OUKA
The University of Osaka
Institutional Knowledge Archive

Title	Discovery of place to belong in recovery process of persons with schizophrenia : combination of grounded theory approach and qda software atlas. ti
Author(s)	Higuchi, Mari
Citation	Osaka Human Sciences. 2016, 2, p. 21-42
Version Type	VoR
URL	https://doi.org/10.18910/56907
rights	
Note	

The University of Osaka Institutional Knowledge Archive : OUKA

https://ir.library.osaka-u.ac.jp/

The University of Osaka

Osaka Human Sciences, **2**, 21-42
March 2016

DISCOVERY OF PLACE TO BELONG IN RECOVERY PROCESS OF PERSONS WITH SCHIZOPHRENIA: COMBINATION OF GROUNDED THEORY APPROACH AND QDA SOFTWARE Atlas. ti

Mari Higuchi*

Abstract

Despite the gradual spreading of use of QDA software in quantitative surveys, there have been few reports that indicate conformance with methodology. Therefore this study used Atlas.ti from the methodological standpoint of M-GTA, and analyzed recovery process of persons with schizophrenia on the basis of participant observation data. The outcome of this has shown, as a factor to direct the recovery of persons with schizophrenia, the importance of mingling with "healthy people" who do not have a peer's perspective.

Key words: person with schizophrenia, recovery process, grounded theory approach, QDA software

1. Introduction

1.1. The "place to belong" as a resource for supporting life in the community

The length of hospital stay for people with psychiatric disorders in Japan is still long as it has been in the past. Above all, for persons with schizophrenia who have a chronic course of disorders (hereinafter referred to as "persons with schizophrenia"), the average length of stay is 561.1 days (Ministry of Health, Labour and Welfare, 2011). This indicates that people with psychiatric disorders in Japan are placed in special environments (= social hospitalization). There are also a great number of cases where, even if these individuals have left hospital, they shut themselves in their homes for a long time and have no contact with people other than

This article is the English translation of the original one "Higuchi, M (2013). Discovery of Place to Belong in recovery Process of Persons with Schizophrenia: Combination of Grounded Theory Approach and QDA Software Atlas.ti. Advances in Social Research, 11, 85-100 (in Japanese)". The publication of its English translation has been permitted by Japanese Association for Social Research.
* Graduate School of Human Sciences, Osaka University, 1-2, Yamadaoka, Suita, Osaka 565-0871, Japan.

medical professionals and family members. Based on these circumstances, support for people with psychiatric problems to be accepted in the community is necessary, especially for those with schizophrenia for whom living in the community is the most challenging.

The importance of "a place to belong" should be noted as one of the resources that underpins the life of persons with schizophrenia within the community (Hamada & Tsutsumi, 2010). Miyoka Nakagawa and others describe day care services provided at rehabilitation facilities which are used by people with psychiatric disorders who have left hospital as: "Day care is a place to belong which functions to connect one's experiences in relation to time, space and other people, and it is where members themselves form their "self" (Nakagawa et al., 2011: 6). They also state that day care helps recovery[1] in users (Nakagawa et al., 2011). On the other hand, Nakamura et al. also point out the limitations of treatment institutions as a "place to belong", that day care is not always effective for persons with schizophrenia to try finding a new job and get reintegrated back into society. Based on this, it is thought that there is a crevasse between recovery provided by obtaining a "place to belong" and social reintegration.

The necessity for a "place to belong" in the community life of persons with schizophrenia is most likely as it has been pointed out in the past by previous researches. However, in research regarding "places to belong", research participants have been persons with schizophrenia who have been living continuously within the community and go to hospitals as an outpatient or to day care facilities. Considering the situation where many persons with schizophrenia are still socially hospitalized, it is necessary to establish the cause of why "places to belong" in medical institutions do not lead to reintegration into society, by conducting a survey involving the persons with schizophrenia who are hospitalized for long periods of time.

1.2. Crevasse between recovery process and social reintegration of persons with schizophrenia

Next, I would like to touch upon the concept of social reintegration that is shared among practitioners in the field of psychiatric service. The current concept of "social reintegration" is mainly established on the foundation of the perspective of medical professionals. Figure 1, prepared with reference to a psychiatric textbook (Nomura et al. ed., 2009: 183–89), which shows the social reintegration process of people with psychiatric problems, clearly demonstrates the concept of the model "social reintegration" employed by medical professionals.

In this model, "social reintegration" of persons with schizophrenia is centered on the "disorder" itself. In other words, as long as symptoms of the "disorder" are suppressed, by providing support

[1] Anthony A. William defined the "recovery" of people with psychiatric disorders is to "overcome catastrophic effects of mental illness and create new meaning and purpose in life" (Anthony, 1993: Translation 67) and presented the importance of "recovery" that differs from curing the illness or mitigation of symptoms. Based on the fact that, after this report was translated into Japanese by Ryunosuke Hamada, "recovery"-related literature increased in the mental health fields in Japan (Tanaka, 2009), it can be said "recovery" in the field of the support for people with psychiatric disorders in Japan is based on Anthony's definition. Therefore, this study also followed Anthony's definition of "recovery".

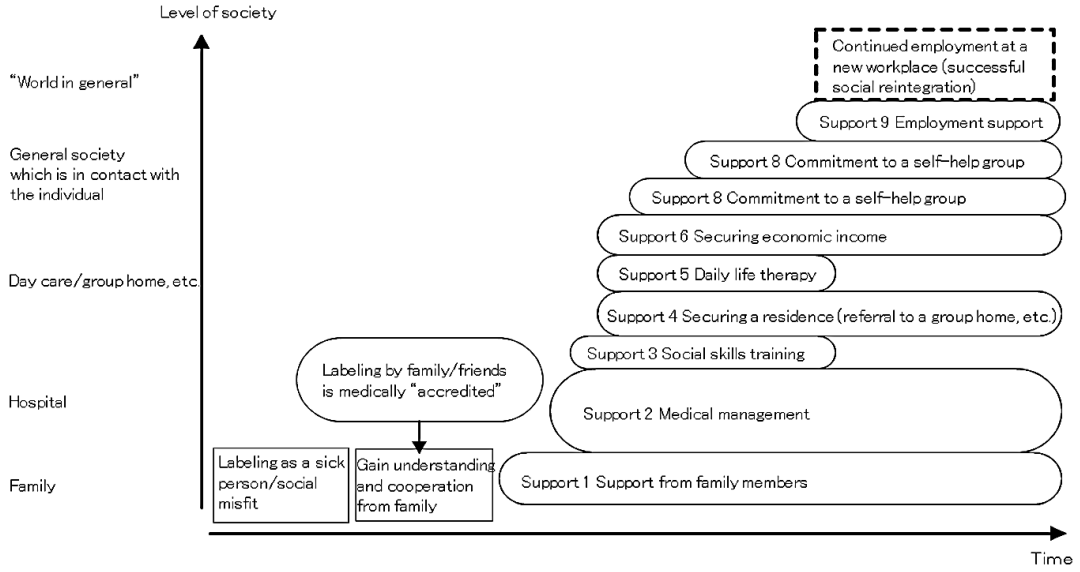

FIGURE 1. Social reintegration model considered by medical professionals

in addition to that suppression, eventually persons with schizophrenia can lead an economically independent life in society and "social reintegration" can be achieved. This "social reintegration" model is based on the life of healthy people, such as work or home life, and it focuses on getting close to the living conditions of these individuals before becoming ill. However, it seems that few persons with schizophrenia reach "social reintegration", most likely because of placing too much emphasis on employment.

