experienced her first psychotic episode at the age of 38. In 10 years, she has altered every dimension of her life.

The episode may have affected the way she now faces and values relationships with others: "maybe before I didn't value [social relations] as much… because in life until a certain point, we don't think of solitude because we are always in company." She emphasises that in many phases of life, a person has many opportunities to be with others, to keep certain company – in school, at work, some develop a family life, etc. Perhaps, she reflects, people do not value these circumstances enough. She only felt this way when she was faced with loneliness.

Her changed way of valuing interpersonal relationships after the psychotic crisis has a decisive role in her decision-making in the present as well. She received aan offer to go work on a farm in Southern Portugal in January, but she did not opt for it since she was conscious of the importance of the relationships she had in Coimbra. From the point of view of her future life, she does not want to go back to Lisbon (because her parents are there and it would imply more involvement with them) or to another city (because she would lose her meaningful relationships in Coimbra). At the same time, the construction of new meaningful relationships, starting from scratch in another place appears to be, for her, too demanding and not desirable.

An important aspect of the recovery process is also the medication. After her first hospitalization, Sofia continued to take antipsychotic medication. When she and her psychiatrist decided she would come off it, she had her second psychotic episode. Now she no longer takes antipsychotics, but continues taking antidepressants. Sofia's psychiatrist recently wanted to reduce her dosage, but she did not think it was the right moment to do so. She recalls that she did not have the necessary "structure" around her to reduce the medication since she has no job yet. She considers it an important aspect because it gives her, in her words, "structure" in her daily life and some stability. And so she feels that another psychotic episode could occur. This is how she reflects on it: "Because I cannot say I am not going to have any more episodes. I also cannot say I am going to have another one. I feel good now. I have a life that I like; I am in contact with lots of people, which is what is fundamental." Nowadays, her contact with psychiatry is reduced to an appointment with her psychiatrist every six months, when they discuss her medication and try to find the best option for her.

Mário: restructuring the self and finding one's own place in the interpersonal sphere
I talked with Mário about his psychotic crisis more or less a year after it occurred. Today he has a job and considers himself as being in the process of recovery. He recognises recovery as

a slow and incremental process of improvement (Jenkins et al., 2005; Jenkins & Carpenter-Song, 2005). The recovery process, he says, is "a victory that one achieves through time, not in a moment. And drugs give us the feeling of instant victory".

A restructuration of one's moral being-in-the-world
Firstly, I would like to point out Mário's personal, intimate journey of recovery. It is closely connected with the fact that he quit drugs. In his case this did not mean just simply quitting drugs but was related to a profound change in his being-in-the-world. He managed to reconfigure his life without drugs, which makes him feel much better:

> Everything has changed completely. I used to take drugs every day, but after that I quit completely. I feel happy about myself, the fact that I quit contributes to my day-to-day happiness, because I feel fulfilled and complete without them, which in turn makes me maintain balance and reintegrate myself socially. Now my life is more connected with my family, just with my family and my girlfriend. I feel alright, I feel welcome. I feel I am constructing the foundation to one day have work and people on who I can count on. This is not simple at all, because people suffered a lot, including my girlfriend who I knew from before, she suffered a lot with the clinical history that I have.

It has been argued that "the ability to be recognized as a locally 'good' person and find intimacy is likely a critical part of mental health and well-being, perhaps especially for people who have experienced psychosis" (Myers, 2016, p. 429). Some traces of so-called "moral agency", to use Neely Myers' term, are also present in Mário's story. A big challenge in his life after the psychotic crisis is the change in his ability to distinguish between the good and the bad: "now I know how to distinguish between the good and the bad. Now I know that instead of walking along strange paths I can walk directly on the path to success." After the psychotic crisis, Mário restructured his everyday life and values: "Nowadays, I feel life in a more palpable way, everything used to be useless, I used to value nothing. Nowadays, I value more what people do for me. I see things from another perspective." The profound change in his moral being-in-the-world can be seen in the narrative of the very beginning of his recovery journey as well. In the final phase of his studies, he did not go to Queima das Fitas (a 'traditional' student festivity in May that he used to attend), he recalls, "because it didn't mean anything to me anymore".

The psychotic episode was a rupture that was big enough for him to take the next step in this process which made him quit drugs. Until his hospitalization, the process was long, and nowadays Mário understands it as a part of who he is today. The drug consumption and alike are "baggage" from the past he feels capable of carrying:

> I used to do many crazy things, to entertain myself… if you ask me if I now repent having done those things, no, I don't. It made me gain the experience that I have today. I think it is like the Portuguese proverb says: it will be as God wills it. I understand these blunders that I've made as my baggage.

Although this process was mainly his own and he did not share it with others, he is now willing to talk about it in order to help others in similar situations: "I am proud that today I can say that I am a guy who learnt something. I am not afraid of showing it and this can be useful for somebody." Let us start right at the beginning. The faculty staff had a decisive role in his recovery process since they enabled him to take his exams after a month-long absence due to his crisis and hospitalization: "In doing exams, in allowing for my absence from the classes, they gave me a great deal of support. I just have to thank them all and I do it every day."

Social support and a person's own resources and capacities play a very important role in their recovery process (Schön et al., 2009, p. 345). We can see that Mário's profound changes in his moral agency are closely connected to his being-in-the-world with others. His recovery process is characterised by his attempts to live a healthy life and to re-enter a social life: "One needs lots of time, luck and friends. But one also needs to work, to struggle, to live, to socialise, but in a sober state of mind, focused, close to reality, not as if certain things don't exist. It was what I used to do."

A change in interpersonal relationships
Before the acute crisis, Mário's being-in-the-world in a social context was marked by various difficulties. He used to cope with them by taking drugs, which did not eliminate his feeling of being "the worst person in the world". He withdrew from many people, including his girlfriend. Another critical aspect of the changes in his attitudes is related to his humility towards others: "you have to know how to look and see people with a sober head. Now I know that I am no worse than anyone else. I am also not better than anyone. It is like this, you look in people's eyes and think: I'm not worse than you." Today, he can recognise the good sides of life and the importance of loved ones. Getting better has also visibly affected his social life, since he now makes an effort to "transform and support the lives of others, like my mom and my dad, to be better people".

Nowadays, his everyday life is full of activities, mostly his work at a call centre as a football coach. He has a girlfriend. The introductory programme at a call centre was suggested to him on the day he delivered his faculty degree documentation to the local employment office. The call centre provides an introductory programme and French classes with the intention of training

new candidates for a job at the centre. Mário attends the course every day. In addition, he has football practice three days a week:

> M: I have days that are full of everything, but I like it, I feel fulfilled, I feel good.
>
> JŠ: Yeah, it sounds nice.
>
> M: It is, it is better than doing nothing.
>
> JŠ: Yes, sir.
>
> M: And it all makes my recovery more enthusiastic, more voluntary, an effort of my will.

Anthropologist Neely Myers (Myers, 2016) has observed three important resources for preserving one's "moral agency" in the recovery process. Cultivating the social bases of self-respect means meeting the local definitions of what an individual should do to be respected. Having a job and not taking drugs anymore are important steps in Mário's case. Autobiographical power is, according to Myers, another important resource and entails the ability to be the editor of one's own life. We can observe this in Mário's narrative of self-reconstruction in the hospitalization phase, when he had enough power to reconsider his own life. The third resource, which Myers terms "peopled opportunities", is also present in Mário's story. As has been shown, he has the opportunity to build significant relationships in his local moral environment.

Mário recognises his social withdrawal in the past and re-entering old social bonds as an important part of his recovery process:

> I don't want to lose touch with good friends of mine who cut their ties with me. Nowadays, I am starting to reintroduce myself to them, like: How are you, what have you been up to? I am trying to re-establish relationships with these friends who are in fact very nice and make me feel respected.

Re-entering his former social life and simultaneously doing it in line with his way of making a recovery journey is quite a challenge. It implies another kind of positioning in these former social arenas: "Going to the usual places where I used to drink beer with people, I used to do it, but now I go out and don't drink alcohol, don't smoke… I have normal conversations but now I'm recovered, how I want to be."

For Mário, re-entering his former social life from before the acute crisis implies re-entering the social circles of people who consume drugs, which does not correspond to his recovery journey. Right now, he is not trying to accomplish his re-entry very quickly and the decisive influence in this is his supportive girlfriend:

I can say that there is still a kind of calm on my part when it comes to entering into those ties. As you see, I haven't seen this friend [the waiter at the bar where we were doing the interview] for a long time. He and the others are still linked with the world of drugs and I am calm about entering this world because maybe I would feel the need to start again. /…/ But in this moment, thanks also to my girlfriend, I like the way I am living, it is a new phase and I don't feel interested in these old ties.

Apart from the people he meets at his job, he is close to his parents and his girlfriend. His girlfriend has had an important role in Mário's life and in his recovery process. She advises him not to return to his old drug companions and this is how he reflects on it: "I listened to her, I saw her point of view and I saw that she wanted what was best for me, so I'm not in contact with those people anymore". Mário's enthusiasm for sport and his way of recovery (through a healthy life) coincide with his girlfriend's way of life. She does lots of physical activity in the hopes of becoming a model. Mário has a strong wish to visit the city where he was living at the time of his crisis. It would help him to "bring the situation to an end". He would like to go there with his girlfriend:

M: I also know that it is going to be a positive thing to return to Chaves, to see the places I used to go.

JŠ: Do you want to do it?

M: Yeah, maybe not now, but a bit later, to be able to say that this circle is finally complete.

The structure, provided by his everyday involvement in the above-described social world, is one of the crucial aspects of Mário's recovery process. This is how he reflects on it: "Nowadays, if I have to write an email, I have to ask my girlfriend, we already live life as a couple".

