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A new approach to the assessment of social functioning of people who have been hospitalized for psychiatric treatment

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A New Approach to the Assessment of Social Functioning of People Who Have Been Hospitalized for Psychiatric Treatment

By

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B.A. Hons., 1983, Wilfrid Laurier University

THESIS

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Abstract

Typical approaches to social functioning assessment--the social adjustment approach in particular--are seen to have a number of conceptual and methodological limitations which develop from a problematic value system. A new approach to the assessment of social functioning is advocated, based on the values of community psychology and giving priority to the individual's subjective experience, social environment, and personal growth, and to a qualitative methodology. As part of the development of this approach, this research sought to describe and interpret what a group of 40 people--previously hospitalized for psychiatric treatment and currently residing in co-operative supportive housing--think and feel about their own social functioning. Social functioning was conceptualized in terms of the working self-concept and in particular by the relationships among the real and ideal self-concepts and others' expectations. Qualitative data analysis revealed that the expectations of specific others were not important, but that participants' ideal selves were often based on what they thought "normal" functioning "should" be, regarding both specific roles and attributes and general themes of competence, self-determination, and integration. In terms of general social functioning, this comparison to normal people led most participants to feel marginalized in society and deprived of acceptance, but many were satisfied with their functioning in certain roles.

Acknowledgements

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My initial (and continued) impression of the literature on the social functioning of people who have been hospitalized for psychiatric treatment was that it is fundamentally inadequate: the conceptual and methodological limitations of the various approaches to assessment seemed to me too great to justify their popularity. I soon realized that my dissatisfaction with these approaches stemmed from a large discrepancy between my own basic values and beliefs about human nature and those inherent in the predominant approaches to assessment.

This thesis represents my attempt to articulate these value differences and their consequences for the conceptualization and methodology of social functioning assessment (and ultimately, to the people who are assessed), as well as to begin to develop a new approach which is more in keeping with the values of community psychology. I begin with an analysis of the predominant approaches to social functioning assessment, paying particular attention to the criteria of social adjustment. The conceptual and methodological limitations of these approaches are discussed in terms of their implicit value assumptions, which do not appear to differ significantly from those of other paradigms dominant in psychology.

As a more humane and helpful alternative, a new approach to the assessment of social functioning is proposed, based on the values of community psychology and on diverse theories in psychology and sociology. Discussion of the theoretical perspective is based on three essential areas: subjective experience, the social environment, and personal growth. Since I conceptualize social functioning in terms of the self-concept, the processes and structures by which this is defined are examined in detail. The advantages of a qualitative methodology for exploring these phenomena are outlined, as well as specific information about the research setting and procedure.

The findings of the present study are presented in three ways. First, the frequency counts for specific roles and attributes are displayed in both textual and tabular formats. Second, the more general themes which emerged from participants' self-descriptions are described and illustrated with extensive quotations. Third, I describe my interpretation of the patterns or relationships among these themes. The Discussion section takes the analysis one step further, interpreting the findings in the context of theories about the systemic processes of marginalization. Finally, I end the study with a discussion of the implications of this research for the assessment of social functioning.

Literature Review

Predominant Approaches to Social Functioning Assessment

The majority of early studies of people who have been hospitalized for psychiatric treatment defined social functioning by length of tenure in the community or lack of readmission to hospital (Rosenblatt & Mayer, 1974). This approach entirely ignores the individual's experience in the community, including his or her behaviour there and its social context. By focusing exclusively on community tenure, nothing is learned about the reasons for the hospitalization, nor how to prevent it.

Rather than indicate a person's psychiatric condition, recidivism may more accurately reflect conditions in the patient's family, the availability of community services, community tolerance, or hospital structure and personnel (Kruzich, 1985, p. 554; Mechanic, 1980; Solomon & Doll, 1979). Furthermore, the possibility that short-term hospitalization may indicate positive social functioning is ignored. An individual may initiate hospitalization, for example, to assert his or her autonomy from family, or to deal with specific outside pressures (Lamb & Goertzel, 1971).

Social Adjustment

The limitations of recidivism as a measure of social functioning, combined with an increased emphasis on the social context of behaviour and on accountability to the community, forced treatment providers to become more aware of how the individual actually functioned in the community (Beattie & Stevenson, 1984). The concept of social adjustment represents a more sociological approach to the measurement of social functioning, using role analysis as a framework to study the relationship between the individual and the social environment.

In essence, this approach evaluates the extent to which one behaves in accordance with social role expectations (Platt, 1981). The assessment of social adjustment has spawned over 27 published scales (Weissman, 1975; Weissman, Sholomskas, & John, 1981), and has become an essential component in the evaluation of community mental health programs (Willer & Biggin, 1976). Despite its popularity, there have been few critical discussions of the appropriateness of social adjustment as a criterion for evaluating social functioning or the success of treatment. However, like recidivism, social adjustment has a number of conceptual and methodological limitations as an assessment tool.

A general lack of conceptual clarity is indicated by the indiscriminate use of a number of terms, as well as by the inclusion of "overlapping and unspecified concepts" (Weissman et al., 1981). With varying emphasis, adjustment scales measure social attachments, social support, symptomatology, social status, and role performance. As Weissman et al. (1981) point out, dysfunction in any of these areas has considerably different implications for intervention.

Another conceptual limitation is that social adjustment scales predetermine the number, type, and content of the roles being assessed (Platt, 1981). Most include occupational, community, marital, and parental roles with "no evidence . . . to support the emphasis on these, rather than other aspects of . . . life" (p. 98). Not only are some of these roles of questionable value in defining optimum adjustment (are married people really more adjusted, for example?), but without empirically determining in wha roles people actually function and what is involved in performing these roles, researchers' definitions of adjustment risk irrelevance for the group under study. A study of participants of psychiatric aftercare programs in Toronto, Ontario, indicates that many of the roles assessed by social adjustment scales are irrelevant to a large number of people who have been hospitalized for psychiatric treatment· well over 63% were unmarried, and only 35% were employed prior to hospitalization (Fischer, Goering, Lancee, & Wasylenki, 1981).

More importantly, the concept of social adjustment rests on a definition of deviance which exaggerates the significance of normative standards and oversimplifies the ways in which deviance is treated, both in everyday intercourse and by formal mechanisms for social control (Hewitt, 1979). Most social adjustment scales implicitly assume that abnormal behaviour is that which violates conventional social norms of conduct, and as such is qualitatively different from conforming behaviour. But according to Hewitt, norms constitute only one of a number of standards against which people evaluate their own and others' conduct. Moreover, in everyday life norms are rarely problematic and tend to be stated "only when an actual or intended violation takes place . . . [and] even then there is considerable flexibility in their application to conduct" (Hewitt, 1979, p. 216). Not only do people differ greatly in their opinions about what constitutes "normal" and "abnormal" behaviour, but they vary greatly in their responses to similar acts (Scheff, 1966).

The definition of an act as deviant, and the imposition of a penalty, is "usually a matter of negotiated agreement, and not simply of objective certification" (Hewitt, 1979, p. 216)--it depends on who commits the act and why, whether it is detected, and the circumstances under which it occurs. The popular observation that "the only difference between being crazy and being eccentric is $40,000 a year" illustrates the inconsistency with which definitions of deviance are applied at the level of everyday interaction. This inconsistency is equally evident at a systems level, as demonstrated by Dohrenwend and Dohrenwend's (1974) discovery of a distinct negative relationship between socio-economic status and psychiatric diagnosis. An objective view of deviance cannot account for such inconsistencies; therefore, a definition of social functioning based on such a view is conceptually inadequate.

This lack of careful conceptual development results in a number of methodological problems in the assessment of adjustment. First, the theoretical definition of adjustment used in most scales has little to do with how it is actually operationalized. Most scales follow the example of Barrabee, Barrabee, and Finesinger (1955), who define social adjustment as "the degree to which a person fulfills the normative social expectations of behaviour that constitute his roles" (p. 252). Similarly, the widely-used Social Adjustment Scale (SAS; Weissman & Paykel, 1974) assesses "the individual's ability to function in social roles" (p. 23), in accordance with "loose" expectations of appropriateness.

To my knowledge, however, none of the adjustment scales in current use actually assesses the expectations of those who relate to the individual in his or her various social roles. This is in spite of the fact that others' expectations are inherent in the sociological definition of role performance, as well as a growing amount of research relating post-hospital functioning to familial and environmental expectations (Angrisst, Dinitz, Lefton, & Pasamanick, 1961; Carpenter & Bourestrom, 1976; Lamb & Goertzel, 1971).

Instead, actual role performance is compared to researchers' conceptions of an ideal norm or to a societal "consensus" of role-appropriate behaviour, or to a statistical average of group behaviour (Platt, 1981). Not only do these standards violate the sociological definition of role (by not empirically determining others' expectations and using these to assess role performance), but as Platt has ably demonstrated, none of these has validity as measures of social functioning. Platt argues that a statistically average behaviour may not in fact exist; the range of behaviours in a population may be so great that a single norm is only a statistical artifact, with no relevance to individual performance. Furthermore, research indicating that values vary by social class (Rokeach & Parker, 1970) and by cultural group (Kluckhohn & Strodtbeck, 1961) seems to argue against the existence of a single, universal norm. "Even within the smallest and warmest of groups there is likely to be some dissensus [sic] and doubt" (Goffman, 1963, p. 5).

Aside from questions of theoretical validity, the greatest problem with using these standards of comparison is that they completely ignore the individual's social environment. This occurs in two ways. First, the norms and expectations used to evaluate role performance are not derived from the person's social milieu and therefore have no meaning for him or her. As Goffman (1963) points out, "an act can . . . be proper or improper only according to the judgement of a specific social group" (p. 5), since behaviour considered "maladjusted" in one cultural subgroup may be normal or even ideal in another.

Second, environmental constraints on role performance are not considered, even though "it is impossible to evaluate or assign significance to a conventional act apart from knowledge of the situation in which the act occurred" (Duncan & Fiske, 1977). In the Structured and Scaled Interview to Assess Maladjustment (SSIAM; Gurland, Yorkston, Stone, Frank & Fleiss, 1972), leaving one's job is considered evidence of "deviant" adjustment, whether because of illness, advancement elsewhere, or dissatisfaction with the job or employer. Because behaviour is not evaluated in relation to its immediate social context, the individual is blamed when circumstances may have stronger causal links.

Moreover, by "de-contextualizing" individual behaviour, statistical validity may be compromised. No allowance is made for "the history and dynamic processes that are part of long-term role relationships," nor for the sources of variance in behaviour caused by the environment or by person-environment interaction (Beattie & Stevenson, 1984, p. 640). In other words, the absence of a key element from the equation explaining behaviour as a function of both person and environment ($B=f(P, E)$; Lewin, 1951) severely limits the power of the social adjustment model to explain and predict behaviour.

Obviously, the idealized conceptions of adjustment and normality which are substituted are highly value-laden. Despite the appearance of objectivity, "too often the norms selected as the standard are those that the researcher thinks are current in his own social circle . . . . One should realize that the standard is arbitrary and that many will not subscribe to it" (Bott, 1957). The Levels of Function Scale (Strauss & Carpenter, 1972), for example, leaves the final assessment to the interviewer's conception of "normal."

In addition, the standard for comparison which is substituted may not be particularly desirable or "healthy." Social adjustment scales typically prize a conventional, middle-class lifestyle and values--especially materialism, productivity, and lack of conflict--without questioning their psychological, social or moral worth. The Community Adaptation Schedule (CAS; Roen & Burns, 1968) rates social functioning higher to the extent the respondent has an income over $10,000, attends religious services more than once per week, likes the police very much, and feels very close to parents (including spending much time with them and never having arguments). As with numerous other measures (e.g., Barrabee et al., 1955; Gurland et al., 1972; Weissman & Paykel, 1974), "the possible functionality of conflict and dissensus [_sic_] . . . is not considered, nor is the ideological bias . . . acknowledged" (Platt, 1981, p. 103).

> The bald fact is . . . there is no general agreement about the precise nature of adjustment and maladjustment . . . . It is quite impossible at the present time to define "success" or "adjustment" in such a way that the definition is both operationally clear and acceptable to all. And even to the extent that there is concurrence of judgement in such a definition, it is simply a pooling of value judgements, which is . . . most unsatisfactory . . . .
>
> (Gordon, Grummon, Rogers, & Seeman, 1954, pp. 28-29)

Other Measures

In the face of these many limitations, researchers have sought more specific, operational indicators of social functioning such as employment (Braff & Lefkowitz, 1979; Tessler & Manderscheid, 1982), community integration (Segal & Aviram, 1978) or contact with neighbours (Trute, 1986). The advantage of these measures is that their conceptualizations of social functioning are highly relevant to daily living and are perhaps more amenable to intervention.

But while information about former psychiatric patients' employment and community integration is undoubtedly important for an understanding of their social functioning, these indicators are purely quantitative, and reveal little about the individual's subjective experience, social context, or personal growth. Segal and Aviram (1978) do measure access to resources in their assessment, but functioning itself is defined only by the frequency of participation in various social activities (cf. Kruzich, 1985). Employment, in particular, seems far too limited as the sole criterion of general social functioning and perhaps indicates more concern for productivity and economics than for the individual's well-being.

In fact, both employment and community integration are subject to the same criticisms as social adjustment in terms of evaluating social functioning. In the process of interpreting the level of activity, individuals are generally compared to group norms. But what constitutes a desirable level of neighbour contact, for example? Even if these are norms for people who have been hospitalized for psychiatric treatment, they may be undesirable or irrelevant for the individual, considering his or her particular abilities, experience, living environment, personal goals, and so forth. Rather than comparing individuals against a single standard, these measures would be more helpful if used to assess individual performance over time and incorporated individuals' own definitions of success.

Value Orientation

In the face of all these limitations, one must ask how helpful are criteria such as social adjustment or community integration for the assessment of social functioning, or for the operationalization of treatment philosophies such as normalization. One's answer will necessarily depend on personal values and beliefs about human nature. Despite its new emphasis on the social environment, the social perspective from which criteria such as social adjustment are derived does not differ significantly in its view of human nature from previous paradigms such as the psychoanalytic, illness, and learning perspectives (Price, 1978). Like these, the social perspective implicitly compares marginal or deviant persons to a perceived social norm. Like these other paradigms, the social perspective assumes that abnormal behaviour is necessarily a negative phenomenon requiring treatment, and that so-called "normal" behaviour is good, or at least preferable. All these perspectives assume that human nature requires fundamental control--either control of primitive innate impulses by the superego, or control of organic disorder by psychotropic drugs, or control of behaviour through reinforcement contingencies. Furthermore, all examine social functioning in a detached, clinical manner in the pursuit of objectivity.

This is a disturbing value orientation, since it suggests that conformity and social order are more important than the liberty, well-being, or development of the individual. As we have seen, the consequences of such a value orientation include "blaming the victim" (Ryan, 1971) for his or her difficulties in social functioning, regardless of social context, discrediting the person's subjective experience, and ignoring his or her own needs and goals. For the person experiencing difficulty in social functioning, these consequences are at best unhelpful and at worst debilitating. For this reason alone, I find social adjustment, community integration, and other such measures inadequate criteria for social functioning.

A New Approach

Clearly, a new approach is needed for the assessment of social functioning of people who have been hospitalized for psychiatric treatment--a new set of values and a more complete conceptualization. An appropriate foundation for this new orientation is provided by community psychology, a relatively new perspective with a more humanistic, phenomenological approach than most other paradigms in psychology. Community psychology tries to find alternative means for dealing with deviance which avoid "labelling differences as necessarily negative or requiring social control" (Rappaport, 1977, p. 1). In so doing, it tries to reconcile individual liberty with the legitimate needs and concerns of society. Multiple levels of analysis are used to study behaviour, thereby avoiding the mistakes of both the humanistic and social perspectives, which focus almost exclusively on either intra-psychic processes or audience reaction to behaviour.

The basic values of community psychology "are exactly opposite to traditional applied psychology" (Rappaport, 1977, p. 22). They include a respect for human diversity, a belief that the resources of society should not be allocated on the basis of a single standard of competence, and an emphasis on maximizing the "fit" or relationship between persons and their physical and social environments (Rappaport, 1977). These values imply a more relativistic assessment of social functioning than that of social adjustment, for example--problems are seen as resulting from a lack of fit between persons and their environments, rather than the fault of inferior or deviant persons.

If one adheres to these values of cultural diversity and relativity, and to an ecological viewpoint, then subjective experience, social context and personal growth are necessarily important considerations. The notion of person-environment fit, for example, is predicated on an assessment of social context, in the belief that behaviour and context are inter-connected and inseparable. Similarly, community psychology's emphasis on cultural diversity and relativity recognizes people's right to articulate their own needs and goals, and to obtain the psychological and material resources required to fulfill them. The aim is simply "maximization of each person's potential to live according to a standard of life selected by the persons themselves, not by those in power" (Rappaport, 1977, p.22). Clearly, these values are incompatible with a conceptualization and methodology which attributes deviant behaviour to the individual without assessing his or her social context, ignores his or her subjective experience and personal growth, and rank-orders people on the basis of a single standard of competence.

Beyond my belief in the inherent value of subjective experience, social context, and personal growth, however, there are several other reasons for including these in social functioning assessment. My argument for their inclusion and the manner in which I conceptualize them are based on a number of diverse theories, even some usually associated with other paradigms. Elements of sociological theories about social roles and symbolic interactionism have been combined with research on self-actualization, and the self-concept. Any of these areas would, by itself, provide an inadequate understanding of social functioning, since each adopts only a single level of analysis or approach. Role theory, for example, is primarily a structural analysis, while some theories about self-actualization are reductionistic, treating social behaviour solely in terms of individual psychological processes. In combination, however, all the various theories complement each other, and provide a more complete conceptualization of social functioning and I hope, assessment criteria that are both humane and practical for intervention. A discussion of these three important elements of soci functioning follows.

Subjective Experience

An often-cited reason for excluding subjective experience is that as a research method, self-report lacks objectivity and is vulnerable to distortion (Brown, 1981), This seems a somewhat specious argument, and ignores the fact--as we have seen--that clinical assessment is also subjective. Nor is self report entirely without empirical merit: Lehman (1983) found subjective indicators of quality of life (measured by personal satisfaction in various life domains such as social relations, finances, and health) to be much better indicators of global well-being than either objective indicators or personal characterisitics. He concluded that the "chronic mental patients" in his study were in fact able to provide statistically reliable responses which explained a substantial portion of the variance in his regression model for global well-being.

