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STUDYING THE ENACTMENT OF SCHIZOPHRENIA: REFLEXION, 'DIFFRACTION' AND 'ANALYTIC' AUTOETHNOGRAPHY

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This paper reports on the methodology used in a study of the enactment of schizophrenia. The study used techniques and theoretical tools derived from science and technology studies (STS) to show how schizophrenia was enacted as a multiple object.

The study used qualitative interview data, information from documentary sources and extracts from what the author termed his 'diffraction diary'. The diffraction diary was conceived as encompassing but going beyond the reflexive diary often kept by qualitative researchers. The metaphor of diffraction is concerned with making differences in the world. In physics, diffraction results in interference patterns. As a psychiatrist the author was being paid to 'interfere' and as a researcher he could not help but interfere in many ways, most obviously 'skewing' responses from people he interviewed simply because of the nature of the relationships he already had with them.

Anderson (2006) distinguished 'analytic' from 'evocative' autoethnography, and this paper demonstrates how the study met four of Anderson's 'five key features' for analytic autoethnography and claims that extracts from the diffraction diary, deployed as data, in part constituted the fifth key feature, 'analytic reflexivity' such that that the study might legitimately be considered as a variant of analytic autoethnography.

Introduction

This paper concerns the methodology of a study of the enactment of schizophrenia (Page, 2011). For practical and ethical reasons I could not carry out a formal ethnographic study in the strict sense as a participant observer and I used individual interviews as an alternative source of data instead. Nevertheless, as these were relatively informal unstructured conversations they are identifiable as one of Hammersley and Atkinson's (2007) salient features of ethnographic work. I also used as data documentary sources including the National Institute for Clinical Excellence guideline for the treatment and management of schizophrenia (NICE, 2002), the tenth edition of *International Classification of Diseases* (WHO, 1992), two mental health policy information guides (Department of Health, 2001 and 2002), a standard postgraduate textbook of psychiatry (Gelder *et.al.*, 2006) and extracts from what I called my 'diffraction diary'. Whilst I used techniques and tools from science and technology studies (STS), including Annemarie Mol's (2002) key theoretical concept of 'enactment'[1], my focus here is to argue that the study might, in part, be considered to be a variant of what sociologist Leon Anderson (2006) has termed 'analytic autoethnography'.

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Evocative and Analytic Autoethnography

Though Anderson (2006) noted that there had always been an autoethnographic element in qualitative sociological work, it seems that he considered autoethnography to be a 'sub-genre' of ethnography, characterised by a self-observational method and by textual self-visibility. More contentiously, perhaps, he made a distinction between *evocative* autoethnography and *analytic* autoethnography. According to Anderson, the purpose of evocative autoethnography is to give accounts of subjective emotional experience with the intention of inducing an emotional resonance in the reader, and analysis is actively avoided. On the other hand, as the name suggests, analytic autoethnography does not reject analysis and Anderson proposed that it had five key features. These key features were complete member researcher status, narrative visibility of the researcher's self, dialogue with informants beyond the self, a commitment to theoretical analysis, and analytic reflexivity. In what follows I will briefly describe how the study incorporated the first four of these features, and will then argue at greater length why the study can be considered to demonstrate the fifth key feature, analytic reflexivity.

Complete Member Researcher Status

By complete member researcher status Anderson (2006) meant that the researcher was a complete member of the social world under study. While carrying out the study I was employed as a full-time consultant psychiatrist in the English National Health Service (NHS) so that day to day I was immersed in the practicalities of treating patients with schizophrenia. My daily activities included talking with patients about their symptoms and their progress, their anxieties and their aspirations, prescribing their medication and monitoring them for side effects. I had daily discussions with professional staff about patients with schizophrenia, and I talked to relatives and carers several times a week. I was required by the Department of Health to use the diagnostic categories specified by the tenth edition of the International Classification of Diseases and expected to make treatment decisions with reference to the national clinical guideline produced by the National Institute for Clinical Excellence (NICE). The various community-based mental health teams I related to were mandated by the Department of Health in the policy implementation guides. I was, then, using or otherwise interacting with one or more of my data sources every day, perhaps for most of every day, and could therefore be considered to be a complete member of the 'social world' under study.