His parents are significant in his everyday life too. When Mário reflects on his crisis, he knows that his parents suffered a lot. The crisis made them think of what could have gone wrong at the time of his early schooling. The crisis somehow made Mário's parents divide and had some implications for the relationship between his father and mother. However, they offered him support and Mário is still grateful for it. His recovery, he further reflects, contributed to positive changes in his parents' relationship: "I facilitate their reunion". He additionally recognises the fact that his parents were willing to forget the bad things that happened and were open to starting again. Mário's psychotic symptoms disappeared when he started to take medication. Parallel to this, his social world started to restructure itself. It seems that transformed in this way, Mário's life does not need drugs and psychosis anymore. He has found a place in his intersubjective space. As the narrative perspective on psychosis underlines:

> /T/he symptoms dissolve when they are no longer needed, i.e., when the sense of agency can be maintained by other means. This happens when patient, family members, and team members working together find a story in which they are actors. (Holma & Aaltonen, 1997, p. 467)

From this perspective, one cannot understand recovery as a merely personal process. From Mário's example we can see the social, relational dimension of the recovery process: "That a person recovers means that other people in his or her surroundings also have to recover; the unequal dependence relationship that was established between the person and his or her social network during times of deep distress must change" (Topor et al., 2006, p. 25). The recovery journey of Mário and his loved ones has enabled him to find a more comfortable position in his interpersonal world. In the contemporary world, we might say there is a certain decline in the importance of family. However, in the context of Portuguese mental health, it has been argued that family has an important role to play in solidarity networks facilitating one's wellbeing and participating in one's recovery (Hespanha et al., 2012, pp. 14–5).[25]

Last but not least, Mário has had positive experiences with his psychiatrist. He has never considered himself to be over-medicated. Right after his hospitalization, Mário managed to pass all his exams, including the physical ones, in spite of experiencing the secondary effects of his medication: "in a manner of speaking, I couldn't talk very quickly, my gestures were slower, I was impatient, I could not stay still". He still sees his psychiatrist with some frequency and positively evaluates their cooperation. As research in social recovery suggests, professional support is decisive no matter what theoretical school it belongs to. Instead, the important aspect of professional support is to be found in the professionals' "personal characteristics and the type of relationship they succeeded in establishing with the person" (Topor et al., 2006, p. 21). It is generally considered unprofessional when a professional 'does more', which implies that their required professional distance from the 'patient' is in some way reduced, while the distance from their profession increases. In other words, "although this new kind of professionalism seems to be beneficial and not at all uncommon, it is seldom accorded the same value as a more formal sense of professionalism. Rather, the tendency is to suppress knowledge of it and to characterize it in official contexts as unprofessional and evidence of 'over involvement' or 'failure to maintain distance'" (Topor et al., 2006, p. 35). Professionals are, in this respect, in a kind of thankless position: by distancing themselves from their professional role, they make

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[25] However, we also have to take into account that negative family involvement is also frequently present (Hasson-Ohayon et al., 2016, pp. 254–5).

themselves vulnerable enough for the 'patient' to consider them supportive or not; if they fail, they open themselves up for the judgement of their profession (ibid, ibidem: 33–4).

In Mário's case, we cannot identify any trace of the mental health professionals he has had contact with "doing more" , but at the same time, it appears this was not necessary. However important professional support can be, people outside the professional community can also play a central role in the recovery process. This was the case with Mário. It reminds us, once again, of the pertinence of Kleinman's (1980) notion of a popular health care system in the context of recovery, where parents, siblings, friends, and peers are generally identified as playing a central role in one's recovery (Topor et al., 2006, p. 21).

ETHNOGRAPHY AS ACTION

Until now, we have been concerned with the subjective experience of psychosis and recovery. Concepts like 'intersubjectivity' and 'narrative' have been employed in order to explore the relational aspect, i.e. the dynamics *between* individuals in these social processes. Next we embark on further (and I hope fruitful) exploration of the concepts of intersubjectivity and narrative, now employed in the methodological, epistemological and ethical reflection of the study.[26] As Johannes Fabian writes on the historical journey of intersubjectivity, "acknowledging intersubjectivity as a condition of possibility of communicative research enabled us to conceive an alternative to a positivist view of ethnographic objectivity" (Fabian, 2014, p. 205). Ethnographic fieldwork is not just the subjective experience of the ethnographer – ethnographic material is produced in relationships, the intersubjective space between the ethnographer and the informants (Viegas & Mapril, 2012).[27] Furthermore, taken into account in the context of anthropological fieldwork, the concept of intersubjectivity is widely employed in two ways. Firstly, when talking about intersubjectivity, anthropologists often refer to "the basic conditions that make human communication possible"; secondly, it is regarded "as a goal or an ideal, something to be achieved" (White & Strohm, 2014, p. 193). The first stance is epistemological in its essence, while the second concerns fieldwork ethics (ibid, ibidem). Moreover, narrative theory has extensively criticised biomedical theory and practice for disregarding the patient perspective, and claims to recover it in the narrative approach. Both intersubjectivity and narrative are complex theoretical concepts, which in turn have some important methodological implications. In addition, one cannot speak of methodology without speaking about the power relations inherent in it. This brings us to both the ethical and epistemological implications of these theoretical categories (Martins & Mendes, 2016, p. 24).

I understand the fieldwork experience of this study as being ethnographic. As has been claimed by many, anthropology and ethnography are endeavours of quite different kinds. The difference between them may echo Clifford-Brown's distinction between idiographic and nomothetic inquiry: if the first aims to document a studied phenomenon, the aim of the second is to arrive at general propositions (Ingold, 2008, pp. 67–70). This distinction was followed by extensive

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[26] The interdisciplinary character of the master's degree programme was felt both by the students and the professors – each class was an encounter between people from various disciplines and we would introduce ourselves before every class. I once told a professor that I was an anthropologist and he immediately responded: "What do you 'anthropologise'?" If previous chapters attempted to respond to this question, the present tries to respond to the question "How do I 'anthropologise'?".

[27] This perspective has been made possible, as Alessandro Duranti argues, only after anthropology distanced itself from the psychological notions of intersubjectivity (researching what the informant thinks) (Viegas & Mapril, 2012, p. 517).

debate on where to situate anthropological production on the continuum between more descriptive and more theoretical endeavours. Without trying to enter into this issue, one thing is certain: knowledge produced by first-hand *ethnographic* experience is the basis for anthropological (and not exclusively anthropological) theory. What is more, ethnography cannot be seen merely as an anthropological methodological tool but constitutes its own process of anthropological scientific production (Sarró & Lima, 2006, p. 21).

What exactly does the word 'ethnography' refer to? The production of ethnography is, as Fabian notes, "not a unidirectional process, it works (starting at the moment when we take notes or make texts based on recordings) from both ends, research and writing" (Fabian, 2014, p. 204). In short, ethnography can be thought of both as an action and as a mode of expression (Salgado, 2015). The crisis of representation (the postmodern turn) has questioned merely one aspect of the ethnographic production of knowledge – writing (culture). It has widely criticised the problem of temporal and spatial distance implied in anthropological writings (White & Strohm, 2014, p. 191). Furthermore, some studies have examined how the investigator's social location, subjectivity, and frameworks of understanding influence their analysis (Riessman, 2003, p. 6). However, some argue that anthropology has not sufficiently considered the intersubjectivity of the ethnographic *encounter*, that is, its epistemology (White & Strohm, 2014, p. 191).[28]

This chapter is based on the specificity of ethnography as an action and as a mode of expression, and further employs the concepts of intersubjectivity and narrative. Firstly, an analysis of certain ethical aspects of the study is made. Secondly, criticism of the narrative approach with regard to methodology is presented. Additionally, the researcher's participation in the informants' lives is discussed and reflected upon: how did the study interact with the lives of Paulo, Sofia and Mário? Thirdly, the techniques that were employed are brought into the discussion, and the researcher's positioning in the field (in interviews and participant observation) is examined. It can be understood as an epistemological counterpart to the earlier methodological reflection, bringing the previous discussion on intersubjectivity to the microlevel. In the final part of this section, further considerations regarding collaborative research are presented.

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[28] An interesting contribution showing the inseparability of the theorical, the methodological and the epistemological has been made from the psychological perspective, inspired by the work of Deleuze and Guatarri (Passos, Kastrup, & Escóssia, 2009).

Because the use of theoretical concepts may sometimes confuse rather than clarify the issue at stake, Fabian calls attention to an important point. Calling for epistemological reflection on the intersubjectivity of the ethnographic encounter, he argues that intersubjectivity cannot be understood in ethical terms: it is not "a prescription for moral conduct" (Fabian, 2014, p. 206).[29] Intersubjectivity has a softer synonym in anthropological literature that can be equally misleading – dialogue ibid: ibidem). A similar point is made by Jackson:

> intersubjectivity embraces centripetal and centrifugal forces, and constructive and destructive extremes without prejudice. /…/ Compassion and conflict are thus complementarity poles of intersubjectivity, the first affirming identity, the second confirming difference. This is why violence /…/ must be accommodated in anthropological analysis as a distinctively human modality of intersubjectivity, and not dismissed as a primitive or pathological aberrations. (Jackson, 1998, p. 4)

Intersubjectivity and dialogue thus cannot be understood only in terms of shared experience and emphatic understanding. However, the ethical components of dialogue can be observed in the references from narrative psychotherapeutic literature that have been cited thus far. (Seikkula, 2011; Seikkula, Alakare, & Aaltonen, 2011), since psychotherapy is itself an ethical practice of creating space for dialogue and shared understanding. However important this view on dialogue may be (and a great deal of the analysis in the thesis is based on narrative therapy references), anthropological thought cannot stop with this biased notion of dialogue and intersubjectivity as harmonic enterprises that are simply taken for granted.