A more compelling reason for including subjective experience in social functioning assessment is that according to the humanistic or naturalistic paradigm, there is no single, objective reality that can be tested, "known," and predicted (Lincoln & Guba, 1985; Price, 1978). Instead, our world is conceived as having multiple realities, constructed by each individual and based on his or her unique perceptions, experiences, and interpretive schema. The individual is valued as the only credible source of information about his or her own particular reality. In fact, outside of mainstream psychology, the phenomenological approach has been enthusiasically endorsed, and long been used in anthropology and sociology (e.g., Estroff, 1981; Clarke, 1985). Humanistic psychology also emphasizes the value of multiple realities for gaining insight about the world and ourselves (Price, 1978).

Given this conceptualization of multiple constructed realities, it is not surprising that, according to phenomenological theories and theories about the self, people react to the world according to the ways in which they perceive it (Fitts et al., 1971) and the meaning they give to their experience.

> It is impossible to understand a person fully, or predict his behaviour accurately without employing the internal frame of reference, without seeking to share his own private perceptual world and especially his views of himself.
>
> (Fitts, 1972a, p. 5)

Although it is impossible to completely adopt another person's internal perspective, one can obtain a phenomenological understanding of that person through knowledge of his or her self-concept--what the person thinks and feels about himself or herself. Rogers (1951) defines the self-concept as "an organized, fluid but consistent conceptual pattern of the characteristics of the I or me which are admissible to awareness, together with the values attached to those concepts" (p.55). More recently, Rosenberg and Kaplan (1982) have defined the self-concept as "the totality of the individual's thoughts and feelings with reference to himself or herself as an object" (p. 2). While the stability and malleability of the self-concept have been much debated (Markus & Nurius, 1986), both definitions emphasize the individual's subjective experience of the self, an experience which is both cognitive and emotional.

The importance of the self-concept to social functioning extends beyond a humanistic belief in the value or even the reliability of subjective experience. Self theorists contend that behaviour cannot be understood without taking into account the individual's perceptions of the world and of himself or herself (Snygg & Combs, 1949). According to Fitts et al. (1971), "we can never completely understand another person's actions or perfectly predict his behaviour, but knowledge of his self-concept can advance such understanding and prediction . . ." (p. 3). Fitts (1972a) further contends that the self-concept is correlated with many variables affecting rehabilitation performance, such as mental health, feelings and attitudes.

Social Environment

The idea that behaviour is profoundly influenced by the environment, and that the self is a social construction have long been explicit assumptions in both social psychology and sociology (James, 1890; Lewin, 1951; Mead, 1934). Furthermore, acknowledging the legitimacy of subjective experience does not preclude conceptualizing the self as partly determined by social structures and processes.

> The behaviour of the individual cannot be accounted for solely in individual terms, by reference to his qualities, characteristics, attitudes, limitations or biology. Rather, individual behaviour is <u>constantly</u> shaped and constrained by social processes . . . and this process of ongoing societal influence on individuals has to be . . . investigated and explained.
>
> (Hewitt, 1979, p. 9)

Symbolic interactionism represents a theoretical framework for exploring this relationship between society and the individual, between social interaction and consciousness (Ashworth, 1979). As developed by Mead (1934) and Blumer (1969), the main thesis of symbolic interactionism is that human interaction depends on conscious, symbolic functioning, "in that one acts on the basis of meanings ascribed to the behaviour of the other" (Ashworth, 1979, p. 7). In other words, we acquire a "self" through inference, based on our observations of how others behave toward us. The process involves imaginatively stepping outside one'self and viewing one'self as an object from another's perspective, at first singly, and then from the viewpoint of the "generalized other."

> The kind of object a child becomes [to himself or herself] thus depends on how role-taking proceeds. The others who surround the child from the moment of birth

> . . . act toward the child in a particular way, and their conduct becomes the basis for the child's inferences about the kind of object it is
>
> (Hewitt, 1979, p. 96)

Although it is likely the self-concept is a joint function of people's interpretation of their own behaviour as well as of others' behaviour toward them (Miller & Turnbull, 1986), there are several implications in Hewitt's description of self-acquisition for a new conceptualization of social functioning. Most important is the notion of behaviour as a continuous interchange between impulse and inhibition, based on a view of the self as both process and object. Mead (1934) differentiated between the I and the Me of the self as phases in which the individual was either behaving subjectively (i.e., on impulse), or else was viewing himself or herself as an object. The latter stage involves anticipating or reflecting on one's own behaviour and controlling it according to the imagined responses of either a specific or generalized other, perceptions which are themselves derived from taking their role or perspective.

In essence, this inhibition stage is the "impression management" of which Braginsky, Grosse, and Ring (1966) write when they describe the efforts of patients in a psychiatric hospital to convey an image of themselves as either "healthy" or "sick," depending on whether they want to leave the hospital or not. Estroff (1981) also found that some people who have received extensive psychiatric treatment seek to maintain a "crazy" identity in order to benefit from the diminished expectations with which it is often associated. The real world is seen as either too frightening, undesirable, or unprofitable. Labelling theory (Becker, 1963; Scheff, 1967), by contrast, regards the individual as a passive victim of social categorization.

Mead's notion of self as both process and object is also similar to Bandura's (1978) reformulation of social learning theory, which postulates that behaviour, the self, and the environment are reciprocal, interdependent determinants of behaviour. According to Bandura, their relationship involves a continuous process of self-regulation, including self-observation, judgement, and response.

The strength of the symbolic interactionist approach lies in the recognition it gives to the social environment in determining not just behaviour, but also the self. Yet the individual is also seen as actively participating in self-definition and in assessing his or her social functioning. In fact, symbolic interactionism makes no distinction between the self and the self-concept, since the former is not considered to be an entity in itself, but rather the result of a continuous process of observation, inference, and evaluation. The self-concept, therefore, is to some extent created anew in each situation as well as accumulated over time.

Personal Growth

The values of community psychology are evident in Fitts' (1972) assertion that the aim of rehabilitation ought not to be to make someone suitable to society, but rather to enhance personal growth. "Good rehabilitation programs adequately tailored to the individual client and his self-concept should help the client move toward self-fulfillment, self-sufficiency, and self-actualization" (p. 10). Variously described as self-realization (Horney, 1950), "creative becoming" (Allport, 1955), a "productive orientation" (Fromm, 1941), and most commonly, as self-actualization (Goldstein, 1939), personal growth is by definition based on the fulfillment of the individual's own needs and goals. Maslow (1954b) gives a general definition of self-actualization as "the full use and exploitation of talents, capacities, potentialities, and so forth" (p. 200). After studying the lives of people whom he thought had exhibited extraordinary self-development and psychological health, Maslow (1954b) developed the concept of self-actualization as an uncommon life achievement of particularly healthy people, associated with such characteristics as superior perception of reality, greater freshness of appreciation and richness of emotional experience, greatly increased creativity, as well as a sense of autonomy and a sense of humour.

But to Maslow, self-actualization represented both an end-state and a process: an "instinctoid" need for self-fulfillment at the highest level of a motivational hierarchy, as well as the process of actualizing one's potentialities as one moved up the hierarchy. The appearance and satisfaction of higher-order needs such as love, esteem, and self-actualization generally require the prior satisfaction of the lower, more pre-potent needs such as hunger and safety. Growth, or progression to the next order of needs is considered natural because "the next step is subjectively more delightful, more joyous, more intrinsically satisfying than the previous gratification. . ." (Maslow, 1968, p. 45). But although higher-order needs are not essential to existence, Maslow (1948) considered their gratification to be crucial for psychological health, preventing illness, and overcoming maladjustment.

Similarly, Rogers (1959a) conceives of a tendency or drive toward self-actualization inherent from birth. In his view, goal-directed activities of infants such as sucking and touching are attempts to actualize their biological and psychological beings as each perceives it. Children develop a need for positive regard from others about the same time as they begin to develop a self-concept by becoming aware of themselves as separate entities. Unfortunately, positive regard is almost never unconditional, but contingent upon certain behaviours or levels of performance, so that children learn to value themselves (i.e., have positive self-regard) only in relation to these "conditions of worth." When people begin to selectively distort experiences to conform to their conditions of worth (and retain positive self-regard), an incongruence is created between the real experience and their self-concepts. It is this incongruence which develops into anxiety and maladjustment.

In order to become "fully functioning" or actualized as adults, according to Rogers, one must become reacquainted with the elements of experience that in the past have been "denied to awareness as too threatening, too damaging to the structure of the self" (Rogers, 1963, p. 23). The purpose of Rogers' client-centred therapy is to provide unconditional regard for the client so he or she feels accepted and comfortable enough to explore his or her developing self. Based on observations of his own clients as they engaged in this process of self-development, Rogers' (1963) description of the "fully functioning person" is reminiscent of Maslow's self-actualized person: he or she is open to experience, not defensive; lives in a fluid, existential fashion, not rigidly; and trusts his or her total self to guide behaviour, not just awareness (pp. 21-22).

Other research (Duncan, 1966; Fitts, 1972b; Fitts, Stewart & Wagner, 1969; Garvey, 1970; Harrington, 1971; McClain, 1969; Richard, 1966; Seeman, 1966; Vargas, 1968) has also demonstrated that people rated high in personal effectiveness and considered well-integrated or self-actualizing tend to have optimal self-concepts as assessed by the Tennessee Self-Concept Scale (Fitts, 1965). More specifically, the self-concepts of these people are characterized by high self-esteem, low conflict and variability, average or moderate scores on defensiveness, self-differentiation, and response-set, below average signs of pathology, and good personality integration (Fitts, 1972b).

Unfortunately, in their conceptualization of the self as largely beyond ordinary awareness, and of personal growth as a spontaneous, unreflective experience, Maslow and Rogers dismiss reflective self-understanding in favour of non-rational "gut feeling." "Taken as a new, scientific gospel. . . [this] Dionysian bias is open to the charge of anti-intellectualism and Romantic impulsivity" (M. B. Smith, 1974, p. 175). Even more disturbing is their implied glorification of human perfection. According to Maslow (1968),

> we can pick the best specimens of the human species, people with all the parts proper to the species, with all the capacities well developed and fully functioning, and without obvious illnesses of any kind, especially any that might harm the essential, defining, sine qua non characteristics. These can be called "most fully human."
>
> (Maslow, 1968, p. 171)

It is a small step from this emphasis on "the ideal, authentic or perfect godlike human being" (Maslow, 1968, p. 11) to the elitism of Carkhuff (1979), who computes human potential in mathematical terms, so that those most able-bodied and intelligent obtain the highest "score."

The value of Maslow's and Rogers' theories for a new conceptualization of social functioning lies in the notion of personal or psychological growtnh as both an innate, common need as well as a process--multi-dimensional and unique to each individual. As M. B. Smith (1974) asserts, "many routes. . . are open to self-actualization, corresponding to the rich variety of human nature and its personal and cultural expressions" (p. 178). The goal for social functioning assessment, as I see it, should be to learn how people define their own personal goals or fulfillment, and to help them discover various ways of achieving it.

The Present Study

The purpose of the present study is to describe and interpret what a group of people who have been hospitalized for psychiatric treatment think and feel about their own social functioning, as part of the development of a new approach to social functioning assessment. A review of the predominant approaches--and of the social adjustment approach in particular--reveals a number of conceptual and methodological limitations, notably a lack of attention to subjective experience, social context, and personal growth. Not surprisingly, an approach which ignores these areas (and contradicts the values on which they are based) leads to blaming the victim for his or her difficulties in social functioning, and to rank-ordering the individual on the basis of a single standard of competence. My contention throughout has been that the standard often used is value-laden, invalid, unhealthy, and largely irrelevant to people who have been hospitalized for psychiatric treatment.

A more humane approach to social functioning assessment would acknowledge that problems in functioning are the result of a lack of fit between the person and his or her environment, that human diversity is desirable, and that people have the right "to choose their own lifestyle while still maintaining their fair share of society's material and psychological resources" (Rappaport, 1977, p. 3). I have attempted to express these values in the present research, not only by including the person's subjective experience, social context, and personal growth in the conceptualization of social functioning, but also by adopting a qualitative, ethnographic method and by trying to develop a collaborative relationship with the research setting. In this section I explain the conceptualization of social functioning used in the present study, while the methodological paradigm and the research relationship are discussed in the subsections headed Methodological Comments and Research Relationship, respectively. Both of these are found in the Method section which follows.

First, however, let me explain what this research is not intended to do. To begin with, this study does not attempt to assess the social functioning of any one individual. While each participant is asked about his or her subjective experience, social context, and personal goals, this information is used to describe and interpret the thoughts and feelings of the group as a whole. The bulk of the analysis, therefore, has been among all participants' responses, not of the social functioning dynamic for each person. Rather than make individual assessments, the purpose of this research is to provide direction for a new approach to assessment by learning what information the participants use to describe and evaluate their own social functioning.

Secondly, this research does not attempt to apply to everyone who has received psychiatric treatment, and certainly not the typically more middle class clients who seek individual psychotherapy for neuroses and such, while still maintaining themselves in a fairly conventional lifestyle in their communities. Instead, this research addresses the concerns of a particular group of people who presently reside in supportive housing because they been hospitalized for psychiatric treatment, often several times. Without denying the validity of the concerns of the former group, it is clear their social functioning is more typically "normal" than that of people who chronically receive psychiatric treatment.

In summary, then, the basic questions I am trying to answer in the present study are as follows:

(1) what does the individual who has been hospitalized for psychiatric treatment think and feel about his or her current social functioning?

(2) what does the individual who has been hospitalized for psychiatric treatment think and feel about his or her goals, or ideal social functioning?

(3) what does the individual who has been hospitalized for psychiatric treatment think and feel about what he or she perceives to be others' expectations for his or her own social functioning?

In order to answer these questions, social functioning has been conceptualized in terms of the self-concept, following the general theoretical assumption that the self-concept is one of the most important regulators of behaviour (Carver & Scheier, 1982). The self-concept--not role or identity--is used as the basis for this conceptualization of social functioning because it provides more informaton about how the person experiences his or her own social functioning--how he or she describes, interprets, and evaluates it, in relation to what standards and social contexts. Since the self-concept is typically regarded as a single, generalized view of the self (Rosenberg & Kaplan, 1982), this conceptualization is based on the working self-concept, the continually shifting "set of self-conceptions that are presently active in thought and memory" (Markus & Nurius, 1986, p. 957). The notion of multiple selves residing at different levels of thought has long been theorized (James, 1910; Freud, 1925; Gergen, 1972), and coincides with the emphasis in symbolic interactionism on the role-taking or rehearsal process that is part of behaviour regulation and self-concept formulation.

The working self-concept represents the self as a much more complex and dynamic phenomenon than is typically conceived in empirical studies of the self. It is composed of a number of self-conceptions or possible selves that may vary in salience (i.e., importance to the individual), accessibility, desirability, and temporality (e.g., a past self) in response to the demands of the immediate social environment and the person's affective or motivational state. It is also composed of the "core self," self-conceptions which are most important or consistent in defining the self and are chronically accessible. These may include ascribed characteristics (Sarbin, 1970) which are conferred at birth and are relatively unchangeable (e.g., gender, kinship role, national heritage), as well as the salient identities (Stryker, 1984) which are especially significant.

In this research, social functioning is seen to be a function of the relationships among the self-conceptions of three planes of possibility: the person's current or real self, his or her ideal self, and the person's perceptions of others' expectations for him or her. The latter have been included as a way of assessing the social environment, acknowledging the prevalence of interpersonal expectancies in social interaction and their effects--direct and indirect--on behaviour (Miller & Turnbull, 1986). The relationship between the real and ideal self-concepts has been conceptualized as personal growth (Butler & Haigh, 1954; Rudikoff, 1954), and as likely affecting self-esteem (Fitts et al., 1971; Maslow, 1954). The exact nature of the relationship between personal growth and social functioning, however, is unclear, as are the relationships among the other self-concepts.

The conceptualization of each self-concept is based on a theoretical perspective which combines symbolic interactionist theory with role theory. Following Hewitt (1979), three components of the self-concept are assumed: (1) identity, which is based on one's social location or social roles; (2) self-image, which is based on one's own attributes or self-description; and (3) self-esteem, which is based on one's own evaluation of the self. The latter two elements are seen as derived from the assessment of one's own social functioning, either in general or regarding the performance of a specific role. In other words, my self-image and self-esteem are derived from how I perceive and evaluate my own social functioning. All three elements are also assumed to include the person's perceptions of how other people identify, describe, and evaluate him or her, although the extent of this would likely vary with each individual.

The theoretical advantages of this conceptualization compared to other approaches to assessment are derived from the fact that it combines several theoretical perspectives, and analyses processes and structures at both the intra-personal and social level, thereby providing a more complete understanding. It is hoped that this new approach will have a beneficial effect on the self-images and self-esteem of people whose social functioning is assessed, as a result of being regarded as a legitimate authority on their own social functioning, from acknowledging the influence others have on social functioning and hence, on their self-concept, and from assessing themselves in relation to their own personal goals, not an irrelevant social norm.

Method

Research Setting

Houselink Community Homes is a non-profit organization in Toronto which develops independent, co-operative housing for people who have received psychiatric treatment and other "hard-to-house," low-income, single people. Begun in 1978 by a small group of professionals, Houselink now considers itself to be controlled by its members, since members are involved at virtually all levels of decision-making within the organization, including staff and the Board of Directors. As a result, Houselink has a strong identity as an alternative to mainstream mental health organizations, and as a strong supporter of patients' rights.

Houselink's primary purpose is to improve the living conditions and well-being of low-income people who have received psychiatric treatment. More specifically, the organization tries to alleviate the inter-related problems of inaccessibility to housing (due to financial restraints and competition for limited space), inadequate housing conditions, and insufficient support, all of which are aggravated by the chronic shortage of low-cost housing in Toronto. To combat these problems, Houselink searches for low-cost rental accommodation for its members, buys and renovates existing housing, and also constructs new housing of its own.

Most of the Houselink units are autonomous, co-operative arrangements involving four to five people, all of whom are expected to be responsible tenants and to share in the daily tasks of running a home, without supervision from staff. Because of the high expectations for independent, co-operative living, the organization has tried to build mechanisms for support at several levels. Members are actively encouraged to rely on each other for emotional and practical support, both within and among the co-ops and the other units, and staff and volunteer co-ordinators for each residence provide assistance on an as-requested basis. The organization itself acts primarily as a central planning and adminstrative unit, including providing general maintenance services, assisting with landlord relations, if necessary, and interviewing prospective residents.

Research Relationship

My involvement in Houselink began in October 1985, when I first approached the Executive Director about the possibility of having my practicum placement at Houselink as part of my Master's studies in community psychology. I had primarily been attracted to Houselink because of its reputation as a non-traditional mental health organization, oriented to self-help. My own commitment to mutual self-help stemmed from my personal relationships with people who have received psychiatric treatment, and my experience working with both a mutual support group and a more traditional social recreation program for people who had previously been hospitalized. Once it was clear that I shared many of the same values about the rights and abilities of people who have received psychiatric treatment, I began to work at the Houselink office one day a week.