In recent years, recovery research that focuses on recovery and peer activity by people with psychiatric disorders themselves have been increasingly active in contrast to the conventional medical perspective of regarding social reintegration on the premise of alleviating the degree of symptom or disorder. In recovery research that places more weight on independent actions of those with the disorder rather than aiming to get closer to the life of "healthy people", it is suggested to make it the goal on the part of the support to allow them to lead a meaningful life with hope even though they have difficulties with illnesses or disabilities (Geoff, 2010). There also is a growing concern among medical professionals and those with psychiatric disorders in Japan regarding recovery from psychiatric disorders, and the knowledge and findings of Ukigaya (2009) and Kato (2009) that focus on independent actions and medical professionals who support it have been accumulated. Efforts centered on supporting people with psychiatric service issues regarding their community life, such as ACT[2], have become more active (Japanese Society of

[2] Abbreviation of Assertive Community Treatment (comprehensive community life support program). It indicates a program by a team of multidisciplinary specialists set up for supporting community life for people with severe psychiatric disorders.

Social Psychiatry ed., 2009) among medical professionals as well. Recovery research like this demonstrates the importance of respecting the values and actualization of hope for people with psychiatric disorders as a guideline towards improving issues regarding their life in the community.

However, in peer activities or domestic research regarding similar topics, there is a tendency to target a minority group of individuals and affiliated medical professionals who completely affirm the disorders, and actively send out information concerning their disorders. Many individuals with schizophrenia still find it difficult to positively affirm their disorders and reach out to the external world. Therefore, it is not possible to get the whole picture of the recovery process to understand how to recover from the state of social hospitalization to leading a life with hope, from research that only involves the aforementioned minority group.

Based on the points stated above, this study analyzed both types of persons with schizophrenia: those who based their lives at home and in day care facilities, and those who had extended stays at hospitals. Then, by using the participant observation data taken at psychiatric hospitals, the study first attempts to clarify through exploration the big picture of the recovery process of shifting from hospital care to day care. Secondly, the study examines the concept of "place to belong", how it is positioned in the recovery process of persons with schizophrenia, and how it links the recovery process for finding hope in life within employment-oriented social reintegration.

1.3. As applied research by use of QDA software and GTA

Before explaining the recovery process, here is a brief note on the methodological standpoint of this study. In the field of qualitative survey methods, the grounded theory approach (Glaser and Strauss, 1967) (hereinafter "GTA") has spread widely thanks to the many predecessors[3] who explained and improved upon its philosophy and technique, adding to its originality which emphasizes building theories from data.

This study adopted the GTA, for the reason that it is considered to be suitable for interpreting actions of people in a specific region as well as for explaining the process of changes, and it looks for possible uses of the produced theories in the target region. On the other hand, the QDA (Qualitative Data Analysis) software, used to improve efficiency of operations such as collecting, managing and analyzing qualitative data, became applicable for data in Japanese. Therefore the QDA software came to be introduced in Japan as well[4], and use of analysis tools is expected to expand its importance in future qualitative surveys.

[3] After Barney G. Glaser and Anselm L. Strauss published "Discovery of Grounded Theory: Strategies for Qualitative Research" (1967), a variety of views over the methodology of GTA have been presented until today. This study referenced the M-GTA analysis method by Yasuhito Kinoshita, who places great importance on the researchers' problem consciousness in data interpretation.

[4] For example, by Sato (2008) etc.

Having said that, when a researcher conducts an analysis of qualitative data for the first time, it could be hard for the users to envision how the selected methodology will correspond to the QDA software, let alone the analysis procedure of the data itself. This may contribute to hesitation regarding the use of the software. An effective way to allow researchers to overcome the first hurdle of analysis is to accumulate research that uses a variety of QDA software. This paper presents an analysis procedure in Section 2 as an example of using the QDA software product Atlas.ti (ver.6) and the GTA.

2. Analysis of recovery process of persons with schizophrenia using Atlas.ti based on M-GTA

2.1. Overview of field work

This analysis used data gathered in a participant observation study that took place at two private psychiatric hospitals in urban areas in Japan, between July of 2006 and May of 2007[5]: T Hospital (open ward and day care center) and K Hospital (day care center only). The field notes (hereinafter "FN") gathered as data are described as follows[6]. The data includes conversations I had with outpatients and medical professionals during my participation in a program at a day care center as a trainee, as well as observations of interactions between medical professionals at hospital wards and the day care center and inpatients, as well as observations of mutual interactions between outpatients and medical professionals. The data also includes everyday conversations I had with several patients at their rooms who had been referred to me by medical professionals, the clothes of the observed individual, and the state of the facility. In general, students who frequently come to health care facilities are medical or welfare-related interns, and thus patients and outpatients are not familiar with students like myself who come to do sociological research. Therefore, upon consultation with the hospital, I introduced myself as a trainee so as to allow the patients and outpatients (hereinafter "psychiatric service users" or "users") to accept me with relatively less resistance. When I talked with them individually, depending on the circumstances, I presented myself as someone who was there for research purposes, or as someone who was doing research regarding social reintegration of persons with schizophrenia or people with psychiatric disorders.

During conversations with the psychiatric service users, I asked brief questions from time to time; however, the research participants fundamentally spoke of their own volition. The remarks by the participants include retrospective stories from the onset of the disorders until the day of

[5] I visited each hospital at a rate of once a week. Aside from that, I also did field work at a local peer group as a volunteer. For the analysis of this study, however, the use of the data related to this group was limited to referencing, to get some idea for the "society where coexistence is possible with healthy people" referred to in Section 4. The activity of this group was intended to create a place where people with psychiatric problems can mingle with local residents through making Renku verses (a type of Haiku).

[6] All institutions gave approval regarding presentation of the outcomes of my research on the paper.

the survey. Therefore, in some cases, the data from one participant is used across more than one concept categories described in the following sections[7]. It should also be noted that a survey using intensive interviewing was not conducted at the request of the hospital and the psychiatric service users.

2.2. From overviewing data to concept generation

Now I would like to move on to discussing the analysis procedure, from data through concept generation. For concrete analysis procedure, Kinoshita's (2003) modified version GTA (hereinafter "M-GTA") was used as reference. The concept category is shown in【 】, the concept in［ ］, and the code in〈 〉.