Furthermore, the narrative approach has had success in the medical humanities but has been, at the same time, a subject for concern because of its foundational, normative claims that (narrative) self-expression is by definition healthy, authentic and desirable (Woods, 2011b). The notion that narrative gives us the opportunity to approach subjective experience lacking from contemporary healthcare gave birth to humanising narrative medicine (Woods, 2011a). Many have argued strongly against the illness narrative approach. Paul Atkinson, for example, in his paper *Narrative Turn or Blind Alley?*, accuses the authors of this approach of methodologically instrumentalising patients' narratives to build up their own ethical pose of the emancipatory and therapeutic role of social inquiry (Thomas, 2010, pp. 649–50). However

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[29]The same perspective is shared by White and Strohm. They claim that intersubjectivity "cannot be reduced to collaboration, even when it is used in the largest sense of the term, and the literature on collaborative ethnography is more interested in the question of ethics than it is in epistemology" (White & Strohm, 2014, p. 192).

interesting, I have to reject Atkinson's argument because he claims that sociological research should not be displaced by "academics' personal commitments to patient empowerment or the therapeutic relief of patient suffering" (ibid, ibidem). The responses to Atkinson's attack on the narrative approach have emphasised, firstly, the need for the primacy of ethics in methodology, and secondly, that the co-construction between researcher and study participant be given ethical precedence over distanced academic knowledge production (Thomas, 2010, pp. 652–3), which is also the view I endorse here.

Broadly speaking, ethics in clinical psychiatry has two distinctive traditions, the deontological and the teleological. The first, traditionally more present in Continental European (including Portuguese) clinical ethics, is characterized by an ethos of 'medical paternalism', and implies the ethics of beneficence. The second is embedded in the Anglo-Saxon school of thought and emphasises the autonomy of the individual to consent. Both have important implications for the therapeutic relationship. Deontological thought is closely connected to paternalism and the notion of scientific competence, and therefore proposes more bipolar power relations. On the other hand, the teleological Anglo-Saxon tradition encourages a more contractual basis of the therapeutic relationship, enhancing the patient's ability to make decisions. (Marques, 2017) As we have shown before, this argument also points to the existing interrelation between theoretical and ethical concepts.

I will now consider and reflect on the ethics of the present study. As has been shown, the narrative theoretical framework implies a particular fieldwork practice, which in turn might seem to be close to a teleological ethical foundation (however one cannot compare and apply clinical ethics to ethics of ethnographical fieldwork). The notion of narrative co-construction, together with the collaborative tendency of fieldwork, can be read in the light of emphasising the individual's agency and their autonomy to give consent. Informed consent was part of the documentation I had to submit to the ethical committee at the Faculty of Medicine. When applied to ethnographic fieldwork, informed consent entails various issues and has been the subject of increasing anthropological concern.[30] It is meant to be a document clarifying the

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[30] "For instance, what are the underlying epistemological assumptions that motivate conceptions of just who the 'subjects' (or objects) of research are? How is it that informed consent documents are marked by an abstracted temporality that extends the boundaries of consent beyond the possibility of informed decision making and thus rely on a truncated sense of the *it* that is being consented *to*? Other disquieting aspects of traditional informed consent include the absence of meaningful consent in instrumental and legalistic documents and the potential for informed consent to practices to mask embodied processes of negotiation and perhaps coercion." (Hamilton, 2009, p. 86) Furthermore, an important contribution to this discussion can be found in Philippe Bourgois' fieldwork on a banana plantation on the border between Panama and Porto Rico. There he observed a quasi-apartheid labour hierarchy. He was given permission to do the study, he says, because the authorities did not know what he was

participtant's willingness to take part in the study, and their consent that the data produced in the study be published. Embarking on the fieldwork, I wondered when the right time was to ask the participants to fill in the document of informed consent.[31] At different stages in the study, a participant may have different preferences about their participation and about the preferred way of handling the data. In any case, what does a written form of consent facilitate, in comparison to oral consent? In addition, many hospitalised individuals may have a specific attitude to the bureaucratic processes of the hospitalization itself, so asking for their written consent may have some additional negative implications for a trusting research relationship.[32] Informed consent was just a small part of the documentation required by the ethical committee in order to accept my research project. As I was not used to the bureaucratic process (all of my previous ethnographic experiences did not involve an institutional setting), a long process of uncertainty made waiting for their response somewhat challenging.

The ethical principles employed in the study were used according to the research relationship in each specific case. However, the participatory character of my fieldwork experiences with Mário and Sofia made it possible to base my ethical stance on the principles of facilitating their autonomy. This can be seen in their participative role in the study, which encompassed not only the fieldwork experience, but has lasted until the writing of the thesis. I shall return to this point later. In the fieldwork with Paulo, I respected Paulo's autonomy in the choices of research themes, facilitated researching only what he permitted us to talk about; I respected his personal information, employing anonymity, etc. Furthermore, I understand his withdrawal from the study without any reference to anything that might have gone wrong in terms of the research relationship. Therefore, in writing about Paulo's case (without his explicit consent), I rely on the fact that I felt a great deal of trust was built in our research relationship. I understand writing about our field experience as ethically sound, since it was produced in a trusting relationship, with him knowing what the aim of the study was. By doing so, I would like to make explicit my concerns about the bureaucratic rationality that binds the ethical character of a study with and only with normative (written) accounts. I suggest, therefore, that there are other possible

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really interested in. However, he did not lie and always *partially* informed the participants about his research. He concludes: "In fact, participant/observation fieldwork by its very definition dangerously stretches the anthropological ethic of informed consent" (Bourgois, 2012, p. 327).

[31] This reflection began at the seminar "A ética na investigação sobre saúde mental", held in Centro de Estudos Sociais (CES) in Coimbra on 14th June 2016. However problematic, in two cases I asked for written consent at the end of the research process.

[32] I owe this reflection to Tiago Pires Marques.

sources that account for an ethical research enterprise, namely those derived from the researcher's lived fieldwork experience.

Speaking of psychosis as a tool for recovery: researcher as a significant other or research as a significant recovery practice

Narrative theory invites us to see fieldwork in a distinctive way. The narrative approach can be said to be sensible to changes in social phenomena. As argued by anthropologist Cheryl Mattingly, clinical action can be understood "as an 'untold' story" (Mattingly, 1998, p. 6). I contend that fieldwork can be understood as creating an as yet untold story. However transformative it might be (for both parties involved), my aspirations for the narrative approach have no therapeutic pretensions.

Johannes Fabian argues that intersubjectivity is not a natural condition but has to be achieved during the fieldwork. Ethnographers must "invoke intersubjectivity in their attempts to understand their practices of empirical knowledge production" (Fabian, 2014, p. 207). In the following pages, I understand *emplotment* not just as the domain of patients, their loved ones and medical professionals – I argue that effective collaboration between the ethnographer and the research participant lies in its successful emplotment within the wider story of them both. Emplotment, therefore, does have an important place in ethnographic fieldwork (noted before in Krause, 2003, p. 5) – at least it has been understood as such in my attempts to make my research significant for the participants in the study. The following pages thus focus on my attempts to co-construct a kind of 'research alliance' between myself and the study's participants. As most of my work is based on speaking about psychosis or related issues, the aim of the following pages is to discuss if, how and to what extent speaking about psychosis – by participating in research about it – can be significant in the everyday lives of people that have first-hand experience of it.

Emplotting participatory research

I understand my relationship with Paulo as full of different kinds of emplotment, some more and some less successful. Like his experiences with psychosis and life after it, our fieldwork experience is marked predominantly by Paulo's confusion, doubts and indecision.

The first time we met at the unit was on 11th October and this was the first time we had seen each other since the Botanic Garden in Coimbra, where I was representing the Hearing Voices group at a community event supporting the integration of university newcomers. It seems he thought of me as someone who was very supportive of others: "you really want to help people". This was my first opportunity, even though we did not know that we were going to collaborate

in the research, to explain to him why I was in the psychiatric hospital. I felt it would be the best introduction to the story that would be closely related to the objective of my research and would at the same time possibly construct a kind of "alliance" between us: "I would like to talk with people and hear their stories because they [the stories] are more normal then one would think".

On 25th October we talked very briefly. It was a bad day to talk since he had just received the news that his release would be postponed. He started to eat a chocolate bar – one of the things that make you survive in there, he said. Paulo offered me some. I was about to take only a small piece but he noticed and intervened: "take half of it". I enjoyed how we shared the food between us and thought that it might be another small step towards our construction of a "research alliance".

In the meantime, I started my visits at the ward. On 31st October we talked briefly on the telephone; I was trying to find out the best moment to visit him and he was about to leave the unit for a day. He expressed some discomfort about sharing his life with me: "it seems that I have to talk about myself and I don't feel comfortable with it". I introduced the idea of us-doing-things-together in place of me-listening-him-talking, which turned out to be a good story to follow. The story reached the point where he said: "we have to do something together, it is our destiny", which I thought to be so, considering we had known each other before.

The purpose of my presence at the hospital was still not very clear to him. On 1st November Paulo asked me: "what would you like to do here?". I went into more detail and explained that I would like to understand the everyday life of a person after their so-called first psychotic episode – what it is like to be in the hospital and after being released. Paulo told me it would make sense if I understood the everyday life in the ward, so he started to explain the everyday routine of hospital life to me. Afterwards, he was happy to share a Snickers bar that I had brought with me. Additionally, that day we also became closer due to the presence of Maria (whom we had both known from before) and her yoga exercises which we all did together.

On 2nd November we spoke about the spirits and his discomfort in speaking about things he does not know well. He also said several times that he would not like to talk about it because he does not want to confuse me with this information which could be either right or wrong. I appreciated the way he showed consideration for me and how he cared about not "confusing me". At that time, he was perhaps referring not only to his strategy of not talking about the spirits but also to his broader strategy to not disclose his intimate space during a time of great

perturbation: "It is one way. But I do not want to talk about it. That is… Nobody… I have to help myself first." However, when I was leaving he said, "thanks for your companionship", which allows me to think that he saw our contact in friendship terms as well, extending beyond the research.

On the same day I tried, this time successfully, to story his idea from the day before so that I could film a short film. I brought my camera and asked him to do the filming if he wanted to instead of me. He liked the idea and the results are several takes shot while we were walking around the hospital units. The same day he expressed a wish to turn one of his texts into rap format, so we started to wonder if it would be possible to practice it, with him on vocals and me on drums.

On 3rdNovember he began thinking about the possibility of starting to visit the gym close to his father's place because some people around him considered physical activity as part of the recovery process:

> P: If you want us to do things together, yeah, that's it.

> JŠ: Yeah, that's it.