Narrative Visibility of the Self

Anderson (2006:384) suggested that 'a central feature of autoethnography is that the researcher is a highly visible social actor within the written text'. I took this to mean that my engagement in the 'social world' of schizophrenia should be evident in the text.

Here, I saw parallels with Donna Haraway's (1991a) notion of 'situated knowledge'. Haraway both rejected the possibility of the kind of 'objective' knowledge frequently believed to be the outcome of 'scientific' endeavour and was equally critical of relativism. Instead, she wrote, she was:

> ...arguing for politics and epistemologies of location, positioning and situating, where partiality and not universality is the condition of being heard to make rational knowledge claims. These are claims on peoples' lives, the view from a body, always a complex, contradictory, structuring and structured body versus the view from above, from nowhere, from simplicity.
>
> (Haraway,1991a:195)

Situated knowledge, then, is a partial view articulated by a particular actor in particular circumstances (not just 'personal', but also historical, cultural, economic, social and technical). I therefore took pains, in the written thesis, to locate myself as an actor within the organisation employing me and to locate myself as an actor within the research.

In relation to my clinical role I described the service I provided as a senior clinician and my position within a complex organisation that had a responsibility to provide mental health services for a defined (but periodically changing) geographical location. In relation to my role as researcher I described how research priorities conflicted with clinical priorities and how this was resolved, and described the ethical issues arising from my dual role as clinician/researcher and how I dealt with these. In the written text I also used extracts from what I called my 'diffraction diary'. I discuss this in more detail below, but for the present this might be considered as a diary in which I recorded thoughts on my day to day work with people with schizophrenia and on the research in progress. These extracts served, amongst other things, to increase my 'narrative visibility'.

Dialogue with Informants Beyond the Self

Much of the written text is taken up by portions of transcripts of interviews I recorded with patients, carers or professional staff and a smaller part by diary extracts recording my thoughts on conversations with patients, carers or staff. These interview transcripts and diary extracts are concrete examples of my engagement in dialogue with informants beyond myself.

Commitment to Theoretical Analysis

It was my intention that the written text of the thesis, taken as a whole, be considered as a contribution to the field of science and technology studies (STS). I used Annemarie Mol's (2002) notion of enactment and applied this to schizophrenia and, in the language of STS, I claimed to show how schizophrenia was enacted as a 'multiple object'[2] and claimed to have delineated 'heterogeneous networks'[3] that enacted specific, located but 'partially connected'[4] *schizophrenias.* I also used Donna

Haraway's (1991b) notion of the 'cyborg'[5] to show how subjectivity might be considered to be a network effect, and Charis Cussins' (1998) notion of 'ontological choreography'[6] to explain how a person with schizophrenia might be actively involved in a process of objectification and thereby make a passage from a temporally unstable 'schizophrenic' subject position to an alternative, more stable non-schizophrenic subject position. I also tried to develop theory by proposing a link (or 'partial connection') between the literature of STS and the interdisciplinary study of narrative. Though crucial to the study as a whole, these technical details are only relevant to this paper in so far as they demonstrate that I used the tools and techniques of STS in the theoretical analysis of my empirical findings.

Analytic Reflexivity

Anderson (2006: 382-383) was not absolutely explicit in what he meant by analytic reflexivity, but it encompassed 'an awareness of reciprocal influence between ethnographers and their settings and informants', 'self-conscious introspection guided by a desire to better understand both self and others through examining one's actions and perceptions in reference to and dialogue with those of others' and a recognition that autoethnographers as authors are in part formed by representational processes 'as the cultural meanings they cocreate are constituted in conversation, action and text'.

I noted above that I kept what I came to call a 'diffraction diary'. Qualitative researchers are often encouraged to keep a reflective diary that might record thoughts about their actions, thoughts about their values and assumptions, and thoughts about the research in progress (Henwood and Pidgeon, 1993). Health professionals are encouraged to reflect on their practice and I had always tried to do this in order to improve my clinical work. I therefore decided to use a diary to record reflections on my research and on my day to day work with people with schizophrenia.