Firstly, the main living places of persons with schizophrenia were broken down into patterns in light of the social reintegration model displayed in Figure 1, to understand how those places have been changing at the time of the survey. As a result of this, the participants were classified into three categories on the vertical axis of the "Social level" in Figure 1: those who are staying in "Hospital"; those who were able to move from hospital care to "Day care"; and those who could step into the "General society which is in contact with the individuals". Next, an analysis theme—"recovery process from the onset of disorders until today"—was set up for each category, and open coding of the target portion was conducted by searching data related to recovery[8]. Codes were allocated to the FN of a day, then, upon completion, codes for the FN of the next day were assigned. After the open coding process progressed to a certain extent and the number of codes reached approximately 100, it was able to be predicted that the participants had different inner characteristics depending on their main places of living.

Then, in conjunction with open coding, I picked out data that indicated inner characteristics and data similar to or in opposition with them, and conducted coding on those data. I then saved the data after attaching appropriate labels to the code groups considered to be related by means of Atlas.ti's Network View Manager (hereinafter "NVM"). M-GTA guarantees that the concept is in line with the data by capturing codes in a planar relationship, not by hierarchizing codes into primary and secondary codes. For analyzing planar relationships of codes, which is the feature of M-GTA, the function of NVM is indispensable. This tool examines the relationship between the codes put together in the NVM, connects the codes with links attached with a name

[7] Retrospective data is used particularly for the concept of【A. Loss of hope】in 3.1.

[8] Although M-GTA directly generates concepts from data without setting open coding, it is not easy while the researcher is still not used to data analysis. Furthermore, it takes time until the researcher can realize which data is meaningful because participant observation data includes more diversified contents compared to interview data with preset questions. Therefore, in this study, I conducted open coding prior to conceptualization to facilitate the concept formation procedure. In doing so, I tried to reflect the context of the data as much as possible while using abstracted data for code names so that "which portion of data can be explained from the concept side" (Kinoshita, 2003: 179) is understandable, and thus the wording is similar to that of the raw data. This, however, enables me to easily generate concepts in line with the data even when there is a large amount of data and as many as several hundred codes.

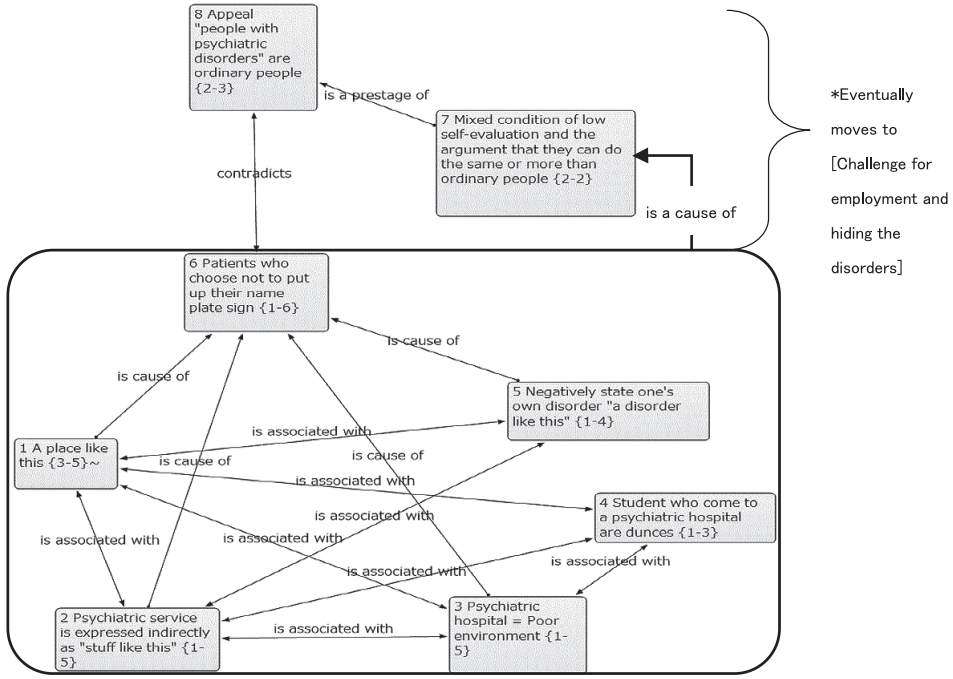

FIGURE 2. Network diagram [Hiding one's name or the disorder name]

indicating the relationship, and creates a network diagram that represents the concept. By visually considering code-to-code relationships through NVM, this allows us to more readily recognize the codes that were lacking in explaining the relationships. Then, we can come back to the data and add a new code to the NVM diagram by using its search function, or delete a code that was initially considered to be relevant but proved to be unnecessary as a result of the study[9]. This function facilitates constant comparative analysis and performs data searches and concept creation simultaneously, thus allowing for the results to meet the M-GTA requirements that the created concept should be in line with the data. Therefore it would be fair to say that Atlas.ti and M-GTA are highly compatible between software functions and methodological standpoints[10].

The process from open coding to concept creation is described below, through use of a network diagram (Figure 2) on the example concept of [Hiding one's name or the disorder name], which is included in the concept category 【A. Loss of hope】 that is detailed later. Here, due to limitations of space, the code that best represents the negative perceptions toward disorders

[9] This work facilitates theoretical sampling as it enables to visualize the type of data the researcher needs to further collect. However, there was a limit to theoretical sampling, as the period of acceptance for this survey on the field had been fixed and data could not be collected after starting open coding due to interviewing not being allowed.

[10] M-GTA recommends creation of "Analysis Worksheet" (Kinoshita, 2003) to write down concept ideas. With Atlas.ti, the researcher can write the definitions of necessary concepts and theoretical notes as well as reference the data showing specific example of a concept from a code on the Analysis Worksheet. This is considered to be usable as analysis worksheet as well.

is indicated, which is the feature of the concept. The underlined sections indicate the coding portions. The data before and after the coding portions are also shown so that readers can understand the context of the original data. The code numbers correspond to the ones displayed in Figure 2.

Code 1 [A place like this]

Ms. H (psychiatric service user): …… Is this your first time coming to a place like this (psychiatric hospital)? […] You aren't worried, or your parents aren't against you choosing to come to a place like this (psychiatry) instead of other places like the physician's office? (FN at T Hospital: August 17, 2006)

Ms. A (psychiatric service user): I suppose coming to a place like this can be considered a kind of social participation. (FN at K Hospital: July 27, 2006)

Code 6 [Patients who do not show their name in front of their room]

Head nurse: To protect personal information, some patients, if they so wish, choose not to put up their name plate sign (in front of their room). (FN at T Hospital: August 17, 2006)

Firstly, 〈1 A place like this〉 is associated in an equivalent relationship with each of other codes: 〈2 Psychiatric service is expressed indirectly as "stuff like this"〉, 〈3 Psychiatric hospital = Poor environment〉, 〈4 Students who come to a psychiatric hospital are dunces〉, and 〈5 Negatively state one's own disorder as "a disorder like this"〉. This indicates that persons with schizophrenia regard disorder-related words as taboo due to their negative perception toward their own disorders and/or psychiatric hospitals. Codes 1, 2, 3 and 5 are also considered to be the cause of actions to hide from other people, namely, 〈6 Patients who choose not to put up their name plate sign〉. Based on the relationships between these codes, it can be considered that persons with schizophrenia view their disorders in a negative light, and thus hide their own names or the name of their disorders from people around them.