Fortunately, the diversity of my practicum responsibilities allowed me to get involved in many different aspects of the organization and to work closely with many people. This included working with staff to determine information and communication needs, providing support to residents of a co-op as a volunteer co-ordinator, and meeting with numerous residents and non-resident members with regard to creating and facilitating a self-help group. After the six months of my practicum were over, I was urged by staff to run for election to Houselink's Board of Directors, a position I currently hold. This involves working approximately one evening a week with members and staff on such diverse tasks as organizing a self-help discussion meeting and determining policy for a new housing development, in addition to the regular business of the organization.

As a result of my previous and present involvement in the organization, I believe I am regarded by both staff and members as "belonging" in Houselink. I think this is true not only because of the length of my involvement (approximately three years), but also because I am involved at a time when the organization is redefining itself as a result of broadening its mandate and operations. I think both staff and members consider me to have more in common with staff, judging from having often been mistaken as a staff person by members and from having been offered employment there. The primary reason for this "status" is the fact that I have never received psychiatric treatment, although my education in psychology emphasizes it even further. Although a few staff members have received treatment themselves, and an attempt is made to eliminate status differences such as by mandating equal representation on the Board of Directors, there seems to be a clear distinction between the "helpers" and those being helped. My impression is that staff and community members such as myself are generally perceived by other members to be more skilled, more middle class, and generally trouble-free. Staff and community members also appear to do much of the organization's work and to hold most of the official leadership positions, though there are several important exceptions. I have sometimes felt, however, that community members are "second-class citizens" in members' eyes, because Houselink is not "our" organization and we are not seen to benefit directly from its activities (though this is obviously not true).

On the other hand, I am not a complete outsider to members, as indicated by my election by them to the Board of Directors. I know many members (especially residents) by name, and a few of them I know fairly well, although it is probably true that I know them better than they know me. I also benefit from the solidarity that results from the organization defining itself in opposition to mainstream mental health services. Members know I share many of their beliefs and concerns, not only about psychiatric treatment and housing, but also about finding a job and living on a limited income. In these respects, my lifestyle as a student is similar to that of many members, in addition to its lack of structure and formality.

On the whole, I think my personal credibility has been established by the length and breadth of my involvement in Houselink, and this cannot help but have benefitted the processes and outcomes of the research project. I know that had I not demonstrated a commitment to Houselink's goals and values (and helped work to achieve them), and had I not acquired the trust of many members, the Executive Director would not have permitted me to conduct any research at Houselink. Her enthusiasm for the research project and the rapport I had established between myself, many members, and staff, appear to have induced the former to participate and staff to assist with the project.

Before data collection began, however, I was prepared for the possibility that the residents of the co-op for which I was volunteer co-ordinator may not want to participate, since there was a fair amount of conflict among us regarding their need for my support, with the result that we agreed to terminate my involvement with them. Likewise, I thought members who knew only of my involvement in the self-help group (which was oriented to employment concerns) might infer from that that I am intolerant of people who are unemployed, or expect people to "pull themselves up by their bootstraps." I also realized that some members might hesitate to disclose themselves fully, or even to participate at all, because they felt I am too young and too privileged (i.e., educated, middle class, married, and not an "ex-patient") to understand their concerns and lifestyle. As it turned out, these concerns were generally unfounded, as the response from most residents was quite enthusiastic, and the majority of the refusals were from residents I did not know (see Procedure for more information on the selection of participants).

Nevertheless, it was partly because of these concerns that I attempted to make my research relationship with Houselink a collaborative one from the start. Shared control with the research setting over the process and outcome of research is consistent with the values of community psychology, particularly its emphasis on consumer participation and empowerment (e.g., Chavis, Stucky, & Wandersman, 1983; Rappaport, 1977), although not always with its practice (Walsh, 1987). "It is useful to view the relationship between researchers and community members as a partnership. . . , based on an exchange of resources. . . which is mutually beneficial" (Heller, Price, Reinharz, Riger, &

Wandersman, 1984, pp. 55-56). Otherwise, the research risks being irrelevant and useless, and members of the setting feel exploited, even to the point of sabotaging the research. Research based on a collaborative relationship with the setting, on the other hand, is more likely to receive full cooperation and have its results implemented because community members feel a sense of ownership over the research. One would expect this to result in research which is of greater quality and relevance.

Yet despite this firm belief in the value and necessity of a completely collaborative research relationship, the reality for this research has been somewhat of a compromise of this ideal. I think it is fair to say that my research relationship with Houselink has been characterized by sporadic collaboration, primarily with the Executive Director and staff, interspersed with long periods in which I worked pretty much alone or with my thesis advisor. There were several reasons for this compromise, including the much larger scope (and therefore time span) of the research project than is customary in qualitative research, the limited organizational resources available, and not least, my own unfamiliarity with the mechanics of a truly collaborative, emergent research design (for further discussion, see Methodological Comments).

But even if the collaboration on the research project was not continuous and did not involve participants to the extent I would have liked, collaboration did take place for the most important elements of the study, primarily the planning of its purpose and and procedures. While the choice of topic was my own, the conceptualization of the study was the result of several discussions between myself and the Executive Director. Her involvement dated to the inception of the study, since the possibility of conducting research at Houselink was discussed during negotiations about the practicum. It was made clear at that time that any research would have to be consistent with Houselink's values, which I interpreted to mean that research adopting a "medical model" (Rappaport, 1977) approach, or which focused exclusively on members' disabilities and ignored social context would be considered irrelevant and potentially harmful for members. I am convinced that the research has benefitted substanially from her recognition of my implicit assumptions about ideal social functioning, and so in directing the conceptualization to its present form. She has been particularly enthusiastic about the qualitative methodology and the emphasis on personal growth, both of which she viewed as more interesting and potentially more useful to Houselink than the dominant approaches to assessment, in terms of improving the well-being of its members.

The most extensive collaboration with the rest of Houselink occurred during the planning of the interviews and the development of the interview schedule. In the initial stages, I solicited the opinions of three people who had received psychiatric treatment, two of whom were Houselink members. This was done very informally: I approached two people I knew fairly well through the self-help group (the third person was a friend of one of these) and asked them for their assistance, though assuring them they were under no obligation. These people were particularly helpful in narrowing the focus of the questions and improving their face validity, as well as in making them less complex and threatening.

After having developed a preliminary set of 30 interview questions, I asked Houselink staff to review them for ease of comprehension and, given the sensitivity of the questions, their emotional threat. In one of their regular meetings, staff suggested I reduce the number of questions and made a few recommendations about their wording. The general consensus seemed to be that this was an interesting and worthwhile study, but that the questions were difficult to answer because they "weren't the sort of thing you thought about explicitly."

At the suggestion of the Executive Director, all staff except one volunteered to be interviewed so that I could get some practice with the interview schedule and refine it. Interestingly, a few staff members said they were quite nervous at the prospect of discussing their goals--especially the discrepancy between their goals and their current social functioning--and two were quite relieved to discover they were not part of random selection for staff interviews. The five staff (out of ten) who were interviewed, however, said they were surprised to find the interviews as easy and enjoyable as they did. In retrospect, I think their nervousness was the result of seeing the questions ahead of the interview and therefore of having too much time to think of the "right" answers, since almost none of the resident participants appeared as nervous as staff.

Since the questions used for staff interviews were still being refined, their data are not comparable to that of the residents (staff, for example, were asked a number of questions about their functioning in a particular role), and so was not analysed to nearly the same extent. It is clear, however, that their self-descriptions--of both their real and ideal selves--contain a number of the same general themes of self-determination, competence, unity, and integration. Interestingly, staff said other people's ideals for them were more important or relevant to them than did residents. This could have resulted from staff feeling less compelled than residents to prove their personal autonomy, or from working in one of the helping professions and being more conscious of others' opinions than usual. Whatever the reason, the number of participants in each case is hardly comparable enough to make any valid comparisons.

After collaborating on the development of the perspective and implementation of the study, the terms of my relationship with Houselink consisted less of collaboration than of periodic updates of the progress of data collection, coding, and analysis. During this time I sent two letters to participants via the Houselink newsletter, explaining the processes I was engaged in, and giving preliminary results. I also met periodically with the Executive Director, first to discuss my initial impressions of the data, then to report on the preliminary results of the analysis, and then to discuss the final results and conclusions. Staff in general had many unofficial updates on how the research was proceeding, since I was at the Houselink offices almost every week as part of my Board involvement.

Participants

Participants were 40 residents of Houselink's 19 co-ops. This number represents approximately one half of the co-op residents and approximately one quarter of Houselink's total resident population. The decision to obtain participants from the co-op resident population rather than from the entire Houselink membership was partly due to the fact that the living situation of the former group is organized and stable and therefore more amenable to any possible intervention by Houselink. It was also assumed that the lack of stable or decent housing which some non-resident members experience probably influences their social functioning in some manner and as such, questions about role performance and personal goals might be superfluous.

Only information about participants which describes the sample and which is relevant to the research has been included. Information about participants' age, sex, employment status, and education level, for example, has been considered relevant to social functioning, whereas specific psychiatric diagnoses has not. It is likely, however, that participants' diagnoses are representative of the most common psychological and affective disorders (i.e., schizophrenia, depression, and manic depression). By their own account, most have had at least three hospitalizations at one of the two psychiatric hospitals or the psychiatric research institute in the area. Most appear to be currently treated on an outpatient basis, receiving drug therapy and periodic counselling.

Women constituted 42.5 % of the sample (17 people), and 57.5 % were men, yielding a ratio of 1 woman to 1.35 men. This is comparable to the overall ratio of female to male residents in Houselink co-ops, which is approximately 1 woman to 1.5 men.

Participants' ages, where available (n=38), ranged from 21 to 57 years, with a mean of 34.18 years, a median of 32.5 years, and a modal age of 32 years. The fact that all three measures of central tendency are so close indicates that participants' ages have a fairly normal distribution, though there is a slight skew to the right. Approximately 68 % of the participants, therefore, were between 25 and 38 years of age. Again, this is very comparable to the average age of all the co-op residents, which previous research by Houselink has determined to be 34 years.

Information about participants' educational experiences was available for 31 people, and the highest level of education attained ranged from public school to some graduate school courses. Approximately half of the sample (16 people; 52 %) had attended university, and 23 people (74 %) had received some sort of higher education beyond high school and upgrading classes, including business or secretarial college, as well as college or university.

Participants' sources of income can be roughly divided into three categories: employment earnings, social assistance, and other miscellaneous sources, such as alimony or disability pensions. It should be noted, however, that any one participant might have an income from more than one of these sources. Of the 33 people who gave information about their finances, 16 people (49 %) said they received some income from work, and 10 people (30%) reported work earnings as their only source of income. The other 7 people (21 %) received a combination of work earnings and income from social assistance, inheritance, or stocks.

The primary type of social assistance received by participants was Family Benefits Allowance, and 7 people reported receiving FBA either by itself or in combination with money from parents, Canada Pension, or a private insurance plan. Other forms of social assistance included welfare (2 people; 6 %) and disability pensions from either the government or private insurance plans. A total of 18 participants (55 %) reported receiving some type of social assistance income.

A few income sources for participants fell into neither of these categories, and included personal savings, alimony payments, money from parents, and investment income, as mentioned above. One participant reported having no income at the time of the interview since she had just finished school and was contemplating welfare if a job hunt was unsuccessful. Only 3 people (9%) relied on these miscellaneous sources for their entire income.

A final characteristic of participants concerns their primary daily activity. Those participants who did not spontaneously give this information were asked, "how do you spend your days?" Seven people (17.5 %; n=40) said they attended school or rehabilitation classes either full- or part-time, and 26 people (65 %) said they worked. Eleven of these (27.5 % of the sample) said they worked part-time, eleven said they worked full-time, 3 people said they worked occasionally, and one person said he worked at home. Four of these 26 people combined working with another activity such as doing volunteer work.

A variety of other activities were described by participants as their primary daily activity: doing volunteer work (1 person), attending a rehabilitation workshop (3 people), and doing "hobbies and chores" (1 person). In response to a direct question, three people said they either were "taking it easy", doing "nothing," or "not go[ing] out much."

It should be noted that the terms used here such as full- and part-time are those used by the participants and have no precise or shared definition. In the opinion of Houselink's Executive Director, participants' definitions of full- and part-time work are probably very different from the usual definitions (e.g., that full-time is more than 35 hours per week), and that many were probably overstating their work involvement to be more socially acceptable. Nevertheless, it would appear that the 40 participants in this study are somewhat different in terms of education and occupational status than those typically defined as "ex-psychiatric patients." By comparison, Fischer et al. (1981) found only 17.9% of their 744 participants--which they claim to be representative of "the entire spectrum of psychiatric aftercare services"--had "some" university education and 27.2% had less than grade nine education. Furthermore, only 35% of their entire sample was employed prior to admission to hospital and 38% of the follow-up group (n=505) was employed six months after discharge. Similarly, Anthony, Cohen, and Vitalo (1978) found a base rate of 10-30% of discharged patients for full-time employment, regardless of follow-up period.

At the risk of oversimplifying, one can see from participants' personal data that in addition to having been hospitalized for psychiatric treatment, the typical participant in this research project was relatively young (34 years) and well-educated, had some sort of structured daily activity such as work or study, and derived some portion of his or her income from either work or social assistance.

The implications of these characteristics are not immediately clear. It is quite possible, for example, that the wealth and richness of the information with which participants provided me is directly related to participants' relatively advanced educational backgrounds. Certainly these people were more articulate and more amenable to the lengthy interview process than might be expected of "chronic mental patients" with more typical educational and occupational backgrounds. On the other hand, it seems probable, as the Executive Director asserted, that the degree of insight and commitment to intra-personal unity exhibited by these participants is characteristic of many people who have received psychiatric treatment. Nor are these two assertions irreconcilable. It seems likely that an unstructured, in-depth, interview such as that used in this research only appeals to someone at ease with analyzing and talking about themselves. Other people who have received psychiatric treatment may prefer a more structured interview.

Measures

The interview schedule (see Appendix A) consisted of 11 open-ended questions concerning participants' social functioning, and was developed specifically for this research. The questions were designed to elicit information about participants' general or cumulative self-concepts, including their current and ideal self-concepts and their perceptions of others' expectations for them.

As the Appendix illustrates, the interview schedule also contains a number of supplementary and alternative questions which were used in place of or in addition to the 11 standard questions. Their purpose was to help elicit participants' information about their social functioning, if the standard questions were not successful in doing so. Therefore, all are simply restatements of the original questions, with different wording.

While either the standard or supplementary questions were asked of all participants, the nature of interviewing is such that each interview was unique. I would often ask additional questions, for example, about the roles, attributes, or issues which appeared to be most important to that person's social functioning. One woman, for example, had definite philosophical and religious convictions about ideal social functioning, and so we spent alot of time discussing these and their relation to her own goals and others' expectations. Another participant insisted on giving me his abbreviated life story as a way of explaining how important his family and job had been to him, and the crisis he experienced when these were lost to him. In each case, the adaptations I made to the interview schedule and my use of various forms of non-directive probing such as encouragement and summarizing responses (Cannell & Kahn, 1968), were in order to "create and maintain an atmosphere in which the respondent feels safe to communicate fully without fear of being judged, criticized, or subsequently identified and disadvantaged" (Cannell & Kahn, 1968, p. 581). The primary goal was to optimize the accessibility of the required information to the participant, as well as his or ehr motivation to impart it (Cannell & Kahn, 1968), in the hopes of getting as complete a reconstruction of participants' personal realities as possible.

One of the primary structural methods of optimizing accessibility and motivation for participants was the use of open-ended response formats. According to Cannell and Kahn (1968), these are preferable to closed formats when the researcher is trying to gain insight into the respondents' situation, which may be outside his or her own experience. Open response formats are also better suited to research which is intended to explore and explain that situation (as in the present study), rather than classify it. Bradburn and Sudman (1979) recommend that "an open-ended response format . . . should always be used in asking about sensitive behaviour" (p. 167) since this format and, to a lesser degree, allowing the participant to respond in his or her own words greatly increases the amount of behaviour reported. As such, the interview schedule allowed the participant to talk about the roles and characteristics that were most important to him or her, rather than about those which I have arbitrarily chosen.

The organization and sequence of the questions was guided by Cannell and Kahn's (1968) assertion that it is the researcher's responsibility "to make the total interview experience as meaningful as possible . . . , to lead the respondent . . . through the process of exploration" (p. 571). The sequence began with the real self-concept since this information was assumed to be most accessible to the respondent. Others' ideals were discussed next, and the ideal self-concept discussed last, so that the interview would end on a relatively positive note, emphasizing personal growth, not just adjustment. Given their possible threatening nature, questions pertaining to the participant's age, source of income, daily activity, and education level were asked whenever it was considered most appropriate, usually at the end of the interview when rapport had been well established.

The other important "measure" used in this research was an adaptation of Gordon's (1968) classification scheme for self-representations (see Appendix D regarding specific codes). Gordon's (1968) typology is based on the work of Kuhn (1960), Kemper (unpublished), and McLaughlin (1965), all of which are attempts to classify and analyze responses to Kuhn and McPartland's (1954) Twenty Statements Test. The latter allows the respondent to represent himself or herself in virtually any framework he or she pleases, in response to the question, "Who am I?" Gordon's categories include roles and attributes, some of which are acheived and others ascribed, as well as more systemic senses of self from which some of the major themes such as competence and self-determination are derived.

Relying on my prior knowledge of the people at Houselink and of other people who have received psychiatric treatment, I immediately revised a couple of Gordon's categories to more accurately represent participants roles and experiences. I included a category for volunteer involvement, for example, knowing that for some, this provided much the same structure and purpose as an occupational role. As it turns out, I revised the typlogy several times, on the basis of how well it was fitting the data. Most important was the addition of a major pattern code for responses regarding participants' interpersonal integration, the deletion of the pattern code for references to moral worth, and the redefinition of the unity pattern code (which Gordon refers to as intra-personal integration) to include references to self-knowledge and personal growth.

Although Glaser and Stauss advocate letting the categories for coding "emerge" from the data, I decided to use Gordon's (1968) typology as a starting point, understanding that it would necessarily be revised--perhaps several times--to conform to the reality of participants' experiences. Whereas a heavy reliance on a priori theory contradicts the subjective approach to category construction of naturalistic inquiry, and can severely distort participants' conceptualizations, a good measure of insurance is provided if the schema is itself naturalistically derived (Miles & Huberman, 1982), as in this case.

Procedure

Initial contact with prospective participants was via an introductory letter (see Appendix B) sent to each of the co-ops explaining the purpose of the study and describing the interview procedure in some detail. The decision to give detailed information about the study to participants prior to data collection was made because I believed Houselink members would be more willing to participate if they felt fully informed and were not afraid of being exploited. According to Bradburn and Sudman (1979), "more detailed, informative, and truthful introductions . . . have no effect on response rates or on responses to individual threatening questions" (p. 170). As seen in Appendix B, the letter clearly explains that participation is in no way linked to any aspects of participants' membership or residency in Houselink and is completely voluntary.