The word reflection shares the same etymological root as the alternative word reflexion - from the late Latin *reflexio* via middle English - indeed the words are interchangeable in the Shorter Oxford English dictionary. Reflexivity, the condition of being reflexive, has a contested meaning in social science but one which nevertheless implies that the values and interests of researchers are influenced by social and historical processes, that these will affect the research carried out and that the research itself will have consequences, both proximally where it may change aspects of research situation, and distally where it may have practical and political effects (Hammersley and Atkinson, 2007). I wondered, however, whether reflection was the most appropriate term to use. The metaphor here is looking at oneself in the mirror, and is derived from optics. Donna Haraway was critical of 'reflection', suspecting that as a practice it raised questions about the possibility of a copy and the original, and of 'the search for the authentic and really real' (Haraway, 1997:

16). Instead, she suggested the alternative optical metaphor of *diffraction*. Karen Barad (2007) developed the metaphor further. She explained:

> Haraway's point is that the methodology of reflexivity mirrors the geometrical optics of reflection, and that for all of the recent emphasis on reflexivity as a critical method of self-positioning it remains caught up in geometries of sameness; by contrast, diffractions are attuned to differences - differences that our knowledge-making practices make and the effects they have on the world.
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> (Barad, 2007:72)

In physics, diffraction is concerned with the way waves combine when they encounter other waves or when they come up against an obstruction. The waves can be light waves, sound waves or waves on water - all will display diffraction under certain conditions. One of the examples Barad gives is of waves on the sea approaching a hole in a breakwater. Waves parallel to the breakwater but moving perpendicularly towards it will be diffracted into concentric half circles as they pass through the gap. A more complex example she gives is of the overlapping circular patterns made by disturbances on the surface of a sheet of water, such as those made by throwing a handful of pebbles into a pond. These circular waves *interfere* with each other as they radiate outwards from their central points.

The specific critique Barad articulates is as follows. She argues that:

> ...reflexivity is founded on representationalism. Reflexivity takes for granted the idea that representations reflect (social or natural) reality. That is, reflexivity is based on the belief that practices of representing have no effect on the objects of investigation and that we have a kind of access to representations that we don't have to the objects themselves… even in its attempts to put the investigative subject back into the picture, reflexivity does nothing more than mirror mirroring.
>
> (Barad, 2007: 87-88)

The metaphor of diffraction, on the other hand, is 'about making a difference in the world' and is 'about taking responsibility for the fact that our practices matter; the world is materialised differently through different practices' (Barad, 2007: 89). Drawing on the philosophy/physics of Niels Bohr, Barad developed the metaphor of diffraction further and proposed that observer and observed were epistemologically inseparable, a philosophical position she called agential realism.

As we have seen, diffraction results in interference patterns. As a psychiatrist/researcher I was also 'interfering'. As a psychiatrist I was actually being paid to interfere- that was my job - and as a researcher, even if I tried to efface myself I was interfering in many ways, most obviously 'skewing' responses from patients, staff and carers simply because of the nature of the relationships I already had with them. No doubt I was interfering in more complex ways as well, but in any event my practices, including my practices of representing inevitably had an effect on the objects of investigation - I *was* making a difference in the world - and I concluded that the metaphor of reflection (or reflexion), was simply not strong enough or

specific enough. To acknowledge this, and to acknowledge the proposition that observer and observed are epistemologically inseparable and partly constitutive of each other, I chose the stronger metaphor and called my diary a 'diffraction' diary.