Until the end of his hospitalization it was easy for us to meet: his afternoons were usually empty, with the exception of a few visitors, and I joined him in the afternoons as any other visitor might. Once he had been released, the gym seemed to be a meaningful opportunity to continue our contact.

In his first week after release I was busy, so only stayed in touch by phone. On 10th November he once again expressed doubt about not being able to help me until the end of the research (even though the end had not been defined at all). He told me he had already had the experience of helping a student with her thesis (on a different topic) and that it became complicated so that she could not finish the work. He additionally told me that he would not like to see this situation repeat itself with my research. I suggested we meet and talk about it more, as the topic had seemed to be important for quite a while. He expressed the concern that following his life is quite a task and that he would like us to talk about it together.

I phoned him on 15th November to fix the hour of our meeting. He already told me on the phone that he would like to withdraw his participation from the research. I asked him if he would still like to discuss the idea when we met and he accepted this. When we met, he explained that he would need to focus on his life and family, and not on my research. He added that he did not

feel like sharing the information about his fall. I asked what fall he was referring to, since I perceived this part of his life as a process of getting back on his feet. He smiled and did not respond. Then he said he was guilty of his fall and that there were lots of problems in his family. He added something about fear. I mentioned that we had already talked about it sometimes. He responded that he had a lot of fears. When I asked how this related to our research, he did not answer.

To summarize, during our fieldwork experience, I tried to further emplot some things which I felt were *at stake* for him. However, there were significant difficulties which turned out to be too big to surpass and continue the work. Everything leads me to the conclusion that the issue did not lie in the absence of meaningfulness of our meetings (both from his and my perspective), but rather in his kind of phenomenological barrier of not being able to share moments of vulnerability and restoration in his own life. Sometimes, I would argue, there is no place for anthropologists.

Contemporary literature on recovery in mental health emphasises a person's active stance in the recovery process. As argued by Romme and Morris, recovery after experiences of hearing voices and other 'psychotic symptoms' often includes an organisational phase in which one can explore their experiences and their understanding of them (Romme & Morris, 2013). The Hearing Voices Movement calls for recovery which includes working, in psychiatric jargon, not just on negative (solitude etc.) but also on positive psychotic symptoms.

Paulo, on the other hand, seems not to follow this emancipatory 'recovery journey'. He copes with his experiences by not talking about them. However important its contribution to alternative responses to psychosis may be, the Hearing Voices Movement approach might overlook the fact that "socialisation is counterbalanced by the choice to be independent, a choice which at times involves loneliness" (Mezzina et al., 2006, p. 75). In other words, refusal, the ability to say no to others or to the world at large, is an important aspect of people's recovery processes. Anthropologist Ellen Corin, when referring to a similar phenomenon, uses the term "positive withdrawal" to describe the lifeworld of non-rehospitalized patients diagnosed with schizophrenia. She observed that for them, "the ability to construct a personal protected space at margins of the ordinary 'normal' world was of central importance" (Corin, 2007, p. 280). Silence and withdrawal are, as these studies suggest, as important as an active outlook in the recovery process.

I wish to suggest neither that for Paulo, living with his difficulties is a rational and reflected strategy, nor the necessity to see it as a strategy that is productive in his 'recovery journey'. I would suggest, however, that Paulo's way of living with his condition is a meaningful response to both his subjective experience of psychosis (including fears etc.) and his intersubjective experience of living with it in his social context (especially in facing psychiatric services).

As shown by Ellen Corin and other phenomenological studies on psychosis, people in psychotic states usually lack the ability to reach out to others. In other words, the ability to engage in the intersubjective world is temporarily lost in psychosis (Corin, 1990, p. 160). The fact that Paulo preferred not to talk about spirits and fears, I would argue, spread to preferring-not-to-talk as a general strategy for coping with the participation in my study which, sometimes implicitly or not, attempted to know something more about his world – the world which was, at that time, too confusing to share with others. Paulo's future collaboration in the research, according to him, would not contribute to his recovery. This is quite a lesson to learn about participative research or simply about the phase of life he was in at the time. Perhaps it is also a valuable piece of insight for recovery literature, which emphasises the subject's active engagement in working on one's own illness experience.

Talking as healing
Paulo's story concerning the research process differs significantly from the stories of conducting research with Sofia and Mário. In the context of their everyday lives, research with Sofia and Mário can in both cases be seen as a relatively rare opportunity for them to speak extensively about questions they consider being at stake in relation to their experiences of psychosis and recovery.

As has been mentioned, Sofia and I got to know each other better through the activities of the Hearing Voices initiative group in Coimbra.[33] She became involved with the peer-support group and sometimes talked about her experience of a psychotic episode. Sofia's recovery journey includes speaking about psychosis (as we will see, this is also the case with Mário), which made

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[33] The initiative started with its first public event in February 2016. We organised them with IPDJ Coimbra. The first was held by José Cunha Oliveira and me. At the second event we had a guest, Erica van den Akker, a psychiatric social worker from the Netherlands, at the time working with Stichting Weerklank, an association that promotes alternative approaches to psychosis. The initiative gained more momentum in September 2016, when we organised a projection of the film *Mette's Voices*, a Danish documentary (with Portuguese subtitles) about the life of a voice-hearer, Mette, by Katrine Borre. The event was met with what we considered a relatively strong response in the context of the city of Coimbra, so we launched our first hearing voices peer support group. It functioned as a mixed group of people with and without first-hand psychotic experiences until January 2017 and then stopped. Our activities since then have been focused more on translating material from English and working on other public events.

it easier to strike up conversations about it. Sofia wants to "forget what happened. I want to get to a day when I don't even remember what happened, you know?". She understands her participation in the group as a suitable way of finding closure to a part of her life connected to the psychotic crisis. She sees this way as "even beautiful, maybe it can carry a message full of hope that it is possible to go through these experiences and to have a normal life, to be a normal person, this is the issue!"

The idea to talk about her psychotic experience more extensively came up when we had dinner after a peer-support group session. As she talked about her story, I was impressed by the fact that she defended her PhD and achieved many things after she had had her first psychotic episode. During the meal I remarked that it seemed important to write this down somehow so that people could read about a first psychosis in different, more positive terms. She told me she found it difficult to start writing about it without a foundation (of questions etc.) and that she would be more likely to produce something in the context of a conversation. This is what we did. Later on, still with a view to publish her story on the Hearing Voices Coimbra website, we revised my transcription and together divided it into various thematic sections to be posted separately on the website. In revising the text, Sofia added some aspects that she considered especially important. Later on, she withdrew from this idea of publishing her story due to the stigma she still feels is very present in society.

I remember that I was somewhat surprised by Mário's willingness to participate in the study, which was apparent the very first time we met: "It is good to talk, to have dialogue and someone who doesn't judge". He also showed he cared about how the work would be done: he asked me how much timeI had to write my thesis and if I had read some scientific articles. We exchanged our e-mail addresses. I wrote an outline of what I found interesting in our first conversation, which he read and added topics he proposed be broached in the study. I realised that I had written my summary of our first conversation based on a before-and-after-the-FPE structure. Mário, on the other hand, wrote to me saying he considered it crucial for the study to speak about "what it's like now coming into a normal life". I find the way I structured the summary understandable because I also wanted to gain temporal insight and orient myself in his story. At the same time, I favoured my preoccupation with gaining more organised insight into his story and not his framing of his preferred research plot.

However different, Sofia's and Mário's narratives about their psychotic experiences do have some commonalities. Firstly, speaking about psychosis sometimes turns out to be a difficult task.

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JŠ: In the beginning of the conversation you said that it was difficult to speak about what had happened. You also told me that at the time of the second episode you went to the hospital and you didn't want to talk about it with the doctor. What made you talk about it with others?

S: I started to speak because in certain conversations it made sense. I spoke to people who showed that they knew what I was talking about at least to a minimal degree, but I haven't ever spoken as much as I speak about it now with you. I've spoken to a music therapist who had worked in psychiatric hospitals their whole life; I've spoken with the person I used to live with. But just up to the point that made sense. I don't avoid to speak. But I speak with certain individuals, right, with people who I feel alright speaking to.

However, talking about drug consumption, a psychotic episode, a hospitalization experience and the incremental process of recovering their everyday life is a difficult task. First, it helps if a person thinks talking about their experiences may contribute to their recovery process. Mário finds talking about his experiences a useful way to regain control over them, control being the basic thing which was lacking and so triggered the psychosis: "If we speak about it, we have more control over it. This makes me speak about it, it opens up my spirit."

Second, one does not talk about sensitive personal issues with just anybody. Sofia considers respect to be a crucial aspect of the relationship which makes it easier to talk about her experiences. She values the respect others may have in relation to her experiences, especially because she finds it to be rare in a society where stigma is so present. She does not want to be identified by her real name here either, because "it can have certain effects on my life that I don't want it to".

Mário does not talk about it a lot with anybody. He recognises that the whole process from the crisis onward was hard for his girlfriend and his parents, which makes it quite difficult to talk about with them. Relatively soon, Mário and I managed to create a safe space to talk about his experiences, which he relates as follows: "it is good for me, I feel like blurting things out. Like releasing energies that can be a bit negative for me and it all makes me calmer in day-to-day life." Outside of our research, Mário does not talk extensively about his psychotic experience because he expects snap judgements from people who "don't look at the situation from within, one doesn't speak to everybody. It is easier to talk with you, a stranger, for a thesis, than to talk with somebody who knows me and knows how I was back then." He would like to talk with his girlfriend and his parents about his psychosis and his life before it, but he feels they are not yet in the right place for this: "We have to have more time until they can start asking: so, how was it, how did you feel…"

In February Mário heard a woman from his workplace talking about her son, who is stuck in a vicious circle of drug use, depression and medical appointments. He told her he would like to talk to her son and tell him his story, open up his horizons and help him get out of the situation. Mário feels that drugs are generally an issue many people tend to ignore, as if this issue does not exist. He does not judge people who take drugs but at the same time, he wants to prevent people from falling in the same way he did: "I hope it contributes to something, right? This is what makes me talk to you, because I feel I am being heard and that it will reach more people and maybe those who hear the story won't be indifferent."