Here, I have added 〈8 Appeal that "people with psychiatric disorders" are ordinary people〉, which is considered to be an act that is contradictory to Code 6. However, it is hard to think that one would make the drastic leap from Code 6 to Code 8, in which they insist that they are not 'special' people. Therefore I added another code, 〈7 Mixed condition of low self-evaluation and the argument that they can do the same or more than ordinary people〉, which mediates Codes 6 and 8. Code 7 shows that persons with schizophrenia, while accepting negative perception toward their disorders, begin to feel a desire to escape such perceptions. Codes 1-6 are the causes of Code 7[11]. In other words, Code 7 is positioned as a pre-stage of Code 8, where persons with

[11] In order to avoid drawing a line from each code to Code 7 and making the diagram complicated, I enclosed Codes 1-6 and added the arrow pointing Code 7 and the asterisks by using separate drawing software.

schizophrenia start to assert that they are “normal”.

At this point, the main living place and the period from onset of the disorders were checked for research participants who provided these codes. The information revealed that both the inpatients and the outpatients coming for day care also had negative perceptions toward their disorders, and that the latter used more words that asserted their capabilities, as shown in Code 7. These words were not heard right after the onset of the disorder or while the users were at hospital. Code 8 was observed only among participants in day care. Consequently, it was presumed that there was a difference in intensity of negative perceptions toward the disorders; these perceptions were observed to be highest in participants whose main living place was in the hospital, as well as those who developed their disorders recently, and lower in outpatients coming to day care who have been living with their disorders for some time. As described later, Codes 7 and 8 were considered to be the component codes when generating the concept [Challenge for employment and hiding the disorders] under the concept category of 【D. Conflict】, which will be elaborated upon later. Since this concept is characterized by negative perceptions toward disorders and low self-evaluation, and because [Challenge for employment and hiding the disorders] is characterized by getting closer to “healthy people”, it was decided to examine these two concepts separately. Codes 7 and 8 were moved to the concept of [Challenge for employment and hiding the disorders] (see upper portion of Figure 2). In this way, concept creation was conducted in conjunction with the creation of other concepts, rather than creating one concept at a time.

In this concept, it was considered that self-evaluations of persons with schizophrenia get lower as individuals hide their name and the name of their disorder due to negative perceptions toward their disorders; this perception would remain after more than ten years since the onset of the disorders. Based on the above, this concept was named [Hiding one’s name and the disorder name]. Other concepts were created based on similar analysis procedures[12].

2.3. From concept to the big picture

Next, I examined the relationships between the concepts which were subject to “selective coding” by M-GTA, and created concept categories. Firstly, because the analysis theme was “recovery process from the onset of the diosrders until today”, the categories were chronologically aligned. Furthermore, along with the classification of living places, the categories representing each classification were connected to create concept categories. Since this shed light on the internal characteristics of the participants classified by their living place, I changed the denotation of each classification from designation by living place into designation by internal characteristics.

“*Escape-from-society type*”: The user has been hospitalized several times or over ten times

[12] The total amount of data was 312,544 letters (196 pages of 1600-letter writing paper), and 751 codes, 18 concepts, and 5 categories were generated.

and has already been committed to the hospital for an extended period of time, or is expected to stay for long periods of time although his or her length of stay at the time of the survey had been relatively short[13]. This type of users cannot find a place to live other than the hospital, and thus have no clear idea of when they can leave the hospital. Participants included men and women in their twenties to fifties, who were unemployed. Between initial hospitalization and re-hospitalization, the user stays at home with his or her parents for a short period of time, but later moves to a facility such as a group home due to rejection by family members. For a while after having the disorder, the user wants to leave the hospital and go back home; however, they eventually lose hope for hospital discharge as he or she is faced with rejection from his or her family. Even when symptoms improve and the user is discharged, the user repeatedly comes back to hospital care after several months or about a year, and gradually wishes for continued stay in the hospital.

"*Unstable-at-present type*": After leaving hospital, the user continues to go to the day care center that was attached to the hospital for an extended period of time. This type involves the largest number of participants among the three types, including men and women in their twenties to sixties, some out of employment, some working part time, and some currently seeking a job. This type of users are not content with their current life of only going to day care, but are seeking a "place to belong" outside of the hospital facility. Some try to work part time, etc., but encounter new setbacks and return to day care-only life, and are unable to find a "place to belong" other than day care.

"*Self-acceptance type*": Like the *unstable-at-present* type, users of this type continue to go to day care but is or was able to find a "place to belong" other than day care, and is content with their current life. The number of participants of this type is the smallest, and includes men and women between their forties and seventies who were out of employment or working part time at the time of the survey.

Finally, I considered the relationships between concept categories by focusing on what kind of "place to belong" the hospital and day care are regarded as in each classification. As a result of that, a turning point of "Can I adjust to the discharge destination?" emerged between the *escape-from-society* type users, who stay in hospital, and those of the *unstable-at-present* type, who live by going to day care. In order for the participants living by going to day care to shift to the *self-acceptance* type, it became clear that there is a turning point of "Can they find a place to belong other than the hospital/day care facility?"

The above analysis results are put together in Figure 3. Concept categories A-E are the integration of multiple concepts representing the characteristics related to recovery of persons with schizophrenia in each pattern. The horizontal axis indicates passage of time, and the types

[13] The length of stay in hospital is roughly 10 years or more. There were users who had stayed in hospital more than 30 years as a result of adding all periods of hospitalization.

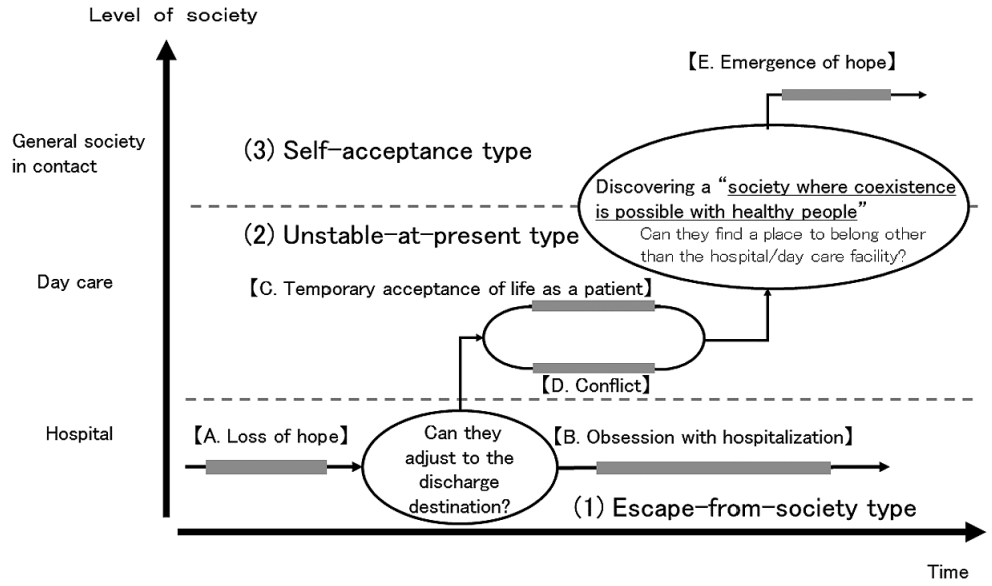

FIGURE 3. Recovery pattern and process in accordance with primary living place after onset of the disorders

of patterns were narrowed down to three in the end. The words in the ovals indicate that these occurrences are a junction point for processes that will happen after that point. In the next section, I will provide an explanation regarding the process of shifting to the *self-acceptance* type, which serves as a bridge to social reintegration by using concept categories, concepts and codes.