The decision to select participants randomly, using a table of random numbers, was made in order to avoid bias and enhance the generalizability of the results. Although naturalistic inquiry generally uses purposive sampling to obtain even extreme or atypical information often missed by random sampling, the relatively large number of participants and the depth of information collected seems to indicate that little was lost by the selection process.

In truth, however, the selection process was not completely random, since three residents (two men, one woman) were excluded before the selection of prospective participants even began. Two of these exclusions were made on the advice of staff, who felt that, in the case of the two men, their antipathy toward Houselink and their somewhat violent natures would make any contact unpleasant for everyone, not least the two residents. The third person excluded from the study was one of the residents of the co-op for which I was a volunteer co-ordinator (see

Research Relationship for more details). Quite simply, I felt that the degree of resentment the resident still felt towards me would obviate any effectiveness or benefit the interview might have, and that random samping was not worth the distress we would no doubt both experience.

Ordinarily this compromise of random sampling procedure would be considered a seious threat to external validity, and hence the generalizability of the research findings. This emphasis on representativeness, however, assumes information can be abstracted from its context and generalized across time periods and settings (Lincoln & Guba, 1985). My growing commitment to a naturalistic research paradigm, however (see Methodological Comments), has convinced me this is neither possible or desirable. My aim in this research has been to reconstruct the personal realities of a group of people who have been hospitalized for psychiatric treatment, as each perceives them. This emphasis on subjective experience means that only working hypotheses can be extracted from these reconstructions, and their transferability to other settings depends on their similarity to this one (hence the "thick" description of the setting and the research relationship). In my opinion, the exclusion of these three residents from the sampling process does not diminish the transferability of the findings.

The other major factor mitigating against a true random selection of participants was their unavailability. The initial selection of 50 names from Houselink's list of residents did not yield the desired 40 participants. Although there were a few refusals (see below), the greatest difficulty was simply in contacting residents to ask for their participation. This was first done about one week after the introductory letter was sent, but it was sometimes several weeks before contact was actually made with the desired resident, and sometimes not at all. In all, three separate reviews of the residents' list were made in order to find 40 people willing to participate. While each of these participants was chosen via the random number table, the sample represents almost all the Houselink co-op residents (of a total of 86) who could be contacted and who were interested in participating, with the exception of 6 people whose numbers did not come up in any of the random selections.

In total, 12 residents (14% of all 86 residents) were unavailable, 4 were in hospital, 19 (22%) refused to participate, and 1 did not show up for our arranged meeting. One resident volunteered to participate, and rather than refuse her the opportunity, we had an interview and I kept these data separate to check for any differences, which did not occur. In addition to the 40 participants, the 3 residents excluded at the beginning, and the 6 who were not chosen, this accounts for all 86 residents. Unfortunately, there is no way of knowing if those who participated were different from those who chose not to, either in terms of age, education, income, or primary activity, or in terms of their experiences of their social functioning. The only exception concerns gender, and in this respect, the proportion of males to females in each of these categories was generally equivalent to that of the total co-op resident population, that is, 1.5 to 1.

Most of those who declined to participate simply said they were not interested, although a couple of people said, "I just don't feel like talking about stuff like that," or "I'd rather not talk about the past." Given the personal nature of the research and the negative experiences many members said they have had with research, I do not consider the refusal rate to be very high. By comparison, Fischer et al. (1981) considered a refusal rate of 16% to be "very small." I also think the refusal rate indicates the desire I have heard expressed periodically by residents for more autonomy from Houselink activities. Since the number of participants was quite large for qualitative research, I do not expect that, had these people been included, the general themes and patterns which emerged would be very different, although specific roles may have figured more or less prominently.

The next stage in the procedure involved telephoning the prospective participants who had been selected to request their participation and arrange for an interview. It was emphasized again that their participation was completely voluntary. Since there were often several residents from each co-op who were selected, an attempt was made to arrange their interviews for the same day, although this was often not possible. Surprisingly, when I asked residents what they had heard about the research, most said they had not discussed it with other residents, and the rest said simply they had heard it was "alright", presumably meaning "safe."

With the exception of three people who had their interviews at the Houselink offices, and one person who met with me at a nearby cafe, virtually all participants agreed to have their interviews take place at their homes. Prior to data collection, I decided this setting would be most familiar and non-threatening to participants, and would make them feel more comfortable during the interview.

The interviews themselves began with asking participants what they had heard about the research, and whether or not they had any questions. The purpose of the study was explained, and participants were asked to sign a consent form (see Appendix C) which acknowleged that their decision to participate was fully informed and voluntary.

Participants were then asked if they objected to having their interview tape-recorded. The rationale for recording was two-fold: (1) I wanted to preserve the depth and detail of participants' responses in order to learn as much as I could about their subjective experiences, and avoid the possibility that I would unconsciously select only the most interesting and eloquent information to record by hand; and (2) I wanted to participate as much as possible in the interview interaction. Recognizing, however, that the prospect of being recorded might be threatening for some, I used a very small, portable audio-recorder and chose not to use a microphone.

Only three participants requested that I not tape their interviews, generally supporting research which indicates the presence of a tape recorder does not affect participants' responses (Belson, 1967; Cannell, Lawson, & Hausser, 1975; Bradburn & Sudman, 1979). For those who did object, I recorded their responses manually in point form and spent time afterward expanding my notes.

Before the interview began, participants were also reminded of their right to refuse to answer any questions about which they felt uncomfortable. This reminder was considered particularly important because of the sensitive nature of the questions and so that participants could feel they could assert their rights. In the end, no one refused to answer any of the questions, although two people did ask that the tape recorder be turned off for a short period during their interviews because they were talking about very personal subjects.

Participants were then asked a series of open-ended questions concerning his or her self-concept on three different planes. Naturally, the interviews were all different, since each was a unique interaction between myself and the participant, each of us with different personalities, motivations, and interpretive schema. As described in the Measures section, the order, terminology, and tone of the questions were varied in order to elicit the greatest depth and detail of information with the least discomfort to the participant.

At the conclusion of the interview participants were asked what they thought of the questions and how they felt about the interview process. The purpose of these questions was to determine how to refine the interview schedule as well as what support each participant might need, if any. Very few participants made suggestions about the questions or indicated they found the process to be uncomfortable, although one participant did agree to talk to a staff member about his/her severe depression, which was unrelated to the interview. Most participants, when asked, said they did not find the questions to be too personal, and in fact several said the interview had been a pleasant or useful experience for them: "I enjoyed it"; "It's good to talk about these things. I don't really have anyone to talk to about this." One participant said she found it frustrating when I asked what other people could do to help, since she felt she had to cope alone, and was also frustrated when I asked not to see some material she wanted to show me about another resident, despite my explanation about wanting to respect the other person's privacy.

Participants were then called a couple of days after their interview so I could thank them for their participation and ask if they had any questions or concerns. At this point one participant said he had found it a bit unsettling to "think about goals and how far away they were," but that it had been a good experience. He said he didn't think it was necessary to talk further about this with anyone.

At the end of data collection, participants were mailed a letter in the Houselink newsletter thanking them again for their participation and exlaining the process of analysis. Preliminary results were then mailed in a subsequent newsletter approximately six months later. In addition to these reports, a meeting with interested participants will be held in order to more fully discuss the findings of the research and to obtain participants' reactions as to the accuracy of my reconstruction of their experiences. Not only is feedback an ethical imperative (see SSHRC Ethical Guidelines for Research with Human Subjects), but participants and other members of the research setting can "provide valuable insight into the meaning of research findings" (Heller at al., 1984. p. 56). The purpose of the meeting, therefore, is to obtain an indication of the credibility of the research findings, as well as to give participants a sense of ownership and some control over the final product. Informational meetings with the staff, the Board of Directors, and the membership as a whole are also planned.

Data Analysis

In the absence of any standard, agreed-upon method for the analysis of qualitative data, I have used a combination of techniques from several sources for generating and verifying the findings from participants' self-descriptions. As a group, these most closely resemble the constant comparative method described by Glaser and Strauss (1967).

As described by Glaser and Strauss, the process of assigning categories to participants' information first involves comparing each unit of information--in this case, words and phrases--with all the others in that category. Although my use of a predetermined set of categories lessened the time it took for this step, it did not eliminate it entirely, primarily because I wanted to determine if the typology was in fact appropriate. Moreover, comparison among units was necessary for me to be able to establish the properties of the categories, particularly for the pattern codes.

> This constant comparison of the incidents very soon start to generate theoretical properties of the category...,the full range of types or continuum of the category, its dimensions, the conditions under which it is pronounced or minimized, its major consequences, its relation to other categories, and its other categories. (Glaser & Strauss, 1967, p. 106).

In order to help myself develop the properties for the pattern codes, as well as a few of the others, such as activities and interests, I followed the suggestion of Miles and Huberman (1982) and wrote both memos and process notes. Their purpose was to record my feelings, questions and dilemmas, the former regarding the content of the categories, and the latter regarding the processes of data collection, analysis, and theory formulation. They allowed me to review the process of definition over time, and hence, to be more thorough and specific, as well as helping me to move to the next stage, that of categorizing information on the basis of its fit with the codes' properties, not just other similar units of information. For example, although it was soon clear that I would have to create a category for interpersonal integration, it was not clear at first what its relationship with the theme of unity would be. After reviewing the history of my thoughts about this in the memos, I was able to determine that many participants felt their goals in these areas conflicted with each other. Similarly, while it was possible to eliminate some of Gordon's categories for judgements, tastes, and intellectual concerns, I found it difficult to decide how to differentiate between interests and activities. Through the use of memos, I was able to devise a solution that, though not entirely satisfactory, was at least workable.

It was in the process of defining the properties for the pattern codes that I developed their sub-themes, or categories. Actually, this was a reciprocal process: clarifying the sub-themes also allowed me to restrict and strengthen the major pattern codes, and to see the relationships among them, as well. For example, it was only after I tried subsuming the notion of a sense of purpose under the theme of self-determination, and saw that it didn't relate well to the other sub-themes, that I realized it was a theme in and of itself, albeit a closely related one.

The last step in the analysis process involved developing a final reconstruction of participants' own experiences of their social functioning. Although this construct of marginalization is used here more as description than an explanatory theory, it is "grounded" nonetheless in the self-descriptions of the participants, though not necessarily in their own language. This has partly to do with the nature of marginalization itself: its success is partly determined by the extent to which its victims accept and believe that marginalization is <u>their</u> fault, not a systemic one (Goldenberg, 1978). Those who are marginalized are possibly the least likely to recognize their condition as such.

In any event, once I had started to think of participants' desire for acceptance and assimilation in terms of images and metaphors, and had developed the pattern of outsiders living in a separate world, it was relatively easy to apply the construct of marginalization. Like all the other stages in the analysis, however, the suitability of this construct needed to be confirmed, and like the other stages, this was done by going back to the original data. This verification process involved applying virtually each quotation to the code, theme, or construct for suitability, looking for exceptions and disconfirming evidence, and counting the instances which actually fit the code, theme, or pattern, in order to avoid seeing only "the brighest lights," or most exotic information. In addition, the data from eight interviews (20% of the entire sample) were kept separate and not analyzed until after the final interpretations had been made, so as to provide triangulation and bolster the credibility of the results. A final check of their credibility will be provided by the participants themselves, when a group meeting is held to ask how well the results "fit" with their own experiences.

Methodological Comments

As may be evident from some of the comments in the Method section regarding the sampling procedure, the initial classification scheme, and collaboration with the research setting, this research represents somewhat of a methodological compromise. Some of these compromises I do not consider serious, such as my decision to use Gordon's (1968) typology as a basis for my own coding scheme. While it is obviously important to pay strict attention to people's terminology and interpretive schema, I do not believe it is necessary to "reinvent the wheel" each time, particularly when there is a solid background of naturalistically derived data available. With sensitive and judicious use--and inevitable adaptation--such data have, I believe, a legitimate and valuable, albeit secondary, role to play in conceptualization and analysis.

On other procedural points, however, I have had the distinct (and uncomfortable) feeling of trying to straddle two opposing methodological paradigms. The reason for this balancing act is that my understanding and adoption of the naturalistic paradigm has developed <u>throughout</u> the research, rather than beforehand. While I have long been a believer in the value of qualitative methods, my acceptance and support of the basic values of the naturalistic paradigm has had to battle with my indoctrination in the methods of the conventional, positivist research paradigm. Thus, I attempted random sampling to avoid the threats of selection bias to external validity before discovering that such concerns are based on a conceptualization of knowledge and reality (Lincoln & Guba, 1985) that I do not share. Similarly, it was only after I happily met demands for a detailed research proposal that I learned the importance of an emergent, collaborative research design.

Despite these compromises, I still believe this research is successful in methodological terms. In other words, I believe that the findings of the research are generally trustworthy as a result of specific procedures followed in the design of the study, and in data collection and analysis. Most of these procedures have been outlined in the various subsections of the Method section, but I will briefly reiterate them here. My prolonged engagement in the research setting, for example, was valuable for establishing trust with those who would become participants, and thereby increasing the likelihood of obtaining full, detailed, and accurate information from them. In addition, I was able to learn much about what was important to the people at Houselink. and use this tacit knowledge to design a research project that was relevant and useful. My lengthy involvement in the setting prior to the start of the research also enabled me to provide the "thick" description necessary for others to determine the similarity of their settings to this one, and hence, determine the transferability of the findings.

Other techniques for establishing credibility concerned the analysis of the data, and included separating a portion of the interviews to triangulate results, consulting with my thesis advisor to determine if the themes and patterns I interpreted were credible, and did indeed emerge from the raw data, and mentally resisting premature closure of these stages of analysis. In addition, once I had developed a hypothesis about a particular theme or pattern, or even the general theory, I adapted it to account for as many negative cases as possible. Finally, the member check with all participants to determine their agreement with the results will be a powerful statement as to the credibility of the findings, whether positive or negative.

In summary, I think that the procedures described above make a persuasive case for the credibility of the research findings. I also believe that the method used here exhibits the most important operational characteristics of naturalistic research, such as the use of qualitative methods, a natural setting, for the most part, an inductive analysis, and a generally idiographic interpretation of the findings. The compromises of purposive sampling procedure and an emergent design, while somewhat confusing, I believe do not end up compromising the findings, given the safeguarding procedures just described. Finally, I think that the final criterion of trustworthiness is in agreement with the basic axioms of the naturalistic paradigm, namely acceptance of multiple constructed realities, of an interactive relationship between the knower and the known (in this case, researcher and participant), of the impossibility of generalization, of the impossibility of distinguishing between cause and effect, and finally, of the belief that inquiry is never value-free (Lincoln & Guba, 1985).

> To the extent to which the inquirer's personal values, the axioms undergirding the guiding methodological paradigm, and the values underlying the context are all consistent and reinforcing, inquiry can proceed meaningfully and will produce findings and interpretations that are agreeable from all perspectives.
>
> (Lincoln & Guba, 1985, p. 178)

Results

This section describes and interprets what participants think and feel about themselves--and by extension, their social functioning--on three different planes. The attributes and identities which participants used to describe their self-conceptions have been analysed and presented in successive stages. First, the frequencies with which specific roles and attributes were referred to in each self-concept are presented in Table 1 and then summarized. Next, the broader and more evaluative aspects of participants' descriptions of their personalities and behaviour are discussed in terms of general themes of competence, self-determination, and integration. Finally, the patterns or relationships which emerged among these themes are then presented. A theoretical explanation of these patterns and their implications for social functioning assessment are provided in the Discussion section.

Roles and Attributes

Table 1 illustrates the frequencies with which specific roles and attributes were referred to in participants' descriptions of their real selves, ideal selves, and the self others were perceived to consider ideal (see Appendix D regarding category definitions). It is important to note that these frequencies are based on a working sample of 32 participants (n=32), since the data from eight interviews were kept separate for triangulation later in the analysis, as described in the preceeding section. More important, however, is the fact that these frequencies do not necessarily imply that the participant actually functions in that role. Of the 26 people who define their real selves in terms of an occupational role, for example, 2 do not have jobs. Similarly, the frequencies noted for material possessions include references participants made to their lack of such resources. It seems important, however, that they should make this an explicit part of their self-descriptions.

It should also be noted that frequencies represent both direct and indirect references made by participants to particular roles and attributes. Membership in an interacting group, for example, was recorded regardless of whether the participant said "I have some good friends," or alluded to such friendships less directly. The psychiatric role in particular was often referred to indirectly by reference to symptoms, medication, or hospitalizations. Even when participants did refer directly to a particular role, they tended not to describe it in terms of an actual identity but rather as an attribute they exhibited or possessed. Participants seldom said "I'm an ex-psychiatric patient," for example, and instead referred to that role by saying, "I'm ex-psychiatric" (attributive), or "I have schizophrenia" (possessive).

Table 1

Frequency Counts of Roles and Attributes for Each Self-Concept

Category:	Real self	Ideal self	Others' ideal
1. Age	28%	-	-
2. Sex	19%	-	3%
3. Name	9%	-	-
4. Religion	3%	-	-
5. Kinship role	53%	13%	-
6. Love relationship	31%	53%	13%
7. Familial role	13%	38%	3%
8. Occupational role	81%	84%	47%
9. Student role	41%	47%	6%
10. Volunteer role	13%	3%	3%
11. Psychiatric role	75%	19%	3%
12. Territoriality	25%	19%	3%
13. Social status	3%	6%	9%
14. Membership in an interacting group	88%	22%	-
15. Membership in an abstract group	22%	38%	3%
16. Existential references	22%	6%	-
17. Beliefs	6%	6%	-
18. Interests	59%	19%	-
19. Activities	72%	41%	9%
20. Material references	53%	75%	16%
21. Physical characteristics	44%	25%	13%
22. Personality characteristics	75%	31%	13%
23. Behavioural characteristics	88%	25%	13%

Note. Adapted from "Self-conceptions: Configurations of content," by C. Gordon, 1968 from The Social Psychology of the Self-Concept (p. 13-23) by M. Rosenberg & H.B. Kaplan (Eds.), 1982, Arlington Heights, Ill: Harlan Davidson. Reprinted from The Self in Social Interaction. Copyright 1968 by John Wiley & Sons, Inc.

The real self. As Table 1 illustrates, there are a number of roles and attributes which the majority of participants used to describe their current or real selves. These include membership in an interacting group, characteristics of interpersonal behaviour, occupational roles, a psychiatric role, personality characteristics, specific activities, interests, kinship roles, and material possessions.

Between 20% and 50% of the working sample described themselves in terms of physical characteristics, a student role, a primary love relationship, age, territoriality, membership in an abstract group, and existential, individuating references.