Diffractions result in interference patterns, events, not just reflections, and this allows them to be treated as data. The use of excerpts from my diffraction diary as data also allowed me to comment on, to develop, and sometimes to critique data from the interviews or from documentary sources. This analysis was an iterative process and involved identifying a theme in one interview then studying the transcript of another interview where that theme, or a closely related theme, was also evident. I could extend this process into documentary sources and to related research literature which discussed that theme, and sometimes the documentary source or the research literature would send me back to the interview transcripts. Sometimes the emergent themes triggered entries in my diffraction diary and sometimes entries in my diffraction diary sent me back to the transcripts, to documentary sources or to related literatures. Sometimes the literatures I found myself drawn towards described primary psychiatric research or an overview of such research and sometimes I was drawn towards the STS literature. The latter might have been empirical work that seemed related to a theme or themes I was following or might have been theoretical work that potentially offered a way of understanding some of the enactments I was describing. The following extract from my diffraction diary, which I deployed as data, illustrates some of the above:

> We were sat round the table at the ward round - me, the staff nurse, one or two junior doctors and a patient. The patient told us how he had been feeling since the last time I'd seen him, and then I asked him what he thought was the matter with him. He answered 'schizophrenia'. I don't think anybody had said this to him, but he is an intelligent man and knew he was being treated with an antipsychotic drug. His symptoms included low mood and thinking that people were deliberately, and distressingly, communicating by indirect non-verbal means with him. He also believed that he was being tracked by a law enforcement agency and had gone to the police station to turn himself in. They told him that he was not on their list of people linked with any crime and that they did not need to talk to him. It was, therefore, a reasonable stab at a diagnosis, but although he had a clear delusional idea and may have been experiencing particular hallucinations, he did not fit the ICD 10 diagnostic criteria for schizophrenia and I told him this. But what diagnosis should I give him? I said that I thought that he had a paranoid psychosis, and went on to explain, as I usually do if I give someone this diagnosis, what this means.

I used the analogy of a chest infection, and said that when a doctor diagnoses a chest infection this is a non-specific term that covers a number of more specific diagnoses such as acute bronchitis, chronic bronchitis, acute tracheitis, lobar pneumonia and bronchopneumonia. I explained that the precise diagnosis depended on the history of the symptoms, the findings on examination and perhaps on investigations such as X-rays. Paranoid psychosis is a non-specific diagnosis covering more specific illnesses that would include schizophrenia but could also

include delusional disorder, depression with paranoid delusions, delirium tremens and certain other psychoses caused by physical illnesses or by prescribed or illicit drugs.

Situations like this where we can't use X-rays to narrow the diagnostic possibilities and where we are limited to interpreting the history and the mental state examination are not uncommon- in fact they are the norm in psychiatry. So a non-specific diagnosis such as 'paranoid psychosis' is very useful. It allows us to initiate treatment but at the same time allows us to keep our options open. If new or more specific symptoms develop, the diagnosis can be refined, and the treatment changed. There is a bureaucratic difficulty, though. The Department of Health requires that I give everybody discharged from the ward an ICD 10 diagnosis, and 'paranoid psychosis' is not a recognised ICD 10 category. If a patient is well enough to go home, I can't keep him or her on the ward until I am more certain about the diagnosis. After all, most people want to be discharged as soon as possible (if not sooner) and anyway, the crisis resolution/home treatment team are always looking for beds.

So what do I do? I tell the patient that he or she has a paranoid psychosis and write an ICD 10 approved diagnosis in the notes. But what diagnosis? Well, fortunately, the ICD 10 includes what Bowker and Star (1999) term 'garbage categories'. Garbage categories are residual, non-specific categories 'where things get put that you are not sure what to do with' (Bowker and Star, 1999: 149). In this case, I wrote ICD 10 F28 'Other nonorganic (*sic*) psychotic disorders'. This is not an illness category that is in everyday use and indeed is not defined except by exclusion. The ICD 10 definition is:

> Psychotic disorders that do not meet the criteria for schizophrenia (F20.-) or for psychotic types of mood (affective) disorders (F30-39),and psychotic disorders that do not meet the symptomatic criteria for persistent delusional disorder (F22.-)…

Clearly, I could not tell a patient that they had 'other nonorganic psychotic disorders' without giving him or her a seminar on the ICD. I'd have to explain that although this diagnosis is in the plural, I didn't think that they had several disorders. I'd also have to explain the difference between an organic disorder and a non-organic disorder. And I'd probably have to explain what 'other' the 'other nonorganic psychotic disorders' were other to.