Third, recovering one's daily life is a difficult task because it seems one has to find or create safe places in which they feel comfortable sharing their rather quite intimate stories of psychotic experience. A research context may be one of these. In the following pages, I argue that Geertz's "being there" maxim was not sufficient in conducting the fieldwork my thesis is based on. Since the crucial aspect of ethnography is the researcher's *presence* in the field, it is important to work and reflect on it.

Making it happen – techniques in anthropological research

The researcher's positioning in the intersubjective ethnographic space is an important aspect of ethnographic work. As we have mentioned several times, according to the narrative approach, psychotic experiences can be seen as a kind of individual's self-narrative which is not emplotted in one's intersubjective world. Although without therapeutic aspirations, we still argue that an important aspect of ethnographic fieldwork in this context is *how* one emplots a participant's story into the research process. This calls for reflection on ethnographic techniques, a topic seldom discussed in anthropology.

Interview

Interviews produce "narratives jointly constructed by interviewers and respondents" (Csordas, Dole, Tran, Strickland, & Storck, 2010, p. 53). Comparing narrative co-construction in the structured clinical interview for DSM and in the ethnographic interview, Csordas et al. detected some interesting differences regarding the data produced on illness, causality, social environment and temporality. To focus just on the last two, the clinical interview was observed to produce illness narratives on an intrapersonal level, while the ethnographic interview produced narratives contextualising the illness experience on an interpersonal level in the social environment. Furthermore, the clinical interview produces temporally linear accounts on the illness process, while the ethnographic interview produces narratives without linear temporality and with references to life events (Csordas et al., 2010, pp. 38–44).

Stating that there are differences within one kind of interview process as well, say the ethnographic kind, does not go beyond the level of truism. My aim is to explore the question of the ethnographer's positioning in the interview. We shall begin on the basis of the interviews conducted for the present study. Broadly speaking, the biggest preoccupation in conducting them was to closely follow the participants' narrative threads. There are several observations we can make in relation to this.

Firstly, it's important not to discount the language issue embedded in the research – the ethnographic fieldwork was done in Portuguese, which is a foreign language to me, but the mother tongue of the participants. We can say that in most cases there were no significant linguistic misunderstandings. When they occurred, additional exploration of the issue in question perhaps contributed to its broader understanding. However, the language issue led to some interesting awkward moments. For example, Paulo and I used to go talk to the peacocks at the Sobral Cid psychiatric hospital. The following passage shows my inability to understand Paulo's joke:

> P: Do you also peacock?
>
> JŠ: Does it mean something? To peacock?
>
> P: It means being a peacock. You are vain [*vaidoso*].
>
> [silence]
>
> JŠ: I peacock.[34]

Secondly, it is possible to observe how the theoretical foundation of the thesis shaped certain aspects of the interviews. Once Mário and I were talking about his hearing voices experience. We had just talked about his social isolation before and during the acute crisis. We started to talk about the voices he was hearing. He told me he heard some voices of his loved ones:

> JŠ: So, voices of people you know.
>
> M: I could identify whose they were.
>
> JŠ: So you had company.
>
> M: I wasn't alone. I was with the voices.

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[34] In the original: P: 'Tu também pavoas?' JŠ: 'Será que isso quer dizer alguma coisa? Pavoar?' P: 'É ser pavão. És um vaidoso.' [silence] JŠ: 'Eu pavoo.'

The Hearing Voices approach has developed certain methodological and technical tools that help validate one's lived experience. In my paraphrase ("So you had [the] company [of voices]."), one can see how this approach influenced the fieldwork. The HVM has shown the importance of acknowledging the experiential reality that hearing voices experiences have for an individual. One may argue, additionally, that validating one's subjective experience can even be crucial for the research practice.

The notion of "narrative" has also influenced the study from its very start. Narrative therapy has claimed its empowering character in facilitating the reauthoring of the dominant story. The same principle can, we might claim, also guide ethnographic fieldwork. For example, let us look at part of an interview in which Sandra and I talked about psychiatric medication:

> S: There are cases, and we know some of them, where the medication is really necessary for a person to stabilize a bit.

> JŠ: What was it like in your case?

In addition, *emplotment* can be detected not just in the relationship between myself and the participants, but also on the microlevel of conducting interviews. The next example is part of a conversation I had with Paulo, where he emphasised several times that we would not like talking about spirits because he did not know a lot about the topic. Talking about it, as has been emphasised already, could lead to confusion, which was one of the most present metaphors in Paulo's narrative of psychosis. The notion of intersubjectivity can here help us to understand how meaning arises in relationships. In the next example, I understood Paulo's preference not to talk about the spiritual as a way of protecting me ("Thanks."). I point out that my understanding is not visible if it is not enacted. Here I opted for the emplotment of my understanding as follows:

> P: Wow, I don't know… I don't want to confuse someone else. I just share this with you.

> JŠ: Thanks.

Although it has been the subject of anthropological reflection since Brigg's *Learning How to Ask* in 1986, it seems there is still room for greater reflection about techniques (Krause, 2003, p. 4). Because the interview is "an accepted speech event in our own native speech communities, we take for granted that we know what it is and what it produces" (Briggs, 1986, p. 2). However, psychology provides interesting insight into conducting interviews (as I reflected elswhere, see Škraban, 2015, pp. 11–2). Humanist psychologist Carl Rogers understood the aim of psychology as many anthropologists would understand their discipline's

maxim of "going native": as entering the perceptual world of the other (Hill, 2004, p. 89). Psychology conceptualises various techniques which can be useful for ethnographic fieldwork, such as open questions and clarification (*What do you mean by that?*), which try by any means necessary to avoid placing the interlocutor in a situation where they would feel the need to defend their position (Hill, 2004, pp. 199–221). Additionally, it may be helpful to affirm one's presence by paraphrasing (*If I understood you correctly…*) and reflecting your interlocutor's feelings (*I see you are quite sad…*) (Hill, 2004, pp. 131–144).[35] I attempted to include some of the techniques described above in the interviews. For example, while staying at the hospital, Paulo talked about his wish to go somewhere. I understand repetition as a sign of the listener's presence. Mere repetition may provide a useful tool to facilitate the flow of narrative threads:

> P: Now, in this precise moment. Just to go away.
>
> JŠ: To go away. What would you search for?
>
> P: Nothing. I would have a good time.

I found another example of asking questions 'from within' the produced research relationship useful: "I heard you telling me that in the hospitalization phase…". The reference to the interlocutor's previous statement is made explicit by "I heard you".

Additionally, I found it challenging to interpret the participants' statements. In fact, I used to avoid doing it, or else I reinforced the request for the other to correct me if I was wrong. In employing this strategy, I tried to see to what extent the interlocutor shared my way of understanding their story. Anthropologist and systemic therapists Inga-Britt Krause emphasises the importance of 'circular questioning' for both anthropology and systemic therapy. It works on the principle "that instead of asking one of the persons in a relationship about their relationship, the therapist asks a third person who is connected to the original dyad and who is present in the room" (Krause, 2003, p. 17). Employing circular questioning demands that the ethnographer pays special attention and reflects on the moment they use it, but it is nevertheless an interesting technique to consider in the context of the ethnographic interview. I think it can

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[35] Some other useful insights about ethnographic interviews can be introduced from systemic psychotherapy, which deals with the collective, the family, rather than the individual. The aim of a systemic intervention is not necessarily that individuals change their point of view but rather that "families or family members cope better with symptoms or cope better with each other, or that they communicate better or have found a different way of interacting" (Krause, 2003, p. 8). Inga-Britt Krause emphasises the importance of 'circular questioning' in both disciplines. It works on the principle "that instead of asking one of the persons in a relationship about their relationship, the therapist asks a third person who is connected to the original dyad and who is present in the room" (ibid, ibidem: p. 17). Employing circular questioning thus requires the ethnographer's particular attention and reflection on the moment they use it, but it is nevertheless an interesting technique to consider in the context of the ethnographic interview.

also be applied within the existent researcher-participant dyad. However, it can be poorly executed, which can result in a forced interpretation. This happened in the next example:

> JŠ: Some moments ago you told me you wanted to stay calm. What do you do to stay calm?
>
> P: I haven't done anything.
>
> JŠ: So, not doing anything.
>
> P: Mhm.

Last but not least, despite my goal of constructing collaborative relationships, I found myself trapped by a presupposed assumption of asymmetrical ones. I had the implicit idea that I was the one who asks questions and 'the other' was the one who responds. However, this was not the case on many occasions. The participants wanted to ask me questions, illustrated below with Paulo explaining how hospitalization means a new beginning for him:

> JŠ: How do you feel about it?
>
> P: Now I am calm. Do you feel calm?
>
> JŠ: Yeah.
>
> P: So do I.
>
> JŠ: To start again. Tell me if I understood you correctly. The fact that you are here allows you to start again, is that so?

I seem not to have been willing to further explore Paulo's thread. Instead, I tried to find a way of getting back to the previous point, and employed a paraphrase. Inverting the roles of who asks whom was even more present in the first interview with Mário. We spent a lot of time talking about his passion for football, my native country of Slovenia, etc. Furthermore, there were many occasions during the interview in which a small divergence from the main theme was used to talk about political issues etc. I initially understood it as, let's be fair, a slight detour from what was *really* at stake. At the end of the same interview, I suggested Mário introduce issues which he wanted to talk about. He responded that we had already discussed some that really matter for him that day, for example, the question of legalising marijuana. I again found myself emphasising the collaborative character of the study and at the same time having some implicit notions about my relationship with the others in conducting interviews.

Finally, it is perhaps important to restate that I do not propose the ethnographer assumes a therapeutic stance in the field. Although they have similar aims (to understand the other), it is important to note that psychotherapy has a distinctive finality in comparison with

anthropological fieldwork. Its particular objective informs its techniques in such a way that they produce a particular professional *mask*. Anthropology here seems to somehow have more options. This makes it impossible to think of the ethnographical encounter strictly within therapeutic terms.