The following roles and attributes were used by less than 20% of the working sample in their descriptions of their real selves: gender, familial roles, a volunteer role, names, and belief references. In addition, religious categorization and social status were each mentioned by one person.

In general, then, most participants described their current selves by their connections to others, especially kin, friends, and other interacting groups; by what they do, be it work or study (and the accompanying economic status) or more specific activities or interests; and by enduring personal characteristics of their personalities, behaviour, and physical selves.

The ideal self. Two categories were particularly dominant in participants' descriptions of their ideal selves: occupational role and material possessions. Twenty-seven participants (84%) wanted to have either a specific job (or a job change) or just a job in general. Twenty-four participants (75%) wanted more material possessions, especially money. A primary love relationship was the only other role mentioned by more than half of the working sample as an ideal.

Between 20% and 50% of the working sample described their ideal selves in terms of a student role, activities, familial roles, being a member of an abstract group, and personality characteristics. Although not a part of the initial coding scheme, another attribute frequently mentioned (by 15 people; 47%) was that of having one's own place to live. Interestingly, several participants said they had ambivalent feelings about this goal, such as knowing they would feel lonely, but still held it as an ideal just the same. Behavioural and physical characteristics were also mentioned by between 20% and 50%, as well as membership in an interacting grou

The following are the specific roles and attributes mentioned by less than 20% of the working sample: interests, territoriality, existential references, beliefs, social status, and a volunteer role. Several participants had specific goals with regard to their psychiatric role, primarily to be off medication and to have stable symptoms. Very specific goals were also mentioned by 7 participants (22%), particularly quitting smoking or drinking. Three people specifically said their ideal selves would have more self-esteem.

Once again we see that a primary activity such as work, relationships with others, and personal characterisitcs are important to participants in terms of their ideal selves, with an added emphasis on material and financial well-being, living independently, and making specific personal changes.

Others' ideal. Surprisingly, participants made little mention of others' ideals for them in terms of specific roles and attributes. This is obvious from the low frequency counts for each of the codes in the table; although there are a number of different roles or attributes listed, very few of these were mentioned by more than two or three people. The exceptions to this were a love relationship, physical and behavioural characteristics, and occupational role. Mentioned by 15 people (47%), the latter was by far the most prevalent role participants perceived others to want for them.

General Themes

Qualitative analysis involves more than just frequency counts, however. In their descriptions of their various self-concepts, participants spoke of broader aspects of their personality and interpersonal behaviour than the specific roles and attributes just listed, and described these in a more evaluative sense. Although a number of different themes were identified, there were three in particular which were dominant: competence, self-determination, and integration. I will first describe each of them separately, and then illustrate the many points of connection among them.

Competence

Perhaps the most prevalent theme in participants' self-descriptions was that of competence: the generalized capability to interact effectively with the environment and to adapt to its instability. A sense of competence, accordingly, is the subjective interpretation of one's general coping capacities and resources, the accumulated "feeling[s] of efficacy... experienced in each individual transaction" (White, 1966, p.20): in other words, the sensed ability to adapt, to cope, to be personally effective.

Interestingly, the theme of competence was much more evident in participants' descriptions of their real selves than of their ideal selves or other people's ideals; a total of 29 people (of a working sample of 32) described their real selves in terms of competence, whereas this was true of 17 people and 7 people for the ideal self and others' ideal, respectively. Furthermore, the number of specific roles or attributes mentioned in relation to competence was much larger for the real self than for either the ideal self or others' ideal. In fact, only three roles or attributes (interpersonal behaviour, activities, and money) were expressed by three or more participants as part of an ideal of competence, whereas descriptions of the real self included references to these attributes as well as to occupational, student and psychiatric roles. Only the psychiatric role was mentioned by three people as an area in which others wished they had more competence.

<u>The real self</u>. In the real self, the sense of coping effectively with the demands of daily life was evident in responses such as "I seem to be in good shape"; "I can function normally"; and "I've gotten my life together." Of course, instances in which participants describe themselves as not coping

particularly well were also interpreted in terms of the competence theme: "I still might screw it up if I had what I wanted right now."

Beyond these references to general coping ability, the theme of competence--like most of the other major themes--can be seen as having a number of constituent categories or sub-themes, according to the contexts or terms in which it was described. Not surprisingly, competence in relation to their psychiatric role or experiences was an important sub-theme for participants. Sometimes this reference was very general, such as "I was very sick," or "I had four nervous breakdowns," or conversely, "I wasn't ex-psychiatric enough [in the professional's view, to warrant subsidized housing]." Sometimes, however, participants made explicit mention of their symptoms or medication and how these exemplified their competence or lack of it: "I was hallucinating all the time"; "I haven't been on Moditen for four years". A couple of participants even attributed their coping problems to their medication or some other aspect of their treatment, for example, "I was so drugged up, I was like a zombie."

Obviously, the categories of general coping and competence in the psychiatric context are closely linked; the lack of symptoms or need for medication, for example, was seen as both evidence of a more generalized competence, and conducive to its development. Sometimes, however, it was difficult to tell whether the participant was referring to his or her general level of competence or to psychiatric competence. Phrases such as "There's nothing wrong with me now", and references to anxiety attacks and mood swings, for example, may suggest a psychiatric frame of reference, but in the absence of other clues, I hesitated to assume these were not just references to the variations in mood or health or adaptation experienced by those of us who have not received psychiatric treatment.

A second sub-category of the competence theme is intellectual competence. Exclusively a component of the real self, this category includes responses such as "I'm way above average in intelligence"; "They thought I was mentally retarded, but I'm not"; and "I can see a snow [job] coming." While this aspect of competence was not mentioned frequently, it seems a more general trait than those of the other categories, and is distinct from them.

Competence in a specific context or as a specific ability or difficulty was more frequently mentioned in connection with all self-concept planes. The phrase "I'm slow at reading and spelling," for example, involves a skill or applied knowledge, not just inherent intellectual competence, and is more specific than the phrases above. Participants often talked of their current level of competence in the context of relatonships: "I'm a good mother"; "I failed at the marriage"; "I find it hard with girls, I get shy." There were many variations of "I failed at..." or "I couldn't handle..." the demands of the role, whether it was children or school or work.

Since many of the participants used anecdotes to help describe themselves, they spoke of particular accomplishments or failures they had experienced, or gave examples of their competence in specific contexts. This is somewhat different from the above category in that these responses referred to a particular achievement or benchmark of their competence, as opposed to an enduring (though specific) ability or skill. Responses in this category generally refer to instances in which some honour or title is conferred on the participant to acknowledge his or her demonstrated competence, such as "I was the first name called [for the job]"; "I was elected to the Board and became Vice-President"; "I got A's in school"; and "I became assistant manager."

<u>The ideal self</u>. As an ideal, general competence was expressed in a variety of ways, such as, "I could take on more responsibilities," or, "I'm not very good at handling stress. And I think that's something that could be changed with some effort." In one case, a participant wished to emulate Jesus, even though "I'll never be perfect, there's only one person in this world that's perfect, and that's all."

Perhaps surprisingly, only a few participants specifically mentioned wanting more competence in dealing with their psychiatric experiences, or more specifically, in getting beyond or over them: "What goals? To get over this ailment. It should be dissipating soon because I've had it for over twenty years"; "If I had my health, if, or a stronger person mentally, you take alot of stress...."

However, psychiatric competence was sometimes considered a prelude to achieving other goals: "I don't know if I could handle my own apartment 'cause I'd be lonely, you know. But someday I'd like to have my own apartment..., you know, when I get really, really on my feet"; Moreover, a number of participants said they had goals regarding their psychiatric experiences, but didn't express them specifically in terms of competence.

Not surprisingly, enhancing specific skills or abilities was important to a number of participants, whether it was developing an artistic ability such as photography, getting better marks or further education, or improving job performance. For one participant, competence at money management was very important because she felt she had disappointed her parents in this area. According to another participant, "I suppose if I wanted to change anything, I might want to change the fact that I'm not very good at handling stress, and I think that's something that could be changed with some effort."

A number of participants said they would like to have more competence in their interpersonal behaviour. Most of these goals concerned behaviour in general social situations rather than in any specific relationships, for example: "I'd like to be more skilled at helping people, stuff like that..., not so much in terms of jobs; it's sort of something to do with my personality"; "I'd like to have my ways of dealing with people day to day, have better rapport, whether I like them or not"; "I'd like to be more social with people. I'd like to be, have the same capabilities as some people."

In some cases, participants had particular milestones in mind when they expressed their goals regarding competence in a given context or area, but these were generally less specific than in the real self, presumably because they were not yet realized. For one participant, more job experience would mean that s/he could apply for "better, more interesting jobs." According to another participant, "Five years down the road I'd like to be holding down a 20-hour a week job--not full-time--maybe full-time, if I could handle it." Again, the range of goals was broad; participants expressed specific goals about physical appearance, interpersonal skills, and daily functioning or behaviour. For one participant, the milestone for competence was "just rising to the point where I'm functioning more like an average person, without getting to the point of crippling myself with symptoms."

The notion of functioning "like an average person" is an enduring one in the data. Participants had very definite ideas about how competence was defined and manifested, as evident in the generalizations they made about the theme, regardless of their own self-descriptions. In one participants' view, for example, "if you can't handle your money, you're not really altogether well." Likewise, "that's what I call a severe problem--a person who avoids social contact out of, 'cause he just can't deal with it, rather than they just don't want to. I think I can see myself just not bothering with alot of situations and alot of people. Which is different from retiring because you feel uncomfortable."

For a few participants, the definition was more general, but the image just as clear, and just as desirable: "I'd like to be like the people I see on the subway--tall and slim and white, with perfect hair, good haircuts, perfectly made up, poised and suave, with briefcases. That's what I'd like to be." Note the conceptualization of competence in terms of race, occupational status, and physical appearance, especially.

<u>Others' ideal</u>. Although general competence was mentioned by only two participants as other people's ideal, the notion of extreme competence, even perfection, is evident in phrases such as "you've always got to be top-notch," and the notion that in order to be "acceptable," one couldn't have any problems at all.

Competence in the psychiatric role was one of the few areas in which participants said other people had ideals for them. One participant said,

> My brother's.. more accepting of me now, but basically he wrote me off somewhere along the line as far as somebody that, you know, would be the kind of sister that he really wants....My brother and my sister see it as a weakness. Not that you're sick, that you have some character flaw....The whole thing scares them.

According to other participants, "other people would like to see me well," "to be healthy," or "well enough to take care of myself."

Self-determination

The sense of self-determination also concerns the subjective perception of one's abilities, but in this case it is the ability to perform all the complex processes involved in attaining one's goals, that is, to be able to "select one's own goals and determine their relative priorities, initiate and vigorously pursue necessary lines of action, and act with freedom from control by others" (Gordon, 1968, p. 18). To be sure, this experience of the self as an active agent depends partly on past triumphs, but the definition of self-determination does not require the actual attainment of goals, only the sensed ability to do so.

The theme of self-determination crops up almost as often in participants' self-descriptions as did competence, and in roughly the same proportions for each self-concept plane. Twenty-eight people (13 women, 15 men) described their real selves in terms of self-determination (both a sense of self-determination and the lack of it), and 19 people (10 women, 9 men) and 9 people (7 women, 2 men) described self-determination in their ideal selves and others' ideals, respectively.

In addition to references to self-determination in general, these participants described a number of specific roles and attributes in connection with self-determination. In the real self, those mentioned by three or more people included the psychiatric, scholastic and occupational roles, territoriality, activities, and characteristics of personality and interpersonal behaviour. In the ideal self, territoriality, occupation, school, and material possessions were mentioned by three or more people in connection with self-determination, and in others' ideal, only material possessions was mentioned as often.

The real self. Naturally, a few of the responses coded as self-determination involved participants' level of confidence, since this is the feeling or faith that one can affect one's will, succeed in one's efforts, and accomplish one's goals. However, the sense of self-determination is more than just confidence in one's ability to succeed; like the competence theme, it has a number of constituent categories, some of which are inter-related. One of the most frequently mentioned categories is independence, defined here as the feeling that one steers one's own course without the interference of other people, structures, or forces. In the real self, this sub-theme of independence is illustrated by such phrases as "I'm an individualist"; or "I do what I want"; and "I have managed to recover a fair bit of control over my life and my daily destinies....I'm not locked into something [such as a job]." Interestingly, only a couple of participants described themselves as not feeling independent, such as the participant who said she was "a conformist" with regard to her goals. One participant said "I still act in ways, I guess you'd call it neurotic. I still haven't gotten out of it yet, because I'm too scared. It's the only security I know." Another participant said this lack of independence was more her father's perception than reality: "I think he just thought that I couldn't do it [live away from home]" that "I needed parents around 'til I was 25 or something."

Closely related to independence is the sub-theme of self-sufficiency. Whereas independence involved avoiding others' control, self-sufficiency emphasizes the solitary nature of the struggle for goal attainment. There were many variations on the notion that "I have to do it alone," whether the goal was coping with psychiatric symptoms, or finding friends outside the psychiatric "community", or whatever.

While some participants seemed to regret this forced self-sufficiency, with others it was a point of pride: "I don't like being helped, I never did....I've always kept people pretty much at arm's length." Similarly, when asked if there was anything other people could do to help achieve one's goals, a participant replied, "No, I've learned to distance myself. I don't rely on other people. Nobody's ever helped me," but then went on to describe how her landlady had "helped me get into the pattern of working everyday."

The third predominant sub-theme of self-determination was that of perseverance, a determination to achieve one's goals despite the odds, even despite a lack of faith in one's own ability to follow through. Sometimes this was described as a general characteristic, such as "I have the drive..., that if you want something bad enough you can get it, but you have to work hard for it." At other times, this perseverance was in relation to a specific goal: "Sometimes I get really tired and I don't feel like going to work, but I have to go. So I usually go." A number of participants described perseverance as a personality trait, such as "stubborn" or some other variation like "bull-headed," "assertive," "opinionated," and so on. This was usually considered a positive or at least useful trait; one participant, for example, was convinced only stubbornness had kept her out of the hospital and in the community.

The essence of the perseverance sub-theme, however, is perhaps best expressed by the following:

> I think that in the many times that there were, that I was too quick to give up, and there were many difficult times. It's probably the greatest thing, to just kind of wake up and say, 'Well, here I am. I'm on my own, and today is my day to do with what I want When for so very long it wasn't.' And that it really has come to an end, and I've still been able to hang in. And that's the greatest thing.

These closely-related sub-themes of independence, self-sufficiency, and perseverance are useful for describing participants' responses regarding self-determination in specific roles in the real self, as well as self-determination in general.

Nowhere is this more true than of the references to the psychiatric role, since many participants conceptualized different aspects of that role in terms of control. Psychiatric symptoms as well as medication were often viewed as oppressive. According to one participant, 'meds' "made me feel helpless. And it's almost like somebody was sitting on top of me because I was so drugged up." Another participant expressed similar feelings of powerlessness: "I'm far too much affected by the mental illness, whatever you want to call it. In my case, depression, anxiety, a disturbance in the mind. The illness colours far too much of my life, just as if a person is crippled, he can't work." Yet another participant was more resigned: "I think, with my moods..., that's a part of my illness. It's not something I have alot of control over, and that's something I have to learn to accept about myself and deal with."

These quotations notwithstanding, most of the participants who talked about self-determination in relation to the psychiatric role said they <u>did</u> experience a sense of self-determination; even the participants who described a lack of such feeling above were referring more to feelings in the past than in the present. Many spoke with a great deal of pride at having attained some independence over their medication--either being off it completely, or being able to regulate it successfully by themselves. One participant was pleased to report that <u>she</u> was in control, not her symptoms: "You know, one thing I'm proud of is that if I had to go into the hospital for another 6 months, I would come out and I would pick myself up and start all over again. I would just refuse to give up because of this illness."

<u>The ideal self</u>. It is obviously very difficult to draw the line between the expressions of a lack of self-determination in the real self, and the goal of having more self-determination, part of the ideal self. My solution was to code as ideal only those references which explicitly stated self-determination as a goal. This means that the frequencies given for self-determination in the ideal self are probably too low to accurately represent the spirit of participants' sentiments about the goal of self-determination.

Even if the frequencies are low, the three sub-themes of independence and perseverance, and to a lesser extent, self-sufficiency, are very much in evidence. In general, participants wanted more of each--to be more independent, more persevering, and more self-sufficient, and these were expressed in a number of different ways. The goal of independence, for example, was expressed as wanting to be "a little more in control" because "it reduces the surprises"; as "carving my own niche"; as having a job that makes money and also gives "a reasonable degree of freedom"; as "trying to establish myself." At the same time, however, one participant said, "I wish I had direction, because when you try to do things on your own it's boring. I mean if I had somebody pushing me through, that helps." Another participant spoke of how useful it had been to have a father who "would make sure I got up in the morning."

Several participants described their ideal selves as ones which would have the determination to follow through on their particular goals: "[My goal is] that I would be motivated to study," or "to quit avoiding things that are necessary"; and from the same participant, "if I can get out of that habit [of going "back to sleep and you don't wake up 'till in the afternoon"], like tomorrow I'm going to get up early, when the alarm goes off. I don't know if I can do it, but I'm going to try."

Most of the references to self-sufficiency as an ideal were in terms of money, that is, having an independent income. Sometimes this independent income was seen as being derived from a job, such as "There will be a time when I will have a job and make my own money and pay my own rent. There will be a time like that." Sometimes this goal was expressed simply as "supporting myself," or as "getting off Family Benefits," if not completely, "to work towards it..., half off it at least." One participant seemed to voice the opinions of many when he described self-sufficiency as the criterion for functioning "like an average person." "Don't need supportive housing, don't need FBA (Family Benefits Allowance). People working, people who claim enough income that you get from another source. It could be wages, working, or inherited money for all I care, other than from a social agency."

Others' ideal. Although there were a dozen references to other people's ideals of self-determination, these were not concentrated in any one context or role. Self-sufficiency was emphasized most, particularly in terms of getting a job and supporting one'self. One participant's mother said it was embarrassing for her daughter to be on welfare, and another said her parents were disappointed that she couldn't manage money. In one instance, a participant was told by a psychiatrist that she would have to give her children up for adoption if she couldn't support them by working.

Integration

The third major theme in participants' self-descriptions (and ignored by Gordon (1968)) is that of inter-personal integration. This is the feeling of belonging, of being a valued member of a group. Moreover, it is a generalized feeling of integration that is distinct from the role of membership in an interacting group, although specific contexts were sometimes mentioned. A total of 25 people (9 women, 16 men) described their real selves in terms of integration, versus 23 people (12 women, 11 men) for the ideal self, and 5 people (4 women, 1 man) for others' ideal. A greater number of specific roles and attributes were also mentioned in relation to integration in the real self than in either the ideal self or others' ideal. In the real self, those mentioned by three or more people included kin and romantic relationships, membership in the Houselink co-op, specifically, membership in an abstract group, and characteristics of personality and behaviour. Integration with regard to romantic relationships, membership in an abstract group, and to a lesser extent, occupation were described as an ideal by several participants. None of these roles or attributes was mentioned to any extent as an area in which others wanted participants to be more integrated.