3. The process from "Loss of hope" up to "Emergence of hope"

3.1.【A. Loss of hope】: The starting point of the concept category

Firstly I am going to describe the concept category【A. Loss of hope】, which is common to all three patterns, then move on to【C. Temporary acceptance of life as a patient】and【D. Conflict】of the *unstable-at-present* type and【E. Emergence of hope】of the *self-acceptance* type[14]. For concepts of particular note, I will quote raw field notes[15]. After this, I will describe the relationships between the concepts and then explain each concept[16].

【A. Loss of hope】is a concept category that is common to all of the three patterns and appears between the time when the user has experienced his or her first hospitalization and the time when

[14] This study focuses on the *self-acceptance* type which would lead to social reintegration as well as the preceding *unstable-at-present* type. Also, due to limitations of space,【B. Obsession with hospitalization】was omitted.

[15] In order to protect the personal information of research participants, when citing from raw data, the portions not directly related to analysis were processed.

[16] Due to limitations of space, this study describes only the concept which was supposed to most affect the recovery process within the other concepts.

he or she is discharged from hospital with a vague prospect of a long-term discharge. This category consists of four concepts: [Blocked hope], [Hiding one's name or the disorder name], [Weakened awareness to adhere to social norms], and [Losing necessity to become an adult]. I will discuss the three concepts that are in preliminary states before becoming the central concept. Under [Blocked hope] come the other three concepts. [Weakened awareness to adhere to social norms] brings about [Losing necessity to become an adult], and strengthens [Blocked hope] through interactions with [Hiding one's name or the disorder name].

1. [Blocked hope]

Individuals with schizophrenia experience, through their disorders, a feeling that they are no longer themselves. The pain of living every day after the onset of the disorder is manifested in such codes as 〈Life collapses completely due to the disorders〉 and 〈Visiting day care on a continuing basis is exhausting〉. Since they become incapable of taking care of themselves, once they have developed the disorders, they 〈cannot be satisfied with themselves〉 or their 〈pride is shattered〉. These individuals experience a collapse of self-esteem. The recovery of individuals with schizophrenia begins from here.

2. [Hiding one's name or the disorder name]

The negative feelings individuals with schizophrenia initially had toward psychiatric disorders before the onset of their own disorder rise to the surface, as they start receiving psychiatric service. This can be observed in the acts of persons with schizophrenia, e.g. 〈Choose not to put up their name plate sign〉 or making reference and demonstrative terms to refer to the psychiatric hospital or the disorders, even among users, a taboo.

[Hiding one's name or the disorder name] continues for a very long period of time, and does not completely go away even after the user has become positive and motivated toward life.

3. [Weakened awareness to adhere to social norms]

In hospital wards or day care centers, there are often people who do not fit into the ambient atmosphere or those who lack cleanliness and are 〈indifferent to their appearance〉— for example, individuals who wear clothes with copious stains without minding them at all. There are also users who ignore unspoken social rules, as observed by 〈Letting out spontaneous strange noises〉. However, for these individuals with schizophrenia, 〈No one takes notice when they make noise in the hospital〉 and few medical professionals and fellow users seem to alert them to their appearances or acts. This indicates that there is a deviation between the social norms inside and outside of the facility. Even if a user is dressed somewhat strangely, it does not readily do harm to him/herself or the people around the user. Therefore, it can be said the urgency associated with these irregularities is low, from the perspective of medical treatment. However, it has a significant representational function and causes a substantial impact on relationships with other people in society outside of the facility.

An interesting point is that medical professionals had already realized the gap between social norms in and outside of the facility, as observed by 〈There are certain behaviors that are

acceptable in day care but not outside of the hospital〉 or 〈There are concerns that the strange voices might be heard in the neighborhood〉, and thus these professionals act as a watchdog and keep an eye on users when they go outside of the facility. Though medical professionals discuss issues that arise from the misalignment of social norms in and out of the facility, they also believe that 〈Perhaps it is difficult to ask users for appropriate attitude〉 and end up merely monitoring the users' behavior outside of the facility. In this way, loosened norms are practiced within these facilities.

Hospitals and day cares also function places of respite. For the recovery of users, it might be effective to loosen in-facility norms as opposed to those outside of the facility. However, it is rarely observed that the level of these norms is elevated in conjunction with the recovery level of each user. Since persons with schizophrenia spend an extended time period under different norms from outside of the facility, it becomes more difficult to relearn external norms.

3.2. Turning point toward discharge

A while after hospitalization, when symptoms start to settle, the user reaches the turning point of "Can they adjust to the discharge destination?" as displayed in Figure 3. The user's trajectory after that point depends on whether the user's family is cooperative with home discharge, and in case the family refuses them, on whether the user can get rid of their obsession with home and accept discharge to a care facility such as group homes. Medical professionals listen to both the opinions of the user and his or her family, and, especially when the user wishes to be discharged back home while the family wants otherwise, medical professionals try to indirectly draw the user's interest towards a discharge destination other than home, by recommending that the user visit a group home. If the family is originally cooperative with home discharge, everything goes smoothly. However, if that is not the case, the user moves into a group home, lives by him/herself in an apartment, etc., or will essentially be socially hospitalized. Individuals with schizophrenia who fall into【B. Obsession with hospitalization】gradually come to regard the hospital as their only place to live, and express a desire for hospitalization by refusing discharge or by causing problems at his or her group home.

3.3. Concept category composing the unstable-at-present type

【C. Temporary acceptance of life as a patient】

The user reaches this category if they were able to find a discharge destination after passing the turning point mentioned in the previous section. This category consists of two concepts, namely, [Talking triumphantly about past experiences and accepting the patient label] and [Temporary security]. The former is based on "Accepting the patient label", which is described in the next section, and the latter concept of [Temporary security] is developed among users who accept the patient label. The two concepts are linked to each other through the aspect of temporarily accepting to live as a patient.

1. [Talking triumphantly about past experiences and accepting the patient label]

This concept is composed of the codes 〈Transferred from a detention center to the hospital in an armored vehicle〉, 〈Users bragging about their experience of having been placed in a detention center〉, and 〈Saying out loud that the people coming for day care are patients〉.