Fieldwork, masks and the theatre metaphor

As ethnographers, observes Krause, "anthropologists have made more efforts to explain *observation* than *participation*" (emphasis in original; Krause, 2003, p. 6). The latter has been described as that which makes ethnography what it is, this cocktail of various methodologies, the most distinctive of other similar methodological approaches (Salgado, 2016, p. 201).

The central characteristic of ethnography which may help distinguish it from other methodological approaches is the researcher's direct and prolonged presence in the field (Salgado, 2015, pp. 27–8), what Clifford Geertz would call "being there". One of its most celebrated methods, participant observation, reflects this emphasis on being present and participating in the worlds of people the anthropologist wants to study. However, participation can be understood in various different ways. Researchers can participate as they are observing, and so they put themselves in the role of a spectator observing interlocutors as social actors from within. On the other hand, they might assume a participative role in the local worlds they want to study (Salgado, 2015, p. 29). However, ethnography calls for the ethnographer to simultaneously observe and do, or to use the theatre metaphor, to make the shift from being a spectator to an actor (Martins & Mendes, 2016, p. 17).

An interesting way of structuring one's presence in the field has been suggested by performative approaches which see ethnographers, similarly to actors, as those who have (or can have) different *personae*. Ethnographers in the field exist, as is proposed, betwixt and between (to use Turner's words) or as not-me and not-not-me (to use Schechner's words in theorising the performance of actors). In other words, ethnographers are not themselves as they are in everyday life, but at the same time are not a complete transformation of their everyday selves either. As life can be understood as the performance of different social roles that 'actors' adopt in different occasions, so ethnography is seen as a stage on which the researcher-performer 'manipulates' different *personae* in order to enrich the production of ethnographic material and which, at the same time, determines the 'nature' of the material that is produced. It is necessary to leave room to describe one's *persona* in the field notes (Salgado, 2016, pp. 205–7). In short, presence is something which is not required in our everyday lives (as performance art knows best). Building one's presence means altering one's everyday being-in-the-world. In this

respect, we might say that ethnography that takes the notion of presence seriously, positions itself closer on the continuum with performative arts.

Another crucial aspect of ethnography to consider is the mode of register, to use Clifford's term. First level notes include a transcription (a careful account of what interlocutors say or do; it can take place at the time of doing fieldwork or, if one does not audio or video record it, a transcription is made afterwards) and inscription (notes taken quickly at the time of doing fieldwork). Second level notes, according to Clifford, are field notes which are made right after the fieldwork, including diaries and alike, which are usually more organised and may already include analysis (Salgado, 2016, pp. 205–6).

The researcher's roles and forms of register are closely interrelated. In his 1985 work *Roles in sociological fields observation*, Raymond Gold created a typology of four different roles a researcher might adopt. The continuum of possible roles stretches from 'complete observer' and 'observer as participant' to 'participant as observer' and 'complete participant'. On the continuum, the researcher's involvement increases and the modes of register decrease from the first to the last (ibid, ibidem: pp. 208–9). Adler and Adler in their *Membership roles in field research* from 1987 added the role of member, stretching from 'peripheral member' (who participates in the activities of the community), through 'active member' (who assumes functional roles in the community) to 'complete member' (where one immerses oneself completely into the studied community) (ibid, ibidem: p. 210).

We continue with another typology useful for reflecting on my positioning in the field in the present study.[36] It was developed by Snow and colleagues.. They begin with the 'controlled elicitor' who listens to the interlocutor closely and patiently, allowing them to help the interlocutor to express themselves more easily. On the other hand, a 'sceptic' always needs additional explanation. The 'ardent activist', another type of researcher, is the contrast to the 'controlled elicitor', because they unquestioningly embrace the ideology and rhetoric of the studied community. In short, they are a complete participant. A 'buddy researcher' is, similarly to the 'ardent activist', very close to their informants, but constructs friendlier and more trusting relations with them. The last type is the 'credentialed expert', whose performance in the field is based on his professional identity (Salgado, 2016, pp. 211–2).

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[36] This started with Salgado's workshop at GEFAC (Grupo de Etnografia e Folclore da Academia de Coimbra) in December 2015, when he presented some ideas which he later included in the article cited above (Salgado, 2016). Additionally, the workshop on the neutral mask technique in theatre, given by Nuno Pino Custódio in March 2016, significantly contributed to certain aspects of the present discussion.

The mask I predominantly wore during the study, mostly spontaneously and in an unreflected way, is the one of 'buddy researcher'. While exploring this mask, I found out that I tried to create a 'research alliance', mostly through sharing one's views, following one's statements, maintaining my interest in the other's story, but never by different means. I have come to the conclusion that I rarely interrupt a participant's narrative flow – which I do just in the interest of further exploring a certain aspect. However, a close relationship with the participants may be fuelled by a researcher's more intervention-oriented mask. My visits to the Sobral Cid psychiatric hospital were quiet – I did not turn it into "an ethnographic event". The mask of 'buddy researcher' can be seen in the interview excerpts analysed above. To conclude, I recognise that this mask made me feel comfortable, but I still argue that it may be useful for the ethnographer to be able to choose and switch to another mask. I found half-hour bus rides to the hospital useful since they gave me enough time to enter into a research being-in-the-world, or in other words, to 'put on the mask'.

Another interesting contribution to the cultivation of the ethnographer's presence, in a way independent of the researcher's *persona*, can be observed in the concept of 'tolerance of uncertainty', as conceptualised in systemic therapy. Systemic therapy has developed from a practice where the therapist's position was based on knowing and expertise. This position has been subject to criticism which resulted in a new understanding of the therapist's position in relation to clients – the therapist explores with the family and yet does not relinquish their position as expert: "It is possible to have strong beliefs and still be consistent with a stance of 'not knowing'" (Mason, 1993, p. 191).

At the intersection of safe-unsafe and certainty-uncertainty continuums, there exist four different positions, which Mason conceptualises in the context of systemic therapy. It is useful to consider them within the ethnographic context too. Unsafe uncertainty is marked by insecurity where everything is fluid. Normally, the need for safe certainty is felt. Unsafe certainty concerns the client's perception that something might be wrong but they do not know how to change it. The tendency to search for safe certainty is very common but can hardly be reached. In addition, if the therapist thinks it is possible to achieve it, many problems can arise. I might add that the same holds true for the ethnographer's potential feeling of safe certainty. As a productive alternative to the three, Mason suggests a position of safe uncertainty, which "allows a context to emerge whereby new explanations can be placed **alongside** rather that **instead of**, in competition with, the explanations that clients **and** therapist bring" (bold in original; Mason, 1993, p. 194).

Ethnographic inquiry is very fluid by definition since it includes work with human beings. A certain level of uncertainty is, consequently, inherent in ethnographic fieldwork. The first and perhaps the most persistent uncertainty was my difficulty in finding participants for the study. I felt that an extensive 'being there' was necessary, but it did not happen. Even if it might not be visible at first sight in ethnographies, we know from Malinowski that fieldwork experience can be full of frustration. In my case, this was due to my problems with entering the field. The fieldwork was limited to a few weeks of accompanying Paulo and to sporadic, although intensive contact with Mário and Sofia. In between these ethnographic encounters there were always big gaps, characterised by waiting for a 'patient' in the psychiatric hospital who might be a possible participant. This was the first time I approached an institutionally structured field such as a psychiatric hospital. The gaps in the fieldwork are in considerable part the consequences of my entering completely new and foreign terrain, without a minimum of previous familiarity with it (the importance of this was discussed by Vasconcelos; see Patriarca, 2016, p. 612).

Further considerations on collaborative character of ethnography

As implicit during the previous discussion, I tried to construct a collaborative research relationship with the participants in the study. Although I have emphasised a few times throughout this chapter that I do not wish to promote a therapeutic notion of ethnography as action, I similarly do not attempt to defend a solely scientific and distanced stance of doing fieldwork. I tried to show that there are many things, not in the *what* but in the *how*, that psychotherapy and ethnographic fieldwork have in common in the context of (mental) health.

Many ethnographers have adopted a collaborative approach in their fieldwork. Principal consultants have served for a long time as readers and collaborative editors, beginning as early as 1851 with Lewis Henry Morgan's research of the Iroquois. Collaborative practice has been reinforced by feminist and postmodernist anthropology. As proposed by Lassiter, "collaborative ethnography extends fieldwork collaboration more systematically into the writing of the actual ethnography" (Lassiter, 2005, p. 84).[37] Kleinman and Kleinman have argued that "the clinician reworks the patient's perspective into disease diagnoses and treatments that reproduce the health profession and its political economic sources" (Kleinman & Kleinman, 1991, p. 275). Human suffering or other social phenomena can be professionally

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[37] Another, though at present less important aspect, pointed out by Lassiter, is that collaborative anthropology offers a powerful way for engaging its knowledge in public arenas – the aim Eriksen so ardently advocates (Eriksen, 2006). As Philippe Bourgois has argued, engaged scholarly analysis cannot be seen only as legitimate but should be part of the researcher's 'social responsibility' (Bourgois, 2012, p. 318).

transformed, the authors add, by anthropological accounts on them as well, and it goes without saying that it is not morally superior to "anthropologise" distress than to medicalise it (ibid, ibidem: 96). We can add that a collaborative stance may reduce the risk of professional anthropological transformation in ethnography so that it can be more 'experience-near'.[38]

One of the crucial moments of collaborative anthropology was the postmodern turn: Tedlock has argued that "there was a shift in emphasis from participant observation to the observation of participation" (Sluka & Robben, 2012, pp. 20–2). There has been increasing commitment to reciprocity and collaborative research in so-called 'new', postmodern ethnography. We might say that reciprocity – giving something useful back to the participants – has become an ethical requirement. (ibid, ibidem)

'Participatory action research' has been adopted by researchers especially in relation to people who have traditionally been oppressed and exploited (Liamputtong, 2007, p. 129). This includes schizophrenia research. Davidson and colleagues contend that "conventional approaches to research on mental illness provide yet one more source of the loss of self, unwittingly undermining rather than promoting recovery by treating the person with the disorder as a passive object to be investigated and acted upon by others" (Liamputtong, 2007, p. 130). The study conducted by Schneider and colleagues contributed "to an understanding of the experiences of people with schizophrenia but also offered the people involved an opportunity to overcome the isolation so characteristic of schizophrenia by connecting with others in the same situation to research a topic of importance to them" (ibid, ibidem).