The real self. An interesting pattern emerged from the references to integration in the real self: the frequency counts for feelings of integration in general were quite low, but with respect to a number of specific roles and attributes, they were quite high, with a total of 17 people (8 women and 9 men) saying they currently felt integrated in some way. Conversely, only the kinship role was mentioned by three or more people as one in which they did not feel integrated, although this was a general feeling for 22 people (8 women, 14 men). In other words, any sense of integration experienced by participants was generally derived from specific relationships, but, with the exception of kinship ties, the feeling of not being integrated was more generalized.

For some participants, their sense of integration was directly related to their social networks--specifically, to the number of ties they had with other people and the number of opportunities they had to be with them. For most, however, the more important aspects of integration were subjective, such as feeling accepted, feeling close, and sharing with others.

In discussing the sense of integration which participants did feel in specific relationships, there was much emphasis on the fulfillment of what I have termed relating needs--being able to share one's thoughts, feelings, and experiences with others, to be understood, and to feel valued by them. Most of the relating references were to how well participants were able to "get along with" others such as members of the co-op, or to the degree of closeness they felt in various relationships: "We're a fairly close-knit family in all kinds of ways, even though we often get angry with each other"; "I have pretty good communicaton with them [sisters]"; and "I had established a rapport there." According to one participant, "I'm starting to get alot closer to my family, and realizing the importance of close-knit families, of having my family around me."

Similarly, people described themselves as having a feeling of belonging at work, or at the co-op. Very often, the family became a metaphor for closeness in these other contexts: "[The street] was like a home"; "She's like a sister"; "[The co-op] has a family feel." One participant said, "I feel I've got a family here [at the co-op], I've got a family at work. And alot of people find that very stifling, you know....And I find that it's helped me get well. Just the security, security everywhere."

Participants also referred to their sense of integration as an ability, or as some aspect of their personality. One participant said her ability to assimilate with others caused people to describe her as "kind of like a chameleon, because I can fit in with different types of people." Several participants spoke of how much they "like people" in general and enjoy being

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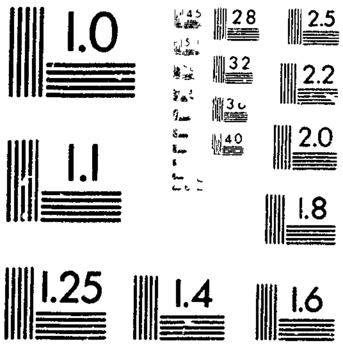

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with them. As one participant put it, "I guess basically I care alot about people. Most people sort of sense that, this genuine care."

As mentioned earlier, the kinship role was the only specific context in which participants said they did <u>not</u> feel integrated. Several participants spoke of not feeling as close to their parents or siblings as they used to be, and a couple of people had the distinct impression they were no longer welcome: "I called a couple of my brothers here and there, and they just don't sound like they want to talk to me. They have their own lives, and, I don't know, I just feel it's difficult...." These feelings of not being accepted for one'self are also evident in the more general references to a lack of integration in the real self. One woman said, "That kind of gets to me, that I can't be [myself]. Cause people don't get to see [the real me] very often."

More prevalent than just the desire for acceptance were participants' concerns about not "fitting in," of not feeling they belonged because they were different from others in some way, for example, "I don't identify with people alot." For several participants, acceptance by society in general was dependent upon assimilation, and this was sometimes difficult to achieve. According to one woman,

> I think psychiatric housing really helped me, because...[it] gives you a social outlet, whereas alot of us are condemned in society, and psychiatric housing

> tends to give you acceptance, gives you things to do. And we've all got a common bond that brings us together. You know, we develop friendships that way.

Other participants, however, found themselves not feeling assimilated even into a psychiatric context, either because they hadn't been hospitalized as often as others, or because they felt their problems were not as severe, or were at least different.

> I didn't understand what I was there for [in the hospital] because the people that were there seemed right out of it, you know. They were on drugs, and this and that, whereas, I'd just come off the street with a problem. And I didn't feel I belonged in there.

Another participant said he had purposely tried to dissociate himself "from everyone who had psychiatric problems." With respect to assimilation in Houselink, one participant described himself as "an outsider" because the social "cliques" in the Drop-in were impossible to penetrate. Finally, another participant had difficulties assimilating into his co-op: "I can't relate to these people's friends, I don't feel, I just don't feel all that comfortable with the people here, so it's a place where I'm going to stay because it's cheap."

The last sub-theme regarding the lack of integration concerns participants' relating needs and the degree to which these were not fulfilled. Isolation was very evident in many of these responses; participants spoke of not being close with anyone--"I'm on my own"--of feeling lonely, and of being withdrawn. One participant described himself as "a bit of a loner. Despite having some friends, it seems it's possible to feel lonely with friends, too." A couple of others attributed their isolation to moving frequently, or to living in Toronto: "It seems in a big city, people don't really notice you or care about you. Sometimes I feel I'm out on a limb."

The ideal self. Many of the aspects of integration which participants said they lacked--acceptance, assimilation, and relating to others--were precisely those which they said they desired in their ideal selves. This is not surprising, particularly when one considers that, of the 23 people (12 women, 11 men) who said they desired more integration as an ideal, 14 people (6 women, 8 men) had previously described themselves as lacking integration in their real selves.

In the ideal self, the desire for acceptance was paramount, whether it was in specific relationships and part of the desire to be close and to share, or whether it was in general terms. As in the real self, the sub-themes of acceptance and assimilation are closely linked. There were many variations on the notion of wanting to participate in society again. One man, for example, said he wanted to build his social network and get more involved in social activities. More often, the desire for acceptance was expressed in general terms, such as becoming part of society's mainstream, getting "back into society again," or trying to "break into the world." One participant said she wanted to be "more involved in the mainstream, involved in society rather than inside of myself....I'm still dealing with stuff on a personal level, and I would like to be more involved in societal problems and society."

A number of participants also said they wanted "to be like everyone else," that is, those who have not had psychiatric experiences or treatment. As one participant put it, "I'd like to be normal, like everyone else." Because participants were referring here to a generalized or collective other, their descriptions of this ideal were often vague, or concentrated on external characteristics. One man, for example, said, "[I want to] be like everyone else. Everyone else, you know, with their houses and their cars"; and another participant said, "I want to go out and do things, I want to do what everybody else does. They all say, 'I went for a vacation....' I want to go somewhere...fantastic, just buy the things I want."

It is clear from the above quotation that the acceptance these participants desire is from society in general, rather than from the psychiatric community, and this is true of many of the participants who expressed a desire for integration. One participant, however, had very definite ideas about the limits to society's acceptance:

> I wouldn't tell...[people] I've had a mental breakdown. Of course not....I...don't want to be stigmatized....I don't want any, to be looked at askance, you know, to be scrutinized, or... have people draw back from

> me....I want to be, feel accepted and I don't have to explain. It's like having AIDS. You don't talk about it too much, because people are afraid. They don't understand it.

Although this was not true of everyone, for this participant and several others, the route to acceptance lay in becoming like "normal" people by generally negating their psychiatric experiences. This person wished she could be open, and admired others who had "gone public," but she found it less difficult not to talk about her psychiatric experiences, except with those close to her.

For the most part, then, the participants who desired integration in the form of acceptance and assimilation were referring to society in general, rather than any particular subgroup or relationship. A number of participants, however, also expressed the desire to feel more integrated in more personal relationships. Instead of societal acceptance or assimilation, they were seeking fulfillment of their relating needs, the need for caring and sharing. These relating needs were expressed both as companionship--finding "people I like being around," or "somebody to talk to"--as well as for caring and sharing on a deeper level, particularly for someone "to feel close to." For many participants, the fulfillment of these deeper relating needs would ideally come from a romantic relationship--finding "a boyfriend", "a wife," and so on. As one participant put it, "[I want] to be in a close, loving relationship. There's no substitute for it."

While not necessarily a substitute, a couple of participants expressed the hope that at least some of these needs could be fulfilled in other relationships. When one participants' symptoms were most acute, she felt, "I need somebody to talk to, I need somebody to listen....I really needed somebody to understand. And hospitalization didn't seem like the answer to me. I needed somebody who would be able to relate to me on a human level. On a very personal level." Similarly, another participant wanted to find friends who would not only be "understanding," but who would "decide they...like listening to me, and they like speaking with me." Note the benefits to self-esteem that are also implied from sharing; participants not only want somebody to care *about*, but also somebody to care about *them*.

It is clear from some of the above quotations that many participants were looking to begin new relationships in which they could share themselves, feel understood, and close. A few participants, however, had similar ambitions for existing relationships they had with partners, children (or parents), friends, even co-workers. Again, integration sometimes meant even basic contact--"[I want] to have my son over to visit me." In general, however, integration in existing relationships meant recognizing and possibly resolving differences with the other person: "I think basically we have alot in common, we have alot going for us. It's just that there's a few major issues that we really disagree on, and I don't think they're insolveable."

<u>Others' ideal</u>. As mentioned earlier, only a few participants said they felt others wanted them to be more integrated, and there were no specific contexts that were at all significant in this regard. For those references that do exist, however, the dominant sub-theme is that of assimilation; other people, especially kin, wanted participants to "fit in" better. In two instances, this was a matter of other people wanting the participant to have more links in the community. Another participant described her relatives as being "used to a person who would fit into their personalities and lifestyle, and with me being ill, I just wasn't doing that." Yet another said her parents were "very critical" and "inclined to think about what looks good, what is socially acceptable." Furthermore, now that her behaviour was more typical, she was more welcome at home.

<u>Other themes</u>

Although not quite as prevalent as the major themes of competence, self-determination, and integration, the theme of unity is nonetheless important, partly because it represents a more introspective side to participants' experiences. Gordon (1968) describes a sense of unity as intra-personal integration, "internal harmony...among personality dispositions, social roles, priorities or goal objects, loyalties, transcendent value standards, and the like" (p. 18). However, I have expanded this definition somewhat to include references to self-knowledge and personal growth in general, as well as to general contentment or satisfaction. It is important to note that the sense of unity referred to here is not concerned with the relationship among the self-concepts, such as between the real and ideal selves, for example, except as it relates to the person's sense of unity in the real self.

Although the number of people who referred to the theme of unity in the real self was similar to that of the major themes, the proportions for the ideal self and others' ideal were much smaller. Of these 24 people (10 women, 14 men), 22 people (9 women, 13 men) said they experienced a sense of unity, either in general or in relation to a specific role or context, and 15 people (7 women, 9 men) said they lacked a sense of unity in some respect. As an ideal, unity was mentioned by 13 people (9 women, 4 men), 8 of whom had previously said it was lacking in their real selves. Only 5 people said unity was an ideal others had for them.

In all these self-concept planes, however, only the psychiatric role was mentioned by three or more people in relation to unity. The connection is obvious: in many ways, mental illness is considered by our culture to be an extreme lack of unity, as evident from terminology such as "mental breakdown," and diagnoses such as schizophrenia and personality disorder.

Like the other major themes, unity has a number of components, or sub-themes. By far the most prevalent of these is self-knowledge and accompanying personal growth or development.

A number of participants made a point of stressing how much they had learned about themselves and grown as individuals as a result of their psychiatric experiences: "I think, too, that understanding more about myself helps, too. And I find out more about myself every day, through other people, I mean, about my illness. I'm still finding out about it." According to another participant,

> [the breakdown] was a very difficult part of my life, a very crucial experience. It left its mark. It was also a very rich experience in the sense that I learned alot from it. It's like any intense experience, times when you really learn alot about yourself...and other people as a result....I got to know myself. I learned how to be gentle with myself, and to recognize my needs and seek their fulfillment.

Along the same lines, a couple of participants described themselves as having recovered to the point of experiencing almost a rebirth--an "awakening." One participant said his second hospitalization had allowed him to finally relax and emerge "a fresh person." Another referred to his psychiatric experiences in this way:

> [It was an] interruption that's kind of put everything on hold...I'm kind of like, starting over again from what I was in my early twenties. So I feel more like I'm coming out of university or something, as I was

> then, and starting a new life, you know, building that up again....You have a second chance to do things, you know?

Several participants stressed the importance of order and stability in their lives, particularly in terms of psychiatric symptoms: "I've had a year now of relatively good health and I don't have any concern for recurrences. I'm finally successfully medicated, and that's been wonderful. It's been such a release, because nothing really was able to control the swing."

The image of wholeness was also very important; participatns talked of "picking up the pieces," "getting it together," and "falling apart." According to one participant, "I've never had the chance to really pull myself together the way I've wanted to. And it's always been six months and I was back in the hospital, so I was always building, even when I was just working."

Most of the references to a lack of unity, on the other hand, were to instability, having no sense of self or identity, and to self-destructive impulses such as constant self-criticism and self-directed violence. One participant said, "I don't have a strong, positive, a real strong image of myself, positively. I just don't have that." Consequently, his goal was to "lose himself" in work, sports, or other activities:

> Whatever I do I do to get lost, because I'm not me when I'm doing those things....I'm just being, [it's] just me and the game and that's it, or just me and work and

> that's it...My personality or whatever it is doesn't come across in whatever those things I'm doing, cause I'm being lost.

In the ideal self, a couple of participants mentioned goals of finding and reasserting their former or true selves, that existed prior to their psychiatric experiences. These participants wanted to experience the "awakening" others had, "to be closer to my old self," just as others wished them to be, too. In some respects, this is an extension of the wholeness theme, but it emphasizes the importance of being authentic, rather than acting, "because you start to lose yourself." According to one man, "[I'd like] to bridge the gap, too, between being a very, acting like, very shy and reserved and reclusive, but by nature not being that sort of person. There's a terrible schism between what I could be and what [I am]."

This notion of being true to ones' self is echoed in a relatively minor theme, which refers to the pace with which one functions. Although a couple of participants described themselves as being active people who always need "to be doing something, or else I get depressed," most of the participants stressed their need for a slow, steady pace to achieve their goals, perhaps slower than most other people. Some referred to their pace at work or school as slow by nature, but many spoke from a first-hand experience of the destructiveness of a frantic pace: "I can't take alot of stress....I tried an awful lot about the three months before I went into hospital, and I just cracked"; "I put too much into it, and then I lost so much, and it took me so long to get back." In the words of another participant.

> I think it's important for me to go slow...[because] the illness can flare up if I get too involved and get caught up in things. I've got to learn to pace myself....,like I have to realize I'm slow, as opposed to working...like as a stockbroker on the floor of the Toronto Stock Exchange or something. That's not good for me.

Not surprisingly, many spoke of their need to "take it easy": "just live one day at a time and be myself."

Last but definitely not least is the theme of purpose. This theme is intended to capture the importance participants felt of just having goals in general. For a few participants, the mere fact of having goals seemed to them sufficient evidence of their self-determination in their real selves, regardless of whether or not they actually took steps to attain them. Furthermore, they felt having goals distinguished them from other people "who don't want to progress...., just kind of sit on the 'hold' button." Several participants, however, seemed to be almost completely without goals or direction, and to be looking for a sense of purpose to justify their existence and give it meaning: "I don't know what my driving force is. I always thought women were, or sex was, or love was, or money was. Now I have to wonder, 'What is it?' I don't have anything."

For many participants, this sense of purpose or motivation appeared to be born out of a distinct dissatisfaction with their current situation. In fact, the desire to "get past" or beyond or over the present was very prevalent. One participant put it this way: "I feel motivated. I think I want more in life. I don't want to stay in the same spot." For some people, the ideal was even more vague: "I'm not sure what I want to do, just that I'm sure of my progress. I'm sure that I'm making headway."

Inherent in this sense of purpose, according to participants, is feeling useful and productive and needed, rather than marginalized and expendable. More specifically, respondents spoke of wanting to feel that they were needed and belonged, that they had a "niche" in society. Ideally, this purpose or niche would not only give them "something to do" (e.g., "I need something to keep me busy"), but would be interesting and challenging as well. Finally, respondents spoke of wanting to feel that they had "something to contribute to society"; that they were valued members of society because they were giving something of value back, and not just on the receiving end.

Although a couple of participants mentioned volunteer work or affiliation with a club as ways to achieve a sense of purpose, most saw this as being derived from employment: "A job helps one feel useful." One woman said:

> I'm exhausted after the end of the day, but it does make me feel like I'm doing something productive,

> something useful for society. It's not a nice feeling to feel useless, you know. Everybody has to feel that they have some kind of niche in society, and if you don't have that it's pretty difficult. Therefore I enjoy working with seniors. It makes me feel like I have some identity and something to offer the world.

Patterns

I began this research with the assumption that one of the major flaws of typical scales for social functioning assessment was that the standards for comparison were largely irrelevant to people who have been hospitalized for psychiatric treatment. My own belief in the importance of personal growth, combined with the persuasiveness of symbolic interactionism and role theory, led me to believe that the person's own goals, and the evaluations and role expectations of other people, were a more appropriate basis for assessment. In this study, however, the expectations and ideals of specific others were clearly not important to participants, at least in terms of their self-concepts. Most participants insisted that "what other people think isn't important to me," or that "I'm more interested in what *I* want."

Given North American society's ethic of rugged individualism, it is possible this pattern of de-emphasizing others' expectations was an attempt by participants to convince me (and themselves) of their autonomy. This explanation would be more likely if participants had then contradicted themselves by talking at length about other's expectations, but as seen earlier, these constituted only a small part of their self-descriptions. Although it is still possible the role expectations of specific others are important in individual interactions, it seems clear that the participants do not consider them to be important in relation to their general social functioning.

But if the expectations of specific others were not important to participants, it was equally clear that the expectations of a generalized other--"society" in the abstract--were in fact, very important, both as a standard against which participants could judge their own social functioning, and as a goal to which they could aspire. Participants were adamant, for example, that they wanted "the same things as everybody else"--a job to help them feel useful, an adequate income and material possessions, a place of their own to live. More subjectively, they want more intimate relationships with others and more competence at interacting with them, as well as more control and independence in their lives, and a sense that their lives had purpose and meaning. In other words, they too, want what North American society values most--goods and power, in the sense of being able to control or influence the conditions in which one lives (Goldenberg, 1978). Often, this pattern of wanting "loot and clout" (Ryan, 1971) like everyone else was conveyed in vague, stereotyped images. One participant, for example, said, "[I want] the American dream..., the picket fence, a wife, kids.... a house." Another said that although success seemed increasingly less likely, she shared her parents' ideal for her: "...to be a nice little suburban wife, with a little house and a nice garage, nice kiddies, and a nice husband."