In general, users do not talk about matters related to their disorders, such as the diagnosis or details about their treatment, at the hospital. Users keep silent, or conduct "passing" (Goffman, 1963: Translation 81), since talking about their psychiatric problems could lead to "losing trust (if they reveal details)" as referred to by E. Goffman.

However, there is an exception to this. When talking about one's experience of an arrest, or detainment at the time of hospitalization or of the onset of the disorder, the user places emphasis on how incredible his/her experience was, and the rarity of the experience and the individuals' bravery is competed against one another and made into a heroic story. This story can only be established if both the speaker and the listener accept the label of "patient". If either of them is in denial of being referred to as "a patient", this kind of experience does not become a topic of conversation[17]. Therefore, it can be considered that users who were able to accept the patient label for some reason or other will begin to talk about their heroic experiences.

The [Temporary security] in the next section begins when these individuals start questioning their life of going back and forth between day care and their home.

2. [Temporary security]

For both of users and medical professionals, 〈Coming to day care is a sort of social participation〉 and it is regarded as something significantly better than being confined to one's house. However, both sides share the same perspective that merely going to day care does not imply "social reintegration". It is a common perception among users that 〈Social reintegration is strictly bound to employment〉; however, "social participation" is 〈something loose〉 with no specific conditions that define it. Therefore, users who are not employed and go to day care every day 〈feel impatient and insecure about leading a life of merely going to the hospital and day care〉 and cannot be satisfied with their current situation.

To users who have felt kind of anxiety, fellow users and medical professionals exhort the importance of staying in their current situation, saying that 〈Users should be praised for continuing to come to day care rather than be criticized about being unemployed〉. Meanwhile, although it is uncommon, there are some users who voice an objection against this advice in front of medical professionals and other users in this way: 〈It's hard to think that there is much value in continuing to come to day care〉. To this opinion, it is observed that people, including medical professionals, around these individuals do not show any reaction but to fall silent. As a result of this strategy of praising users for coming to day care and "going silent" against opposition, it

[17] This acceptance of the patient label is not equal to what is called "awareness of being ill". Because, for instance, a man, at the onset of his illness, explained the action of 〈hitting his boss's wife〉 in totally different spheres from his illness, and thus it is considered he was not aware he had been ill when he took that action.

was observed that these particular users ceased to voice impatience or dissatisfaction for a while after receiving this brand of treatment. These user lead lives at the day care center along with other users and medical professionals without making any waves. However, they remained in the state of "social participation", and missed opportunities to advance to the "social reintegration" stage.

Mr. D (psychiatric service user): I have been in day care for four months now, but I recently feel worried, if it's OK to continue like this. I went to the hospital, and then came here (day care). Didn't even get a job. Sometimes thoughts like that fill my mind and make me wonder what I should do.

Medical professional: Ms. E, do you have any advice for Mr. D as someone who has started living by yourself?

Ms. E (psychiatric service user): Well, he just said it's been four months since he started to come to this day care center […] first of all, I'm impressed and amazed that he's continued to come to day care for four months. I think it'd be good for him to think in those terms.

Medical professional: Those were nice words, Mr. D. Thank you for the good advice, Ms. E.

Then Mr. F, in a self-deprecating tone, begins talking:

Mr. F (psychiatric service user): He said he keeps coming to day care, but, on my part, I don't understand why I come to day care, myself. […] One day after several years (after voluntary hospitalization), my wife came to see me with divorce papers, so I signed them as requested. […] Then, in the same flow, arrangements for my move to day care were made, so I really don't know why I'm here.

No one responds to Mr. F. (FN at K Hospital: August 25, 2006)

Scenes like this lead us to the following interpretation: Medical professionals, of course, value employment more highly than day care; but hasty attempts toward employment pose significant difficulties. However, if medical professionals publicly admit to this, it may lead to the worst case scenario in which users would stop coming to day care and confine themselves at home and have their symptoms deteriorate. It could be the case that because medical professionals face these dilemmas, when users express negative opinions about coming to day care, they are unable to provide a clear opinion and instead try to keep these negative opinions from being shared among users by means of silence. To users who have felt anxious and felt that they should perhaps go somewhere other than day care, the only advice left is to say "Let us praise the current situation". This advice is considered to provide provisional relief, namely temporary security.

People with schizophrenia go back and forth between【C. Temporary acceptance of life as a patient】and【D. Conflict】, which is mentioned in the next section. However, if they can free themselves from this stage, they can advance in their recovery process to the *self-acceptance* type.

3.4. Concept category composing the unstable-at-present type

【D. Conflict】

Individuals with schizophrenia within this concept category are leading a stable life after discharge but are dissatisfied with as well as anxious about their current situation, where they have no choice but to keep going back and forth between day care and their home, and have doubts regarding their current way of life. This category includes four concepts: [Challenge for employment and hiding the disorders], [Seeing day care as a workplace], [Romance is a never-reaching dream] and [Living just to get older]. The last one is the consequence of the first three concepts. Here, I will only discuss first and main concept.

1. [Challenge for employment and hiding the disorders]

Individuals with schizophrenia who wish to escape from the loop of day care and home try to temporarily accept their situation through the above-mentioned【C. Temporary acceptance of life as a patient】. However, they are not able to positively accept their status of being taken care of by their parents or tax money, and regard their situation as: 〈I am hopeless compared to other people in their twenties〉. Furthermore, in the case that their parents are their supporters, family members are also anxious about the individuals' future because of their unemployed status, and recommend that they get a job. At that point, individuals with schizophrenia rekindle their wish that 〈I want to live by myself and work〉 and think 〈I want to distance myself from places to which people with psychiatric disorders come〉. These individuals then try to get a job and seek a place where they can mingle with "healthy people" as a means of escaping from day care.

Meanwhile, since these individuals 〈do not have confidence regarding working〉, in order to secure a safety net in case of failure, they explain their motivation of getting a job to medical professionals this way: 〈I am going to get a job because my parents tell me to, to get real-world experience〉. Therefore, in consideration of the fact that initiative to work which is not based on the users' own will could be highly stressful and is likely to deteriorate their conditions, medical professionals 〈advise to users that their wishes be prioritized over their parents' wish〉, as well as 〈recommend that users listen to their doctor's opinion first before beginning job hunting〉. They also advise that 〈You should be careful when starting job hunting〉, and take a somewhat passive attitude toward job hunting.

〈Wanting to get a job while hiding the disorders〉 reflects the fear of suffering a disadvantage in case their disorders are revealed during job hunting or at their workplace, as well as being gripped by a negative awareness toward their own disorders. However, they also simultaneously wish that people around them would regard their disorders in a positive way light, observed in 〈I would be happy if people regard my psychiatric disorder as an individual characteristic〉. Also, in order to recover self-esteem, users eventually attempt to remove the negative awareness that other people might have toward people with psychiatric problems by 〈making appeals that "people with psychiatric disorders" are ordinary people〉. However, at the【D. Conflict】stage, this wish never surpasses the negative awareness toward their disorders.