As argued by Baresford and Wallcraft, 'survivor-controlled research' is establishing itself in proximity to participatory action research, but is still closer to emancipatory disability research (Russo, 2012, p. 4). Survivor-controlled research calls into question the biomedical psychiatric theory of the 'broken brain', therapeutic and research practice. In terms of the latter, it is concerned by the unquestioned division of research roles, which places research subjects (patients) on one side, and "ostensibly objective, value-neutral researchers" on the other. The "service user involvement in research" approach, a softer counterpart of survivor-controlled research, has become increasingly popular. While the former remains an optional, add-on component to dominant perspectives, in the latter, people with first-hand experience guide the

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[38] In addition, by employing the collaborative character of study in the writing phase as well, the possibility of negative native 'writing back' is dramatically reduced; one example is the famous case of Nancy Scheper-Hughes, whose book, *Saints, Scholars, and Schizophrenics,* was harsly rejected by the local Irish community. She wrote about it in her 2000 essay, *Ire in Ireland* (Scheper-Hughes, 2000).

whole research process, including seeking funding and writing up final reports.[39] (ibid, ibidem: pp. 1–5). However participative user involvement research may be, Russo points out that it does not ensure the serious inclusion of first-hand perspectives. Additionally, the proximity between the researcher and the survivors of psychiatry in survivor-controlled research is not the same as the proximity produced by the ethnographer 'going native' (ibid, ibidem: 2012, p. 4).

How does this inform our fieldwork? As we have stated several times, ethnography depends substantially on the participation of people with first-hand experience. As a researcher without previous experience of psychiatric services, I was the one who mapped out the study and wrote it up when the fieldwork was finished. However, first-hand experts collaborated with me not just during the fieldwork phase but also in reviewing the text. What is more, a person with first-hand experience was involved in defining the pertinent themes to be discussed in interviews in one of the cases (Mário). In short, there is still room to increase the collaboration of participants in other phases of the study, namely in defining the research themes and in combining analysis and interpretation (including writing). However, I do not advocate the need for a survivor-controlled framework to be applied everywhere, and note that it is not possible to do so in many cases (it also depends on the participants' willingness to be more immersed into the study).

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[39] This aspect has similarly been supported in collaborative anthropological research, where "the participants attempt to work together as equals, and this teamwork includes every aspect of the project – planning, implementation, problem solving, and evaluation" (Sluka & Robben, 2012, p. 22).

DISCUSSION

The main observations related to the FPE in this study do not differ considerably from the outcomes of other studies in the same clinical context – the first hospitalization usually occurs in the sequence of acute crisis that had not been experienced until then (Hespanha et al., 2012, p. 212). The subjective experience of psychiatric services structures the person's story of the future. In the transition from hospitalization to the community, one can see the duality of hope, motivation and sense of empowerment on the one hand, and feelings of despair on the other (Hasson-Ohayon et al., 2016). In early recovery dynamics, the interplay between psychiatric and non-medical threads are present in user narratives (Cohen, 2015, p. 40), which indicates the power relations present in the field.

In analysing early recovery processes, I have focused mainly on interpersonal relations. However, there are bigger narratives, written by the system of psychiatric care. It has also been observed elsewhere that the Portuguese psychiatric system usually does not provide continuous support or include family participation (Hespanha et al., 2012, pp. 222–33). In analysing the relational level of psychosis and recovery, it is important not to overlook the importance of the structural questions regarding the organisation of the mental health professional sector.

Furthermore, Paulo's case enabled us to observe a considerable degree of incompatibility between the patient's explanatory model and the biomedical one. In fact, there are many people whose explanation of their own condition significantly differs from biomedical explanations. In the study, this issue only occurred in Paulo's case. It is not at all rare that when user narratives conflict with psychiatric narratives, no room is given to the user's personal construction of reality (Cohen, 2015, p. 96). In such cases, the patient might even be thought of as lacking insight on the disease. This power relation between psychiatric and first-hand experience knowledge is still striking and has to be a subject of concern. The question of how to overcome it exceeds the scope of the thesis, although I have referred to some possible alternatives, namely the Hearing Voices approach. The importance of exploring meaning in experiences of psychosis and recovery has increasingly been shown by the Hearing Voices approach and can also be seen in the cases of this study. The biomedical disease model, I would suggest, has to be a working hypothesis at best (as already argued in Jablensky, 2010). The same is true for the narrative model of psychosis, since imposing whichever model implies oppression. In contrast, I advocate for the practice (to a certain degree applied also in this study) of opening up dialogical spaces to include different narratives, which would make it possible to explore what is really *at stake* for people experiencing psychotic crises and in their everyday lives after them. As we

have already discussed, having a significant "something" and "somebody" have been extensively shown as crucial aspects in the transition from hospitalization to the community. A possible implication for psychiatric practice is to systematically take this aspect into account.

This study additionally supports an important argument that is present both in Kleinman's discussion in the context of medical anthropology and in Anthony's advances in recovery research: both psychosis and recovery cannot be thought of exclusively as the domains of "doctors" and "patients". On the contrary, they are the domains of a person's everyday life, and include their relationships with others as well I have tried to take this relational perspective into account. However, my emphasis of this aspect relies only on the personal accounts of psychiatric users; unfortunately, accounts of the participants' loved ones could be better explored and could crucially contribute to the present discussion.

It is of course possible to view this study critically from many perspectives. Firstly, it is based on scarce ethnographic material due to limited access in the field. Much more material would be needed to better understand the dynamics of the transition from the first hospitalization to life in the community after the discharge. The analysis of narratives that are more temporally removed from the experience also present a valuable contribution to understanding it. However, I see potential in exploring narratives as practically enacted in the process of transition, as shown in the example of Paulo's interactions with Maria and Carlos. It implies 'being there' and through participation and observation in the ward grasping such enacted narratives. Additionally, the perspective of medical professionals needs to be taken into account, but alas remains unattainable within the scope of the present study.

This study has given precedence to the subjective and nearly completely discluded the medical understanding of psychosis and recovery (for example, there is no review of clinical FPE literature). We do not wish to suggest that these perspectives are incompatible. On the contrary, there is much work to be done on an interdisciplinary approach that would permit various simultaneous explanations of the same phenomenon.

And yet it is also possible to say that there is too much medical influence in the study. Psychiatric survivor Jasna Russo has investigated people's experiences of their first breakdown. She calls attention to the fact that for many authors, "thinking through their first breakdown meant thinking through the first intervention they received" (Russo, 2016, p. 63). She continues by arguing an important point: "It seems almost like we have to think through the psychiatric intervention first and position ourselves in relation to it, in order to be able to articulate and

claim back what happened and who we were before. It is the massive nature of the intervention and the impact it leaves that interfere with a chronological order of things." (ibid, ibidem) Bearing this argument in mind, the social constructionist justification in the present study – that we use psychiatric labels because they are 'there', available and real – may still be valid, but it seems to adopt the view so much influenced by the hegemony of psychiatric treatment, and criticised by mad studies (Russo & Sweeney, 2016).

Finally, I have to draw attention to the main concepts used in the study, as they have become the subject of increasing concern. One may say that the theoretical perspective that one adopts might be related to the studied reality. We can hardly imagine adopting a narrative lens in a context involving a high degree of social violence and inequality. However, a narrative perspective was adopted, I suggest, because the studied reality allowed for a more interpretative lens (and not, for example, a critical medical anthropological one).

Rethinking narrative

The narrative approach can be understood as perspectives that try to take into account what is *at stake* for informants. Narrative theory in the context of health and illness prioritises personal verbal accounts of experience. Methodologically speaking, the narrative approach primarily uses interviews or other methods where subjects can express themselves verbally. As mentioned, Kleinman's notion of an explanatory model and the concept of illness narratives made it possible to see the patient's perspective, "ways of thinking and telling that had been impossible in medical ways of framing patients" (Pols, 2005, p. 204). However, the performative analytical tradition prefers the concept of *patient positions* rather than of *patient perspectives*. This is because the latter is always normative in that "non-speaking or scared patients cannot participate in research. Their perspective does not exist. Without language and cognitive abilities, there appears to be no perspective—and thus no subject." (ibid, ibidem: p. 210) Patient positioning is therefore observable also by other means, by analysis of interaction and practice. In terms of methodology, this suggests other approaches, for example, participant observation. It appears, therefore, that the narrative approach has its limits. Patients are both passive and active in the process of creating their positions, and anthropology has to be able to grasp them both (ibid, ibidem:, p. 216).

Furthermore, Brian Schiff has argued that in describing this project as narrative, "we are reifying a Western, arguably middle and upper class, concept as a universal mode of shaping and articulating subjective experience" (quoted in Woods, 2011b, p. 12). The scholarship on illness narratives has been accused of rejecting 'big narratives' (Littlewood, 2003, p. 257) and

privileging "individuality, interiority and authenticity, downplaying the interpersonal, the performative, and the culturally contingent dimensions of narrative" (Woods, 2011a, p. 7). In addition, some scholars argue that a methodological emphasis on patient narratives leads to ethical bias (to a greater extent already explored in the chapter on methodology). Narrative research has emphasized patient integrity and authenticity, leading scholars to observe its emancipatory or even therapeutic role. Since in Atkinson's opinion, one should remain 'neutral', such commitment to patient empowerment is seen as something negative (for this and more extensive debate on related advantages and disadvantages, see Thomas, 2010).

Some authors have also argued that in the narrative approach, not everything is narrative. It is important to emphasise the potential inherent in emplotment as a concept that combines the analysis of verbal and non-verbal phenomena, and takes from 'narrative' the main metaphor for its elaboration. In studying occupational therapy interventions (fieldwork which serves as the basis for *therapeutic emplotment*), Cheryl Mattingly (1998) does not find many occasions of explicit storytelling, yet recognises the narrative character of therapeutic practice. The conventional narrative approach was not very useful, for example, in Paulo's case. Sometimes, as his case illustrates, the "patient position" could be grasped only by the absence of narrative. As in music, pauses can be as important as sound (or words).