Ironically, participants' own ideals differ little from the expectations of specific other people; in a couple of instances, participants had barely finished denying the importance of others' ideals before they started talking about wanting exactly the same things for themselves. Just as they said other people wanted them to be well enough, in psychiatric terms, to take care of themselves, so too did participants; just as others wanted them to have a job and be self-sufficient, so did they; and just as others wanted them to "fit in" better with society, so did they, desperately. In fact, the single most important pattern to emerge from participants' self-descriptions is that of being outsiders in society, living in a separate world.

Consequently, if there is one common, all-important goal or ideal, it is to "break into" society and become accepted by the "normal" world. In many ways, however, participants' conceptualizations of the "normal" world were exaggerated and simplistic. Although many spoke of wanting to function like "an average person," three of these participants described as their ideal the people they saw on the subway, often attributing competence, power, and success merely on the basis of physical appearance. Similarly, a couple of participants compared themselves to me in the interviews, one of them saying,

> Look at you--you're a year younger, but look what you've got for yourself. You're going to school, you're functioning. That's what really makes me, really frustrates me, because I see people my own age or that are younger than I am, <u>who've really gotten their lives together</u>, and I was psychotic for two and a half years [italics added].

In fact, there were several times during the interviews when I felt I was being treated like a "type," not a person, as though the fact that I had not had psychiatric treatment meant that any problems I might have were insignificant compared to participants' own.

The assumption that normal people have "got their lives together" results in definitions of optimum functioning that are quite rigid, even extreme. In one participants' view, "if you can't handle your money, you're not really altogether well." Likewise, another participant said,

> That's what I call a severe problem--a person who avoids social contact out of, 'cause he just can't deal with it, rather than they just don't want to. I think I can see myself just not bothering with alot of situations and alot of people. Which is different from retiring because you feel uncomfortable.

This is the same participant who felt that functioning "like an average person" meant not receiving social assistance of any kind, including housing.

As much as participants talked of wanting to be like normal people, therefore, it is clear they are talking about a mythical ideal--how normal, fully functioning people ought to be, rather than how they actually are. Several participants even said they believed so-called normal people are not necessarily supremely competent, even in psychiatric terms: "You know, there are so many people out there that may not have seen psychiatric help, but probably need it" [italics added]. Furthermore, many paid lipservice, at least, to the idea that our social definitions of normality are arbitrary and meaningless, referring to "the so-called normal, whatever that is." Yet the fact that many normal people do not fit this idealized portrait did not lessen the power of this image as an ideal they felt they ought to fulfill. It did not seem to matter that the ideal was unrealistic, only that they compared themselves and were found wanting. In the minds of participants, they "should" be functioning at a level which seems quite extreme; they seemed to believe that if they really "had their act together," they would be supremely competent and capable, be thoroughly integrated with others, and be completely self-determining and independent, relying on no one for anything. Furthermore, they believed that if only they worked hard and long enough and "got past" their disability, they too could "have it all" and be accepted in the normal world.

The primary obstacle to their assimilation, as participants saw it, was their identity as "ex-psychatric patierts." As one participant put it, when asked about her roles,

> You mean non-psych or psychiatric? There's a difference. There's two different worlds. There's the psychiatric world where everybody accepts the psychiatric person. The first thing you would ask is what hospital they go to, or what their illness is, or what medication they're on. There's a common bond there that brings you closer together and opens up doors, right?...But with society, I'm having a hard time with that, because I'm just trying to get into society again.

Not surprisingly, this separation between two worlds leads some people to feel as though they have to overcome not just their social identities as "ex-patients," but the psychiatric condition itself. As one participant put it,

> I'm not one to sit back and just take my pills and smoke and drink coffee all day. I'm always trying to find a cure to the illness. I'm always on the go, finding a cure and all that....But there's people in the Drop-In that just live day to day..., and just accept it. I can't see how they can just accept it.

Others talked about how difficult it had been for them to accept *themselves*, especially at the onset of their problems:

> When I got the manic depressive illness, I was quite young at the time and I denied it and went through all the stages and whatever, and found it hard to cope with. Because I'm a nurse originally, and I was always used to taking care of people, helping people--this is part of my personality, you know.

Yet more than one person said they accepted their psychiatric experiences as a fact of life: "I can't pretend I'm the same as other people, I'm not....So I figure I take a few pills at night, it's well worth it. At least I can function that way. I can lead a fairly normal life." One participant said she felt lucky to have such an active fantasy life, that schizophrenics were "special."

Whether participants felt they had to overcome their condition in order to gain acceptance, or simply cope with it and be accepted *despite* their differences, nearly everyone felt this was *their* responsibility, and required only sufficient perseverance and determination to achieve. Likewise, they felt that if only they worked hard and long enough they could bridge the gap and finally be accepted by the normal world. This extreme self-reliance is evident in phrases such as "I've never had the chance to really *pull myself together* the way I've wanted to" [italics added]; "Stigma was a real difficult thing *for me*" [italics added]; and "If you don't help yourself, then nobody's going to help you. And then what can you do?" One participant was particularly emphatic:

> If you set your mind to it, you can get out of it. Because that's what I did. I had to set my mind to it. [I decided], I don't want to end up like this for the rest of my life. And I worked on it. It was alot of work, but I worked on it....My social worker [said] 'I can't believe it....You've finally crossed the bridge.'

Unfortunately, the perception that self-determination is all that is needed to overcome their disability and hence, their marginalization, left a few participants grappling with the implication, as they saw it, that it must have been a lack of self-determination that created their difficulties in the first place. Many felt it was not their fault they were different: "we don't choose to be this way. It happens just like any other illness," yet most seem to feel responsible just the same. One man was particularly undecided as to where to place blame: "It's hard to explain whether the street drugs made me this way, a manic depressive...,[or] if it was there all the time and would have come out eventually, I don't know."

It would be unfair to lay all the blame for participants' feelings of marginalization on the mental health system, especially since many spoke of having been greatly helped by the "right" therapist, medication, or treatment. Yet even many of these same participants said their experiences in the hospital had only made them feel <u>more</u> different, incompetent, and powerless. For one woman, recovery had only felt possible once she rejoined her family--"getting out [of the hospital] and being a part of their lives again." Like other "ex-inmates" who criticize the psychiatric system for being inherently coercive and dis-empowering (Chamberlin, 1979), several participants felt it had only exacerbated their feelings of marginalization.

According to another participant, "Psychiatry is very crude....There should be an appreciation of the human element of mental illness....I'm not a machine, we're not machines, we're not textbook cases, we're human beings." The advantage of Houselink, in this person's view, was that "I wasn't seen as some kind of an idiot, or some kind of mental patient. I was a person, and people related to me as a person." One participant was particularly eloquent about the paradox of being "helped" to be more competent:

> When you're put in the psychiatric system...you're supposed to act like a well-behaved child. In a hospital you have to be way more normal that you ever would be expected to be outside of a hospital. I mean, like you literally have to go to bed at a certain time, you have to eat this, that, and the other thing, you have to take pills, you have to tell people when you've been to the bathroom...,are you taking a bath, and everything. You never have to do that as an adult, so

therefore you're not treated as an adult at all. You wouldn't be able to express any kind of emotion about it. you're again treated like a child. You're supposed to grow up, or accept responsibility for yourself, yet all responsibility for yourself is taken away from you. How can you accept something you don't have?

...You have to be so normal to be in the hospital, you have to be so incredibly normal. You have to be a super, super person to be in a hospital, to survive that ridiculous system where you're thrown back into kindergarten again, but you're not allowed any of your emotional responses of people in kindergarten, you know? It's really, really, <u>really</u> a double-bind.

Discussion

A Theory of Marginalization

In my opinion, the construct that best describes (and accounts for) participants' experiences of their social functioning is that of marginalization; as a result of being "ex-psychiatric patients," these people feel like outsiders from mainstream society, and unworthy ones at that.

According to Goldenberg (1978), this feeling of being different is one of the primary characterisitics of oppression or marginalization. As he sees it,

> the process [of oppression] leaves in its wake the kinds of human beings who have learned to view themselves and their world as chronically, almost genetically, estranged. The end product is an individual who is in fact alienated, isolated, and insulated from the society of which he nominally remains a member. He and his society are spatially joined but psychologically separate: they inhabit parallel but nonreciprocal worlds.
>
> (Goldenberg, 1978, pp. 2-3)

Unfortunately, in the eyes of both the participants and society in general, the normal and psychiatric worlds are not parallel in status--participants not only feel different from normal people, but less valued as well.

In fact, the participants as a group describe virtually all the feelings associated with being marginalized, of feeling limited in one's possibilities for change, of being expendable and powerless, and of being isolated and incomplete. "[Oppression] is a pattern of hopelessness and helplessness, in which one sees one'self as static, limited, and expendable...." (Goldenberg, 1978, p. 3). If this description seems somewhat exaggerated, recall how many participants said they felt constrained and dependent financially, whether they were trying to live on an income that barely covered necessities, or because that income was derived from social assistance and therefore stigmatized. Although many described themselves as having achieved some self-determination in psychiatric terms, they were eloquent about their sense of helplessness and dependence in the face of overwhelming symptoms or the side effects of medication and other treatments. And despite the fact that most participants saluted Houselink for allowing them to have more control than most other forms of housing they had experienced, for many it still represented dependence on "a social agency" and on the other members of the co-op; it was still a compromise of their dream of living "in a place of my own."

Yet Goldenberg's description would still be exaggerated if it implied that the feelings of marginalization pervade every aspect of one's life, all the time. Likewise, it would be too simplistic to characterize the participants in this study as generally lacking a sense of competence, self-determination, integration and unity in their real selves. As we have seen, participants were very clear that, in many cases, in many different roles and contexts, they often felt competent, self-determining, integrated and so forth, in their day-to-day functioning, in some ways more than ever before.

If there is a lesson to be learned from this research, then, it is that any sort of generalized trait approach to a description of the self and social functioning is useless unless it is adapted to allow for the importance of social context. As we have seen, not only does context define what it means to be competent, for example (or self-determining, or integrated), but it also profoundly influences one's <u>behaviour</u> in that role or context. Similarly, it would be too simplistic to say that everyone who is hospitalized for psychiatric treatment--or even all the participants in this study--are equally marginalized, or that they experience their marginalization in the same way. While no one I talked with had yet attained the dream of living in a place of his or her own, a few had "made it" in their own eyes and those of their peers, by having a full-time job (or career-related schooling) and hence, a more conventional lifestyle. With this elevated status, furthermore, came higher expectations as well:

> I think that [the residents of the co-op] may expect [that] because I work...that I should have things fairly well-organized and under control. I mean, if I flipped out I think they'd be surprised, and I

> think...they assume that because I work...that somehow my problems aren't as severe as theirs.

Yet despite having attained, for the most part, a more comfortable and conventional lifestyle, and the ability to influence their lives more directly, these quasi-normal participants still feel different from normal people, as if they are not quite a part of society. Like the other participants (and perhaps more so), they want to break into the normal world and be accepted, not stigmatized. They too are victims of marginalization, just as surely as the participants with less in the way of goods and power. In some ways they are even more marginalized, since they belong to neither the normal world nor to the psychiatric community, as such. Several felt the need to dissociate themselves from others who had received psychiatric treatment or otherwise deny their former identities as psychiatric patients. Whereas most of the participants seemed to view their stigma as a fact of life, these people had sought to either escape or overcome their stigma, only to find acceptance in the normal world elusive.

This pattern or meta-theme of marginalization can also be seen in other research that has attempted to learn about the subjective experience of people who have been hospitalized for psychiatric treatment. In Estroff's (1981) book, Making it crazy, for example, many of the people she spent time with didn't want to be different from other people, but the medication and income support programs they needed to function even minimally in society were precisely the "badges of patienthood" which prevented them from assimilating at all. Similarly, a qualitative study by Hutchison, Lord, Savage and Schnarr (1985) revealed the struggle for an identity without stigma to be the most important--and difficult--problem for a group of people who had received extensive psychiatric treatment. They too wanted to have an adequate income, and to integrate themselves into their communities by working, and by developing relationships with people "who believe in you."

It is not clear if the reason the participants in this study felt they were different and devalued was that they had psychiatric "problems," per se, or that these had required treatment and hospitalization. In other words, do they see their marginalization as rooted in their hospitalization--an external circumstance--or in some inherent characteristic of their psyche that distinguishes them from members of mainstream society? What is clear, however, is that virtually all the participants I spoke with do not feel accepted by society because of their psychiatric identities and that they have therefore failed in some way. As seen earlier, this leads some to hide the fact that they have had psychiatric treatment from those by whom they want to be accepted. It leads others in a Quixote-like quest for a "cure" to their "illness," in the hope that this will also cure their marginalization. Few feel it is realistic to hope they will ever be accepted <u>despite</u> their differences.

Implications for Social Functioning Assessment

In calling for and developing a new approach to social functioning assessment, I have made my case primarily on the basis of values, and on the values of community psychology in particular. I have emphasized subjective experience, social context, and personal growth because I believe them to be intrinsically important, and if anything, my belief has been strengthened as a result of doing this research.

But aside from the intrinsic value of including these elements in a conceptualization of social functioning, and of a naturalistic methodology for exploring them, this research has provided a great deal of information about what each of these means to the people in this study, and how they operate in terms of people's self-concepts and social functioning. Before discussing the implications of these findings, however, it is important to emphasize that this research was never intended to make generalizations about everyone who has been hospitalized for psychiatric treatment, or even about all the participants in this study. One of the axioms of naturalistic inquiry is that all information is context-bound (Lincoln & Guba, 1985), so that one can only evaluate the transferability of the findings based on the similarity of settings and contexts to this one.

However, the participants in this study were also clear that their feelings of marginalization were somehow related to their being "psychiatric," and further, that these feelings are often exaggerated by hospitalization. It seems possible, therefore, that many others who have been hospitalized for psychiatric treatment may also feel marginalized, just as described by Chamberlin (1979), Estroff (1981), Hutchison et al. (1985), and others. Whether or not they experience marginalization in the same way as the participants in this study can only be determined by assessment with other groups. Any implications I draw from this study for social functioning assessment, therefore, are made within the parameters of similar contexts and experience, while acknowleging that there may be common elements of this experience which are shared by many.

After reading the results of this research, it is abundantly clear that the ways in which the participants view themselves and their social functioning are varied and complex. Although participants tended to describe themselves more in terms of attributes than identities (apparently contradicting Kuhn & McPartland's (1954) assertion that the latter are dominant constructs in the self-concept), they used both of these in a descriptive and an evaluative sense to characterize how they typically think, feel, and behave, both in general and in specific roles or contexts. It is clear, then, that one-dimensional operational indices of social functioning such as recidivism (Rosenblatt & Mayer, 1974), or employment (Braff & Lefkowitz, 1979; Tessler & Manderscheid, 1982), or community contact (Trute, 1986) are far too limited. While each of these factors is relevant, by themselves they do not begin to capture the depth, variety, and complexity of people's experience of their own social functioning.

It is also very clear that a two-way approach to the assessment of social functioning is needed. As we have seen, how participants view their own social functioning depends heavily on the specific role: participants may see themselves as sufficiently competent in the co-op, for example, but not at work. Social context not only provides an explanation for a person's behaviour, but it also defines what is appropriate or ideal behaviour within that role. At the same time, it was possible to identify general themes in participants' descriptions which were relevant to a large number of roles, to each self-concept plane, and to virtually all participants, to varying degrees. This suggests that a generalized trait approach to the assessment of social functioning has some validity, but only if some effort is made to distinguish among roles and between the real and ideal selves. Unless one is assessing the extent to which behaviour fulfills role expectations, it does not appear necessary to assess others' ideals as a distinct self-concept plane, although the importance of specific others in transmitting and reflecting general societal values should be kept in mind.

Throughout data collection and analysis, I was often struck by how similar participants' descriptions of themselves were to some of my own self-conceptions. This is not to say that participants don't experience very real and seemingly insurmountable barriers to integration--this much is clear. Nevertheless, I suspect that the tendency to compare one's self to how one "should" be, for example, is likely not limited to people who have been hospitalized for psychiatric treatment. Comparison with Gordon's (1968) sample of 157 high school students revealed competence and self-determination to also be the most frequently mentioned themes (in Gordon's terminology, "systemic senses of self"). There was little similarity, however, regarding specific roles and attributes, presumably because of the vast differences between the two groups in terms of age and life experience (not surprisingly, age, sex, and student role were most frequently mentioned by the students). It would be interesting to compare the roles, attributes, and themes that figured most prominently in this study's participants' self-descriptions with those of other adults.

The emergence of competence, self-determination, and integration as dominant themes in participants' self-descriptions, and of certain sub-themes and contexts as particularly important have more specific implications for the ways in which social functioning is conceptualized and assessed. As the reader will recall, competence was expressed almost entirely in terms of a specific skill or activity, or in a specific context, indicating the appropriateness of a skills development approach. According to Bloom (1979), "competence-building is the single most persuasive preventative strategy for dealing with individual and social issues in the community" (p.184). Interestingly, participants' emphasis on interpersonal skills, the need for intimacy, especially in love relationships, money management, and specific activities and interests closely corresponds with the skill needs of another group of Toronto residents who have received psychiatric treatment (Crocker & George, 1986). This group identified getting, keeping, and losing friends, goal setting and motivational training, sexuality and dating, use of leisure time, and money management among their top six skills needs, with anxiety and depression management as their top priority.

Similarly, the emergence of independence, self-sufficiency, and perseverance as sub-themes of self-determination, and of a general pattern of marginalization, points to the possible relevance of research on locus of control (e.g., Lefcourt, Martin, & Saleh, 1984) for people who have been hospitalized for psychiatric treatment. If anything, participants seem to place an inordinate emphasis on internal locus of control, judging by their tendency to blame themselves for their marginalization and for their difficulties in particular roles. This acceptance of personal culpability may also have repercussions for the person's self-esteem that warrant further research. As a motivational state, self-esteem is clearly an important link between cognition and behaviour (Rosenberg & Kaplan, 1982), and on goal-attainment in particular (Fitts, 1971; Maslow, 1968). It seems likely, as Ryan (1967) asserts, that

> self-esteem is partially dependent on the inclusion of power within the self-concept . . . . A mentally healthy person must be able to perceive himself as at

> least minimally powerful, capable of influencing his environment to his own benefit and further. . . , this sense of minimal power has to be based on the actual experience and exercise of power.
>
> (Ryan, 1967, p. 50)

It would also appear that objective measures of community integration (Segal & Aviram, 1978) assess only one aspect of integration, and by no means that which is most important to participants. Participants were not concerned, for example, with how often they used the local transit system in a two week period, or with how often they saw their neighbours. When they did talk about frequency of contact, it was with friends and kin and other members of an actual interacting group, not the community at large. Much more important was a <u>subjective</u> sense of integration, both acceptance and assimilation by society in general, and intimacy in specific relationships. For these participants, one of the most important means of assessing their integration was the amount of caring, sharing, and closeness they experienced in their relationships, and the satisfaction they derived thereby. Far more appropriate than objective measures of integration, then, would seem to be measures of social support (Ganellan & Blaney, 1984; Gottlieb, 1978) and other aspects--negative and positive (Rook, 1984)--of social interaction within one's natural social network.