Moreover, to users who 〈fear their disorders might be revealed at work if they carry a disability certificate〉, medical professionals 〈try to convince them that their disorders will not be known to their employer merely even if they carry a disability certificate〉. Medical professionals, based on their support policy of respecting the users' own will, leave it up to the individual as to whether they disclose their disorders to others or not. Consequently, individuals with schizophrenia choose to get employed while keeping their disorders concealed. However, this forces them to pretend to be or concoct stories to show evidence that they are also "healthy people" at their workplace. That leads them to fear even more that their disorders might become known to other people and leaves them no choice but to self-affirm that they can never be "healthy people".

Mr. G (psychiatric service user): [...] I guess a lot of stress had piled up. I'm here because I thought I should come to see a doctor. After all, it's tough to hide my disorder (at the work-place where I work part time). […]
(FN at K Hospital: December 8, 2006)

Due to fatigue from hiding their disorders, as well as disappointment in themselves, these individuals quit their jobs and return to day care to rest. Their recovery process does not develop further than life as a "patient".

3.5. Concept category of self-acceptance type【E. Emergence of hope】

Individuals in this category are similar to those of the *unstable-at-present* type in that they go to day care for long periods of time, but different in that they have found a place to belong outside of day care. This category consists of concepts which indicate that the indivisuals are satisfied with their current daily lives as well as life as a whole, and have hope because they have found a place to belong. These concepts are: [Positive evaluation by people other than the 'wise'[18] and a breakthrough to self-acceptance], [Recognizing oneself as an ordinary citizen], and [Wanting to enjoy the rest of their lives]. The first concept triggers the second concept, and the third concept is positioned higher than the other two.

1. [Positive evaluation by people other than the 'wise' and a breakthrough to self-acceptance]

This concept indicates that positive evaluation by a third party other than medical professionals and family members serves as a trigger for persons with schizophrenia to regain self-esteem. This includes not only work-related experiences such as 〈Worked part-time for three years〉 or 〈Became the top in the employment test〉, but also successful experiences like quitting smoking which works as a trigger to recover confidence as observed in 〈Boasting of successfully quitting

[18] Here, the 'wise' indicate medical professionals and family members, and I adopted Goffman's term to as a word to mean these people. Wise persons are "the marginal men before whom the individual with a fault need feel no shame nor exert self-control" (Goffman, 1963: Translation 55).

smoking to a field worker〉. This is because working or quitting smoking are actions that are recognized by people who make assessments without regard to disorders, not by those who positively evaluate individuals with schizophrenia by setting their disorders aside, i.e. medical professionals and family members (= the 'wise').

It may seem that there is a big difference between working and quitting smoking, but it is considered that "evaluation by people other than the 'wise'" brings forth a breakthrough for persons with schizophrenia to accept their present self as someone with a disorder. Based on this breakthrough, [Recognizing oneself as an ordinary citizen] arises.

2. [Recognizing oneself as an ordinary citizen]

Persons with schizophrenia go through a stage of "accepting the patient label", then come to recognize themselves as "ordinary citizens"[19]. This recognition is considered to be based on the confidence gained from positive evaluation by people other than the 'wise', as observed in 〈Though I have a disorder, since I am working, if only a little bit, I am not a patient but an ordinary citizen〉, as well as a sense of security that they have a place where they can get this type of positive evaluation.

Ms. I (psychiatric service user): Although it's only one day a month, I AM working, so I want to be seen as an ordinary citizen even if I do have a disorder. (FN at K Hospital: October 13, 2006)

Because of this confidence, unlike the users of the *unstable-at-present* type, for the users of this category, the disorder is no longer a factor for viewing themselves in a negative light, as seen in 〈I want to be seen as an ordinary citizen〉. Eventually, this turns to 〈announcing that one is schizophrenic〉, at which point the obsession towards the disorder is no longer observed.

Owing to this "awareness of being an ordinary citizen", it can be considered that persons with schizophrenia gain a new perspective of themselves; that, instead of merely being someone with disorders, they are someone who is going through a life like no other. These individuals can then move through their recovery process while incorporating their experience of disorders into their being.

3. [Wanting to enjoy the rest of their lives]

Individuals with schizophrenia, who have come to incorporate their disorders into their perceptions of self and regard their lives positively, have succeeded in finding new meanings in life and in having hope. This concept includes 〈It's a miracle that I've recovered so much〉 and 〈Although I have become this old, I want to start enjoying life because I was able to recover so much〉, in which we can see a positive attitude towards trying to make their present life meaningful while carrying their disorders.

[19] The term "ordinary citizen (Seikatsu-sha)" is in use in the field of disability studies as well as rehabilitation. However, its definition or concept has not been specified (Kojima and Okuno ed., 1994). It is unknown where the participants of this survey acquired this term.

4. The place to belong connecting recovery process and social reintegration —From a relevancy-based place to "society where coexistence is possible with healthy people"

The following has been examined concerning the role of a place to belong in the recovery process, by analyzing the recovery process of persons with schizophrenia using the GTA. Additionally, it is assumed that this study could show, as a case study using GTA, corresponding points between the QDA software and the methodology, as well as the procedure for story creation from data which is susceptible to becoming opaque by describing, if not all, the analysis process.

Persons with schizophrenia were aspiring to regain their self-esteem and a "place" in which they could base their living that was lost due to long-term hospitalization and their label as a schizophrenic. These users were looking for this "place" in many places. Initially, when their symptoms settled, they thought that this "place" should be their home where they had been living. However, there was no longer a place to belong at home. When there was no one but the medical professionals at the hospital who would extend their hand, they replaced this "place" with the hospital, and shifted to the *escape-from-society* type.

Persons with schizophrenia gained a new "place to belong", at home once they were discharged under positive cooperation by family members or at day care center, and once they discarded their attachment to home and accepted discharge elsewhere. However, just attending day care provides little chance to mingle with people other than the 'wise'. This means that these individuals are unable to acquire a more meaningful life rather than life as a "patient". Here, some users think that it is indispensable to reintegrate themselves into society to create their "place" within the society of "healthy people", and consider it necessary to show other people that they are "close to healthy people" in order to join the society of "healthy people". As a means to accomplish this, they conducted passing of information related to their disorders. However, these individuals gradually start realizing that they are not able to adapt themselves to the culture of society constructed by healthy people, and they have no option but to withdraw. It was the *unstable-at-present* type users who could not find a "place" other than day care. It seems fair to say that there is a "functional limit in Ibasho (a place to belong)-type day care" (Nakagawa et al., 2011:7), as pointed out by Nakagawa et al. The reason why medical institutions are not able to lead persons with schizophrenia from the recovery process to social reintegration is perhaps because these places consist only of users and the 'wise'. Persons with schizophrenia are accustomed to rules that apply only within the medical institution, so they cannot readily adapt to social norms outside of the medical institution. Furthermore, there are medical professionals and fellow users who consider it alright if progress of users stopped at the social participation stage where they mingle only with the 'wise', rather than trying to find a job by taking a risk of recurrence of the disorders. It can be said that existence of medical professionals

and users like these is one of the factors that hamper the recovery process of persons with schizophrenia who want to have free exchange with healthy people.