This study uses two concepts, narrative and dialogue, that are nowadays widely used in public spaces. Illness narratives, for example, have become increasingly present on television, blogs, newspapers etc. Narrative may have become a neoliberal, Western and middle-class product, and as such, a highly biased concept (Woods, 2011b). Similarly, there has been a noticeable increase in peer-support groups, spaces of dialogue and alike, where dialogue and narrative play a decisive role. The fact that the study employs these concepts shows how deeply it is embedded in its own historic and social context.

Scientifically speaking, the thesis tries to simultaneously read dialogical/narrative theories in psychotherapy (based primarily on Scandinavian scholars: Jakko Seikkula, Juha Holma, Jukka Aaltonen and others) and anthropological narrative theories (principally based on Cheryl Mattingly). While the former understands dialogue specially through speech acts (talking), the latter is also ready to account for non-verbal narrative aspects. However, both take into account a primarily enacted dimension of social life.

Rethinking recovery

The concept of recovery has been the subject of increasing criticism as well. Recovery has become a paradigm in mental health and as such, it is possible to argue, almost an obligation. It is true that in most cases, people experiencing psychosis withdraw from the social world and that the recovery phase, whatever else it might entail, includes re-socialisation, re-entry into society. Where do we then place recovery on the continuum between the point before the crisis on one side, and transforming one's life and consequently place in society on the other? Nikolas Rose argues that "the obligation to recover is linked to a reduction in the tolerance our society has for difference" (Rose, 2011). Similar critical commentary can be made today on the concept of recovery that were made by Ellen Corin on the concept of 'social adjustment': "The research instruments that measure social adjustment assume that relating to the world is a question of individual instrumental abilities. From this perspective, the adoption of normative social roles, such as working, being married, or earning money, is seen both as a criterion of outcome and as a goal to achieve." (Corin, 1990, p. 163)

This study, embedded as it is in the wider field of social recovery literature, has hopefully illustrated the importance of finding one's place in the intersubjective world in the recovery process. However, this aspect has to be seen in a broader socio-economic context: the lack of governmental founding in mental health and of job opportunities for people with mental distress (Myers, 2016, p. 430).

The ethnographic data in this study supports the idea that recovery is a "*slow, incremental, but definitively discernible subjective process of improvement*" (emphasis in original; Jenkins & Carpenter-Song, 2005, p. 389; see also Jenkins, 2005). The anthropological point of view calls attention to the daily rituals of recovery where people struggle to live "ordinary lives after having passed through the portals of tremendous suffering" (Jenkins & Carpenter-Song, 2005, p. 408). Additionally, beyond the psychological insight, anthropology emphasises recovery "in the very dynamic of unmaking and remaking one's world, progressively, over time, within the context of meaningful personal relationships" (Lester, 2013, p. 760). My anthropological orientation steers me towards speaking of 'recovery' and 'everyday life after a psychotic episode' interchangeably, since the second is a locus of the first, and the term recovery can sometimes be misleading.

In short, this thesis suggests we look at human existence as "emerging in the interplay of the world with others in this world" (Bøe et al., 2013, p. 19). Applied to mental health, this perspective promotes seeing recovery as a specific way of *becoming*. In other words, recovery

has narrative character inasmuch as it is an action of a yet untold story. My thesis is an attempt to map the subjective and intersubjective narratives that occur in one's everyday life after an FPE.

SUMMARY

The introductory chapter attempts to map the terrain related mainly to the anthropological research of psychotic experiences. Concepts like narrative and experience are explored because they are of great importance to the thesis. In short, a social constructionist view on 'mental illness' is proposed. Furthermore, the Hearing Voices approach is presented, since it has contributed considerably to the analysis of meaning in psychosis and recovery.

In the second chapter, concepts such as narrative and intersubjectivity are employed in the analysis of the ethnographic material. Psychosis and recovery are seen as interpersonal, relational processes. Firstly, the life stories of the three participants in the study are presented. Paulo's story is characterised by the duality of his "good life" on the one hand and by "doing nothing" on the other. Additionally, he has been marked by his spiritual quest. Two major themes are identified in Sofia's narrative about her life before the FPE: a process of achieving independence and, subsequently, some challenges that accompanied it, namely loneliness. Mário's story is dominated by the narrative of his involvement with drugs and football.

Secondly, we discuss how the participants make sense of their psychotic experiences. The biomedical model of psychosis, suggested to Paulo at the psychiatric ward, seems not to have made a lot of sense to him. The CT brain image which would establish the veracity of the biomedical model did not detect any significant alterations in Paulo's brain, and this has contributed to the confusion that surrounds his experience of psychosis. At the same time, his narrative (marked by his spiritual quest) was not emplotted in the ward. His psychotic episode is explored in the context of his life before it: prior to the crisis he did not attempt to actively change the life that he considered stopped. Meanwhile, the psychotic crisis is interpreted as his self-narrative, where he has shown active participation (agency), which he was unable to do in his social interactions. In contrast, Sofia adopts medical terminology but still preserves her own etiological narrative, distinct from the biomedical explanatory model. It is related to the world of interpersonal relations, or more precisely put, her withdrawal from it. She identifies loneliness and social isolation as the main causes of her psychotic crisis. Mário, however, sees the main reason underlying his psychotic episode in drug consumption. This he understands as a way of coping with his discomfort in his intersubjective world. Drug use led him into the vicious circle he was not able to escape until the psychotic crisis after which he received medical help.

Thirdly, we focus on experiencing psychosis. We begin by exploring our participants' subjective experiences of psychosis and then frame them within their individual interpersonal contexts. Paulo's psychotic experiences seem to have been overwhelming to the point that he temporarily lost the ability to engage with the intersubjective world. As is observed to be quite common, Paulo was no longer a performer but more like an audience member to his performance of a story. When it comes to Sofia, we can describe her experiences as hyper meaning. Her social isolation made her see connections in the world that others could not see. Psychosis, it is suggested, was her way of connecting with others in her lonely situation. It was her attempt – albeit an idiosyncratic one – of reaching out to people and the outside world. Similarly, once Mário ran out of spaces in which he could construct meanings through social interaction, he found dialogical intersubjective spaces in his psychotic world. He heard and saw principally his loved ones, and we analyse his experiences of psychosis and how he coped with it. We can conclude that the constant presence of people which could not be logically explained caused a great suffering and resulted in some damage to his relationships with his loved ones.

Fourthly, the participants' experiences of their first hospitalization are analysed. Paulo's dominant experience with psychiatry is negative due to his explanatory model: since his problems are not necessarily an illness, he does not see psychiatry as a suitable solution for him. At the same time, during his stay in the ward, the psychiatric explanatory model became strongly emplotted and Paulo's own explanatory model stayed unemplotted. Interestingly, Paulo started to see his hospitalization phase as "rising up from the hole". The schedule in the ward gave him structure – by the end of his hospitalization, despite his desire to leave the ward, he started to feel uncomfortable facing life outside the hospital without a palpable structure. Sofia's experience of hospitalization was also ambivalent. She remembers it as a primarily negative experience due to the radical change to her everyday life imposed on her. At the same time, due to her feeling of being persecuted, she felt relieved because the ward had a security service and closed doors. Mário experienced his first (and only) hospitalization as a lone journey of personal reconstruction. His narrative is characterised by his introspective journey and reflection about his past life experiences, especially his drug use.

The final section of the main ethnographic chapter focuses on the analysis of everyday life after the FPE, particularly on the subjective and intersubjective experiences of recovery. Paulo's case reveals the dynamics of the transition between hospitalization and living in the community. Paulo's life, as is argued, is structured by his interactions with his loved ones that emplot his future. A dynamic web of narratives can be observed, all of them emplotting various aspects

considered beneficial to Paulo's recovery. They range from Paulo's own journey narrative to the narratives of those who want him to stay in Coimbra. The concept of *emplotment* becomes especially useful here because of the variety of narratives that structure Paulo's everyday life in his transition to the community, which he finds disturbing and confusing. Meanwhile, Sofia's case shows us that the crucial aspect of her recovery was finding her place in the intersubjective world. It also shows that Sofia considers her FPE as a part of a wider process of personal reconstruction. This began when she was 26 or 27, and she had her FPE at 38. A similar importance of reconstructing interpersonal relationships can be noted in Mário's story as well. His narrative shows that his drug use and the FPE led to a recovery process where he is more successful in finding his place in the intersubjective world. Finally, this part of the chapter demonstrates the importance of understanding recovery on the intersubjective level, as everyday life after the FPE encompasses not only the subject but also their loved ones.

The thesis concludes with a chapter that sums up various ethical, methodological, and epistemological concerns. This chapter proposes further drawing on the concepts of narrative and intersubjectivity in order to critically rethink the ethnographic study on which the thesis is based. Firstly, the deontological and the teleological ethical traditions are presented, since they both serve as foundations for the ethnographical study. The bureaucratic logic involved in informed consent is critically approached and challenged by proposing an ethical research practice based on the researcher's lived fieldwork experience of mutual trust. Secondly, the extent to which the research has impacted the lives of participants is examined. Two patterns are found. The first is present in Paulo's story: his withdrawal from the study is seen as a kind of strategy to construct a safe personal space previously damaged by the FPE and the experience of hospitalization. However, the experiences with Sofia and Mário show the importance that participation in an ethnographic study might have for a person with first-hand FPE experience. They both understand their participation in the study – mostly talking about past experiences and their current attempts to live in the community – as part of their recovery journey. Thirdly, we try to approach intersubjectivity not as an ethical guideline but as an epistemological disposition in the context of ethnography. Certain aspects of the research techniques are considered with this in mind. In doing so, we propose to further employ the concept of emplotment as a mechanism that "makes it happen", since Geertz's "being there" is found to be insufficient. The issue is related to the researcher's position in the field, which we try to examine based on the notion of the researcher's *persona*. The chapter ends with additional

reflection on collaborative research, its potential for further research and its limits in the context of this one.

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