One of the most important implications of the research findings, however, is that in general terms, the standards and values used by social adjustment scales to assess social functioning are not irrelevant after all. The participants in this study are just as eager to acquire goods and power over their lives as the typical scales imply they should be. Questions about occupational status, income level, and familial roles, for example, are the same means by which participants assess how they are functioning in comparison with so-called normal people. No matter how one feels about using the acquisition of goods and power to assess people's social functioning, on the basis of this research at least, it is impossible to dismiss it as inappropriate for people who have been hospitalized for psychiatric treatment.

Yet, given the fact that a large number of these participants see themselves as having failed to live up to this standard, the challenge for social functioning assessment is to remain relevant to their goals and standards without exacerbating their feelings of being different, incompetent, and powerless, in short, without contributing to their marginalization. The somewhat tautological solution to people's feelings of powerlessness is to empower them, psychologically as well as physically. Rappaport (1981) and others (Goldenberg, 1978; Heller et al., 1984) have stressed the need for community psychologists to help people develop skills which give them access to and control over their own environment, "to enhance the possibilities for people to control their own lives" (Rappaport, 1981, p. 15). An obvious starting point is the process of assessment itself.

In suggesting how to make the process of assessment more empowering for the person being assessed, my conceptualization of social functioning remains based on the elements of subjective experience, social context, and personal growth, and I remain convinced of the necessity of using a naturalistic methodology for exploring these. The reason for this steadfastness, as explained earlier, is that I believe both the conceptualization and the methodology are inherently more empowering than traditional approaches to assessment, since they acknowledge people's right to choose their own goals and give their own point of view about their social functioning and the contexts that are important to them, and finally, to do so in their own words. Using this conceptualization and methodology as a basis, then, I suggest that the most effective means of empowering the person being assessed are to (1) incorporate the principles of the ecological paradigm into the conceptualization and procedure of assessment, and (2) fundamentally change the power structure of the assessment procedure itself.

Trickett, Kelly and Todd (1972) have elaborated on the work of the "Chicago school" (Heller et al., 1984) using concepts from biological ecology for understanding the behaviour of social systems, and articulating the principles of adaptation, succession, interdependence, and cycling of resources. In this case, adoption of the ecological paradigm means conceptualizing the person's social functioning as taking place within a "system" of inter-connected roles and relationships, in which he or she develops abilities and resources to adapt to the continually changing (and sometimes competing) demands of his or her various roles. Most importantly, adoption of the ecological paradigm emphasizes the person's strengths and abilities, not weaknesses or "problems." The assumption is made that, "given available resources or alternatives, most individuals will solve their own problems in living" (Rappaport, 1977, p. 139).

As the participants in this study have made abundantly clear, their problem is a lack of access to resources and alternatives. One of the most important functions of social functioning assessment, as I see it, should be to help the person identify the external and internal resources available--his or her own strengths and abilities--and to devise ways of developing or gaining access to these to help the person achieve his or her goals. This obviously implies a much broader function for the assessment process. Rather than simply identify the extent to which the person has failed to live up to society's standards for success, assessment should be combined with intervention; otherwise, assessment devolves into mere labelling, the last thing needed by someone who is already feeling marginalized. Instead, assessment would focus on those areas the person wants to change, and the intervention would involve helping him or her to develop a plan to achieve those changes. In combination, assessment and intervention provide the individual with a means for personal development, and by definition, for empowerment.

The ecological paradigm's assumption that problems in functioning derive from a poor fit between a person and his or her environment necessarily implies that they are not due to some personal defect or failure for which the person is responsible. Yet this is precisely what many of the participants in this study believe. Another function of the assessment procedure, therefore, should be to help people "see" the systems in which they are embedded, and to stop blaming themselves for all their difficulties. One way to achieve this would be to tackle the issue of goods and power from the standpoint that these are something everyone has the right of access to, rather than something everyone should have. Similarly, it might be helpful for the person to consider if, as Goldenberg (1978) asserts, marginalization is a systemic process, and rather than stemming from personal failure, it is the inevitable consequence of our competitive and exploitive social system. Rather than indoctrination, the goal is to help people rid themselves of the burden of personal culpability, to see themselves not as agents of their own marginalization, but as competent individuals who have the same rights to goods and power as the rest of society.

The rationale behind changing the fundamental power structure of the assessment procedure is inherent in the goal of empowerment for the person being assessed. Building on the ecological paradigm's emphasis on strengths, it assumes that everyone--regardless of level of functioning--has an opinion on his or her own social functioning, that everyone describes and evaluates their functioning as part of the process of regulating one's behaviour (Hewitt, 1979). The power shift proposed here is an extension of that used in the current research, since the assessment is based on the person's evaluation of his or her own social functioning. Essentially, the basis for assessment would become the person's level of satisfaction with his or her own social functioning, both in general and in specific roles or contexts. This builds on the work of Lehman (1983), which used satisfaction in various life domains as one of the measures of quality of life. Unlike Lehman, however, my intention is for the subjective evaluation to be the sole basis for assessment.

Another important aspect of this power shift is the collaborative relationship between the assessor and the person being assessed. This collaboration depends heavily on the latter's participation in every stage of the assessment procedure to the fullest extent possible, from describing his or her current social functioning, to outlining personal goals, to developing a detailed outline of the steps and resources necessary for their attainment. According to Riegel (1975), the use of cooperative (as opposed to segmented) tasks in assessment or testing not only yields substantially richer information, but a more rewarding experience for both tester and testee. In my vision of the assessment procedure, therefore, the role of the assessor is limited to <u>helping</u> the individual communicate that level of satisfaction, clarify the goals being used as a standard in his or her internal evaluation, and develop a clear, measurable, and rewarding plan for personal growth.

Rather than letting the assessor be solely in charge, this method shares control of the assessment procedure, and allows the individual to control the actual assessment. In my conceptualization, in fact, there is no tape recorder or handwritten notes, because these give control of the person's information back to the assessor, allowing that person to decide what is important or relevant enough to write down. Instead, the recording of information should be a joint and open process, shared by both parties. Chart paper could be used, for example, with the assessor continually checking as to the importance and completeness of the notes being made.

The product of the assessment process would be two-fold: an assessment of the person's current social functioning, based on his or her level of satisfaction with the relationship between current and ideal functioning, as well as a detailed, step-by-step plan for achieving his or her personal goals. The emphasis on full participation is also necessary because, as we have seen, the specific ways in which competence, self-determination, or integration are conceptualized and the contexts in which they are important may vary from one person to the next. Not everyone who described themselves in terms of self-determination, for example, was equally concerned about each of the sub-themes of independence, self-sufficiency, and perseverance. Likewise, while membership in an abstract group, occupational role, and love relationships were most often mentioned in relation to integration as an ideal, these may or may not be the most pressing goals for any given person. If the combination of assessment and intervention is to be truly helpful, the person must feel that the goals are his or her own, not externally imposed.

Summary and Conclusion

I believe this research represents a significant improvement over typical approaches to social functioning assessment, primarily because of the emphasis given to subjective experience, social environment, and personal growth in both the conceptualization and the methodology. As a result of this emphasis, I believe this research has managed to avoid the paradoxical problem faced by the social adjustment approach, of being both too person-centred (i.e., "blaming the victim") and not personal enough (by ignoring how the person experiences and evaluates his or her own social functioning and its context). Conceptually, I think the discovery that the majority of the participants in this study experienced feelings of marginalization should be a starting point for assessment: do others who have been hospitalized for psychiatric treatment also feel marginalized, and if so, to what extent? How do they describe it? How do they evaluate themselves as a result?

Methodologically, I feel this research is a vast improvement over traditional, "objective" methods. Not only is a qualitative, ethnographic method more suited to an exploration of subjective experience, social context, and personal growth, but I believe it is inherently more empowering. Indeed, as I have demonstrated, it has the potential for being a truly collaborative and helpful experience.

It would be naive to expect that we will ever stop assessing one another's social functioning, or even that in the near future we would begin to use a more humane standard than just competence at acquiring goods and power. The process of social comparison (Festinger, 1954) seems almost inherent in human interaction, if only because it is so useful for evaluating and defining ourselves.

It is not unreasonable, however, to hope that we can change the way our society treats people we label as deviant because they somehow failed (or did not choose tc) to live up to our standards of competence. It should not be necessary for us to isolate, blame, and convert them to the prevailing social values. At the very least, it should not be necessary to make them feel less valued as a result.

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Appendix A

Interview Questions

1. How would you describe yourself to someone who knew nothing about you?
2. How comfortable are you being the person you just described?
3. Tell me something about yourself that you're proud of.
4. Are there any changes you'd like to make in your life?
5. How would you describe the person other people would like you to be?
6. How close is that to the person you are now?
7. Has that always been the case?
8. How would you describe the person you'd like to become, maybe five years down the road?
9. How close is that to the person you are now?
10. What would help you become the person you want to be?
11. What could Houselink do to help?

Alternative and Supplementary Questions.

1. If someone were to ask you what your goals are, what would you say?
2. What can other people do to help you reach your goals?
3. What do other people do that isn't helpful?
4. What do you think is the difference between you and most other people who have been through the psychiatric system?

The rest of the questions are to help me describe the group of people who have participated in the study.

Would you mind telling me. . .

1. How old are you? _______

2. How you spend your days? (i.e., do you work, go to school, etc.?) _______

3. What was the last level of education you completed? _______

4. How do you support yourself? _______

That's all the research questions, but I'd be interested in knowing...

(a) How comfortable did you feel with the questions?

2. Is there anything I could have done to make you feel more comfortable with the questions?

(b) How did you feel about how you and I talked together?

(c) How differently do you think you would you have answered the questions if you had not heard about the research from other people?

(d) Do you have any suggestions about either the questions or the interview, or about any part of the research?

APPENDIX B

Letter to Participants

Dear Houselink resident:

My name is Heather Smith Fowler. As you may know, I'm doing research for my Master's degree in psychology at Wilfrid Laurier University in Waterloo, under the supervision of Dr. Geoff Nelson. I'm writing to ask you to consider participating in this research and to give you some information about it to help you decide.

The research is about people like yourself who have received psychiatric treatment and are now living in the community. I am trying to learn what roles or activities people such as yourself are involved in, how you see yourself doing in general, and what goals you and others would like for yourself. The purpose of the research (aside from my thesis) is to develop a new way of assessing "social functioning"--how people are doing in the community.

If you decide to participate, you and I would meet for about an hour, and I would ask you general questions such as "What qualities or characteristics would you like to have?". There are no right or wrong answers, only your opinion.

Although we're both involved in Houselink, this has nothing to do with your membership or residency, and you are under no obligation to participate if you do not wish to. Your participation would be completely anonymous, since no one's name will be used anywhere in the research. Also, everyone's responses will be put together and summarized, so that when the results are reported, no one person's answers will be singled out or identified, except in brief (anonymous) quotes.

As far as I can tell, the only risk involved in participating in this research concerns how comfortable you feel talking about yourself, your goals, and other people's expectations. Of course, you wouldn't have to answer any questions you didn't wish to.

On the other hand, you might even enjoy being a participant, since we'd be talking about what you think is important. I'm trying to get away from the traditional approach of evaluating how different people wo have received psychiatric treatment are from so-called normal people. I'm more interested in what <u>you</u> think.

I will be calling about half the Houselink residents--all chosen at random--over the next week or so. In the meantime, if you have any questions or concerns, please feel free to call me at 226-3581, or to call Pat Morrison (537-4794) or Lea Caragata (968-0242).

Thanks for your time and consideration.

Heather Smith Fowler

APPENDIX C

Consent Form

I have fully agreed to participate in research conducted by Heather Smith Fowler, knowing that it concerns the assessment of social functioning of people who have received psychiatric treatment.

My rights as a participant have been explained to me, particularly my right to refuse to answer any questions about which I feel uncomfortable, and to withdraw from the research at any time.

I understand that the information I give will be kept completely confidential and that my participation will remain anonymous.

Date	Participant's signature

APPENDIX D

Category Definitions

Whereas the section above described the general process of analysis in this study, the purpose of this section is to take the reader through the classification process in particular, explaining the properties of individual categories and highlighting particular coding issues or dilemmas, in order that the research findings might be better understood.

While some of these roles and attributes are straightforward, such as occupational or student roles, others require a bit more explanation. One of the most frequently mentioned codes, group membership, refers to an actual interacting group such as a club or a team, or some other social connection outside of kin, family, or a love relationship. Most of the responses in this category referred either to friendships or, to a lesser degree, to the co-op. Other responses included psychiatric housing or social programs (e.g., another Toronto drop-in centre), sports teams, and specific organizations such as Weight Watchers. Although some participants appeared to have several relationships or connections to an interacting group (e.g., "I have alot of friends I can call"), a large number of people appeared to have only one, and for some this was limited to the co-op.

The responses about participants' interpersonal behaviour, not surprisingly, were wide ranging but for the most part appeared to have two related dimensions: how participants treat other people, and how they express themselves. Responses such as being "kind," "bitchy," "patient," "a good friend to be with," or "controlling," seemed to convey a sense of one's effect on other people. There were also several references to participants' concern for other people--about their welfare or their feelings, about making them comfortable in social situations--as well as references to helping others or behaving in a caregiver role. For example, a few participants said such things as "I feel I can help other people because of what I've been through...."

A somewhat larger body of responses seemed more concerned with participants' interpersonal style or the expression of some aspect of their personality: "I don't talk much to people about things like this"; "I keep people pretty much at arm's length"; "[I'm] not rebelling against authority as much"; "I'm easy to get along with"; "I'm fairly gregarious." As seen from just this small sample of responses, many participants described themselves as either introverted or extroverted, or, as participants' put it, as either "someone who's a bit of a loner," ad "doesn't associate much," versus someone who is "sociable," "outgoing," and "able to navigate socially." Approximately twice as many participants described themselves as extroverted as did those who said they were introverted. Other responses concerned more with the self than with the effect of one's behaviour on others included those such as "I like control," and "I'm good at surviving double-bind situations."

The category of interpersonal behviour is obviously closely linked with that of personality, defined here as how one typically thinks and feels. This link is seen by the emphasis above on interpersonal behaviour which expresses the self, or personality. Many of the responses dispalyed above could as easily have been coded as personality traits, except that they seemed to require some sort of social context for their expression. The term "jovial" for example, suggests a behavioural style as much as it does a mood, whereas "happy" is more clearly a mood reference and therefore was more appropriately coded as personality.

Other references to mood which were coded as personality include "cheerful," "joyful," and "pleasant," as well as "depressed," "sad," and "melancholy," with somewhat more negative references than positive ones. Also coded as personality were references to temperment, such as "angry," "frustrated," "quick-tempered," or "not bitter," as well as references to participants' sense of humour. Other ways in which participants said they typically think and feel include "serious," "curious," "helpless," "down-to-earth," "cynical," "self-conscious," "trusting," and "opinionated."

Two other categories which are very similar are interests and activities. While Gordon (1968) differentiates among judgements and tastes, intellectual concerns, artistic and other activties, not all of these were justified by the data in this study. Participants did not appear to differentiate among tastes, judgements, and interests--for example, between "I enjoy photography," "I'm interested in photography," and "I enjoy photography"--and therefore these are combined in the interests code. This category also includes more general references such as "I have alot of interests now."

Since artistic activities and intellectual concerns were not very evident in participants' self-descriptions, a more useful, though admittedly arbitrary distinction was made between those interests or activities which for the most part are solitary and passive such as stamp-collecting (coded interests), and those which require more active participation and presumably more social interaction. Examples of the latter--coded activites--include "going bowling," "dancing," or "going visiting." According to these criteria, the response "I enjoy watching sports on T.V." would be coded as an interest, regardless of the reference to tastes, whereas "I like to play sports" would be more appropriately coded as an activity. The latter code also incorporates more general references to a participant's level of activity, such as "I don't go out much," or to his or her specific actions such as "I go to primal therapy," or "I visit my parents on the holidays."

Material possessions appears to be a fairly straightforward code, but includes a variety of different responses, including references to material objects owned by participants as well as resources such as money or income, and how they spend it. In a few instances, participants described themselves in terms of social assistance, sometimes with great feeling, such as the response "I'm a welfare bum," and sometimes with pride: "I've never been on welfare." Although two participants mentioned having some money--"I've always had a few dollars in my pocket"--for the most part, it was a lack of money which was mentioned in this category of responses: "It's kind of tight even though I'm working in the [sheltered] workshop because...I like spending money generally. So when it gets down to this time of the month, it gets kind of tight and I have to rely on what I make at the workshop [instead of FBA]"; "I find it's a difficult position to be in when you're on FBA and you're trying to date. There's not enough money for it." All of these references are more specific than the general references to "background" and socio-economic class which are included in the category of social status.

While a couple of references to participants' own physical characteristics were distinctly evaluative (and negative), such as "I'm really overweight," most of these references were to objective characteristics such as height, hair colour, etc.

The territoriality code includes all references that participants made to where they lived, such as "in Parkdale," "in a nice neighbourhood," and so forth.

Familial roles are distinguished from kinship roles by the fact that the latter are roles or relationships within the participant's family of origin, while the latter refers to his or her roles as a spouse and/or parent. The predominant kinship roles mentioned were in relation to participants' siblings and parents.

The last three codes are abstract identifications rather than references to distinct social identities. The first of these categories includes references to an abstract or universal group, without implying that interaction necessarily takes place among its members. Not surprisingly, this includes a variety of responses, such as "I'm a productive citizen"; "I'm a Leo..., born almost on true noon"; "I'm what I consider a punker"; "In some respects I feel like I'm still in my early twenties"; and "I still keep in contact with a few...people [who]...had nothing to do with the psychiatric system."

Existential references, on the other hand, "portray the individual as a unique, irreducible part of Being, not defineable by reference to anything outside himself" (Gordon, 1968, p. 16). Examples of such references include self-descriptions such as "just me, myself, and I"; "I'm just the same as anybody else..., just surviving"; and "I'm whoever I am."

Finally, belief references are those which connect the participant to "some relatively comprehensive idea system, whether theoretical, philosophical, ideological, religious, or more narrowly political" (Gordon, 1968, p.16). In this case, the references were related to participants' religious beliefs, either as an identity, such as "[I'm] a person whom God loves," or as a philosophy of life: "I'm trying to reject money as the main motive for living life, and work as the main activity or ambition."