On the other hand, the rest of the users who successfully reached the *self-acceptance* type were not obsessed with the ideal of getting closer to healthy people (Figure 1) or getting together only among peers and the 'wise'. Rather, they found a "place" or a "society where coexistence is possible with healthy people". That is a place where persons with schizophrenia can mingle with healthy people while admitting each other's differences, and where persons with schizophrenia can regain confidence through these exchanges. Because this society includes others who do not fall under the 'healthy' category, the level of necessity for hiding their disorders from others is lower. Therefore, individuals worry less about disclosing or not disclosing their disorders and can stay within this society for long periods of time stably, which can be considered to reduce negative awareness towards the disorders and allows persons with schizophrenia to find a new hope in life and go through the recovery process. For people who follow the *self-acceptance* type path, this "society where coexistence is possible with healthy people" is the "place" they have been looking for so that they can lead a stable life[20]. The "society where coexistence is possible with healthy people" observed in this study's survey includes care support centers where persons with schizophrenia are registered as peer helpers, the NPO-hosted Renku Couplet Circle where local residents who are not medical welfare specialists can come as volunteers, and the workplace where they work part-time with people who assess their performance without regarding the fact that they are suffering from psychiatric disorders. It seems reasonable to call this a situation in which healthy people can share the same place with persons with schizophrenia without requiring them to behave similarly to healthy people. The very finding of the "society where coexistence is possible with healthy people" is considered to accelerate individuals' recovery and transition them to social reintegration. As illustrated here, living side-by-side with so-called ordinary people in the community blurs the line between "healthy people" and "people with psychiatric disorders". This is thought to allow persons with schizophrenia to remove their obsession to compare healthy people with themselves and begin to have hopes for trying to find a job at their own pace as well as trying to live in the community. Perhaps sharing this concept of "society where coexistence is possible with healthy people" throughout the entire society will support not only the community life of persons with schizophrenia but also the process of their social reintegration.

[20] Since healthy people and people with psychiatric disorders are not actively differentiated in the "society where co-existence is possible with healthy people", it is inherently different from a place for fostering "disability culture in which the disability is considered one's greatest identity" (Ishikawa and Nagase ed., 1999: 23).

Acknowledgements

I would like to extend my heartfelt gratitude to everyone who provided cooperation for conducting the survey of this study.

In addition, I am grateful to Ms. Manami Shirano, the research assistant at Research Support System at Osaka University, for her assistance in editing the translation of this article.

References

Anthony, W.A. (1993). "Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s," *Psychosocial Rehabilitation Journal*, 16(4): 11–23. (Translated with notes by Hamada R., 1998, *Recovery from Mental Illness—The Guiding Vision of the Mental Health Service System in the 1990s*, 2(2): 145–154)

Geoff, S. (2010). "The Concept of 'Recovery': Implications for the organization and delivery of mental health services." (Ogawa K., K. Hasegawa, et al., tr., 2010, *Concept of "Recovery": Establishing of Mental Health Service and Meaning of Provision—Trends of psychiatric care reform and psychiatric care in UK" "Clinical psychiatric care*, 39(2): 165–179)

Glaser, B.G. and A.L. Strauss (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*, Chicago, IL: Aldine Publishing. (Translated by Goto T., H. Oode and S. Mizuno, 1996, *The Discovery of Grounded Theory—Strategies for Qualitative Research How to produce a theory from a survey*, Shinyo-sha)

Goffman, E. (1963). *Stigma: Note on the Management of Spoiled Identity*, Englewood Cliffs, NJ: PrenticeHall, Inc. (Translated by Ishiguro, 2001, *Stigma: Note on the management of Spoiled Identity (rev.)*, Serika Shobo)

Hamada, K. and Y. Tsutsumi (2010). *Kokoro no yamai wo motsu hito no chiiki ni okeru ibasho to kokoro no yoridokoro no kakutoku no jittai (Actual Condition of Creating a Place to Belong (ibasho) and Subsequent Gaining of Self-Motivation in Mentally Challenged)*, *Journal of Japan Academy of Psychiatric and Mental Health Nursing*, 19(2): 22–32.

Ishikawa, J. and O. Nagase ed. (1999). *Shougaigaku eno shoutai: shakai, bunka, disuabiriti (Invitation to Disability Studies: Society, Culture and Disability)*, Akashi Shoten.

Kato, M. (2009). *Seishin shougai no aru hitobito no jiritsu seikatsu: Toujisha sosharu waka no kanousei (Independent Living of Individuals with Mental Disorders: Possibilities of Peer Social Worker)*, Gendai Shokan.

Kinoshita, Y. (2003). *Guraundeddo seori apurochi no jissen: Shitsuteki kenkyu eno izanai (Practicing the Grounded Theory Approach: Invitation to Qualitative Research)*, Kobundo.

Kojima, Y. and N. Okuno. ed. (1994). *Shin shakai rihabiriteshon (New Social Rehabilitation)*, Seishin Shobo.

Ministry of Health Labour and Welfare (2011). *Heisei 23 nen, kanjachousa (Japan National Health*

and Nutrition Survey 2011), Vol. 2, Dai21 pyou: Taiin kanja heikin zaiin nissuu (Kanja juusho hoka), Todoufuken x Shoubyou bunrui x Byouin—Ippan shinryoujo betsu (Table21: Average length of stay of discharged patients (per month) (place of residence of patient) by prefecture, classification of diseases, and hospital/general clinic) (http:www.e-stat.go.jp/SG1/estat/List.do?lid=000001103074, Obtained August 8, 2013)

Nakagawa, M., K. Obinata and H. Kuranishi (2011). *Menbaa no katari ni miru "Ibashogata deikea" no igi to kadai (Significance and Issues of "Ibasho-Type Day Care" Observed in Members' Remarks), Practical Study on Day Care*, 15(1): 3–7.

Japanese Society for Social Psychiatry ed. (2009). *Shakai seishin igaku (Japanese Bulletin of Social Psychiatry)* Igaku-Shoin.

Nomura, S., T. Higuchi and N. Ozaki ed. (2009). *Hyoujun seishin igaku (Standard Textbook (4th Edition))*, Igaku-Shoin.

Sato, I. (2008). *Jissen shitsuteki deta bunseki nyuumon: QDA sofuto wo katsuyou suru (Introductory Practical Qualitative Data Analysis—Using QDA Software)*, Shinyo-sha.

Ukigaya, S. (2009). *Kea to kyoudousei no jinruigaku: Hokkaidou Urakawa sekijuuji byouin seishinka kara chiiki e (Anthropology Based on Care and Cooperativity—From Psychiatric Ward of Urakawa Red Cross Hospital in Hokkaido to Local Regions)*, Seikatsushoin.

Tanaka, J. (2009). *Seishin hoken fukushi ryouiki ni oite rikabari gainen wo mochiirukoto no igi to kadai: Tasha tono deai ni mukete (Implications of and issues in the concept of recovery in the field of mental health: For encountering the Other), Social Issues Research*, 58(137): 171–184.