'Paranoid psychosis', then, is a useful non-specific diagnosis that on the one hand guides treatment and on the other allows for a more precise diagnosis to be made as an illness evolves. It is not, however acceptable as a discharge diagnosis. 'Other nonorganic psychotic disorders' is useless as a diagnosis in everyday practice as it is too cumbersome. It is, however, an ICD 10 category and therefore occasionally useful in satisfying the bureaucratic demands of the NHS. In Nicholas Dodier's (1998) terminology, this is an example of a confrontation between what he called clinical and administrative frames – 'paranoid psychosis' is a useful

clinical diagnosis but unacceptable to NHS bureaucracy. Dodier (1998: 73) based this distinction on his ethnographic study of French occupational medicine and he suggested that 'the clinical and administrative ethos should be seen as distinct and opposite codes of practice'. Nevertheless, he suggested that the two frames may co-exist and this is clearly the case here. Compared to French occupational medicine, the demands of the NHS administrative frame are very weak – the only requirement is to record an ICD 10 diagnosis – and the clinical frame dominates the medical encounter. Dodier proposed three modes of co-existence, and the one that seems to fit best in this instance is his mode of temporal succession, where the two types of framing follow each other relatively smoothly without undue conflict. In the clinical frame the diagnosis of paranoid psychosis is used to plan treatment, and at the point of discharge the ICD 10 diagnosis of 'other nonorganic psychotic disorders' is written down to satisfy the requirements of the administrative frame.

This diary extract describes an incident occurring in my clinical practice. Deployed as data the diary extract situates me within a narrative where meanings are created in conversation and action but the extract is also part of the representational process of textual production. The descriptions of my engagement with the technicalities of diagnosis, of my engagement with the bureaucratic demands of the NHS and of my interaction with an individual patient constitute, I hope, a self-conscious examination of my thoughts and actions and at the same time illustrate a reciprocal influence between me as ethnographer and as psychiatrist and between my professional and my organisational settings. It also allows me to analyse some of my actions through theory relating to classificatory systems and through theory relating to 'frames'. I argue, then, that my deployment of the diffraction diary demonstrates an awareness of those types of interaction between ethnographer and research situation such as would constitute, in Anderson's sense, analytic reflexivity.

CONCLUSION

I have described the methodology I used in a study of the enactment of schizophrenia. I contend that the text describing the completed study incorporated four of Anderson's five key features of analytic autoethnography: complete member researcher status, narrative visibility of the researcher's self, dialogue with informants beyond the self and a commitment to theoretical analysis. I have also argued, at greater length, that deploying extracts from my diffraction diary as data for analysis demonstrates the fifth of Anderson's key features, that of analytic reflexivity, such that the text of the completed study might, in part, be considered to be a variant of analytic autoethnography.

Notes

1. Enactment is 'the claim that relations, and so realities and representations of realities…are being endlessly or chronically brought into being in a continuing process of production and reproduction, and have no status, standing or reality outside those processes' (Law, 2004).

2. Multiplicity is a consequence of particular enactments. Diseases (and other objects) are made real in and through practices, so where there are multiple practices there must be multiple objects.
3. Relations, in this case between patients, illicit drugs and alcohol, psychiatrists, antipsychotic drugs, hospitals, national treatment guidelines, inpatient nurses, carers, diagnostic criteria, organic brain disease, various community-based mental health teams, and policy implementation guides.
4. Relations through partition, where the logic is that half of a whole is one of a pair but addition and subtraction do not reduce complexity such that one thing may be included in another but neither is reducible to the other. The term 'partial connection' is Donna Haraway's but the concept was developed by Marilyn Strathern (1991/2004).
5. A cyborg is a metaphor enacting a set of partial connections between two or more parts. The parts may, for example, be material, social or political and may be real or fictional. The metaphor questions long-established dichotomies (such as between organism and machine, mind and body, public and private, man and woman, nature and culture).
6. Ontological choreography is the co-ordinated action of heterogeneous actors in the service of a long- range self.

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