THE LEARNING AND EMPOWERMENT
of
PEOPLE WITH SCHIZOPHRENIA

by

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These days more and more schizophrenic people are being "mainstreamed" into society. This change in perspective has numerous implications for public policy, mental health services and families but, most importantly, for schizophrenic people. They have to "learn" how to live in the community and "normal" people have to adjust to and learn about schizophrenic people. Learning is a corollary of empowerment and it has become necessary to understand the subjective experience of schizophrenics.

The purposes of this study were to interrogate Saljo's developmental model of learning conceptions from the perspective of schizophrenics, and to analyze the interrelationship between schizophrenic conceptions of learning and elements of empowerment. The researcher employed a qualitative methodology and interviewed ten men and ten women (n=20) with schizophrenia living in Vancouver about how they learn to survive with respect to six dimensions of living - housing, income, social support, work and education, leisure, mental health services. Saljo's model of learning conceptions and Davis' model of empowerment were operationalized to provide a framework within which to analyze the twenty transcripts. After the interviews were transcribed the author highlighted and analyzed excerpts concerned with learning and empowerment.
Three procedures were used to examine the validity of the researcher's judgments pertaining to the transcripts and the researcher's final interpretation of the data.

At the centre of this study was the notion that learning is a corollary of empowerment. The author found limitations within the two chief heuristic devices employed in this study (Saljo's conceptions of learning and Davis' elements of empowerment). Nevertheless, the twenty schizophrenics seemed to go about learning much like so-called "normal" populations. However, the same could not be said about empowerment. All felt significantly disempowered by the schizophrenic experience and an entire chapter was devoted to analyzing "subjective" and "objective" constructions of schizophrenia made by macro-level "authors" (e.g. government), macro/micro level authors (e.g. mental health services) and micro-level authors such as citizens on the street. It was concluded that disempowerment and marginalization result more from the way "normal" people construct schizophrenia than from the psychological disorganisation of the schizophrenics themselves. In future, it would be desirable to approach this problem from a critical perspective that focuses on the context as much as or more than the individual.
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CHAPTER ONE

THE PROBLEM

Introduction
Living in the community is a way of life that most take for
granted. For others, it is a painful, challenging,
threatening and stressful experience. People with mental
health problems are one of many groups whose ability to
survive in the community is challenged on a regular basis.
This is not a new phenomenon but has become a pronounced
focus of media attention. Those deemed "mentally ill" are
learning that they have a voice and there appears to be a
national consensus that "something should be done" about
street people and "mental patients" released from hospitals.
For example, Canada's national newspaper, the Globe and Mail
dedicated two pages to mental health stories in the March 6,
1993 edition (Appendix A). Part of this issue involves
schizophrenics attempting to survive in the community.
Their needs are complex and the community response confused.
There are no easy answers and much depends on the
perspective from which the issue is viewed.

The traditional psychiatric view considers most "serious
mental illness" the result of biological rather than
environmental factors. The underlying ideology is that
"mental illness" is located within the individual rather
than in the social context inhabited by the individual.
Accordingly, "mental illness" is seen as an antecedent of an inability to survive in the community. Many people in the community would tend to disagree. While acknowledging that some individuals experience difficulties following the onset of mental health problems, one cannot dismiss the debilitating effects of the "community response" to their situation. For many, it is the reaction and surveillance of the community that is the greatest source of pain.

Few Canadians realize that an estimated one in five people are affected by a mental health problem some time during their lifetime. Of these, one in eight will be hospitalized for a "mental" problem. This study is about schizophrenics living in the community. This chapter will introduce the reader to the challenges faced by people with schizophrenia and the focus of this study.

Mark was a healthy, happy, athletic 19 year old who seemed to have everything going for him. He was looking forward to writing his final college exams and then becoming a fireman. During his college years, he had worked part-time at a lumber mill. He had lots of friends, a loving family and recently had become involved in his first intimate relationship. It seemed so sudden and out of the blue when Mark’s employer called police and ambulance one Saturday as Mark was standing on a sixth storey window ledge wanting to demonstrate that he could fly. Because his boss was wearing
number one on his shirt, he believed his boss to be God and himself to be Jesus Christ. He could hear God talking and controlling his mind. He wasn’t afraid even when God was telling him to hang himself.

Mark’s difficulties were not as sudden as they seemed. He had been experiencing some of these symptoms for several months. Mark later spoke of attempting to deny or rationalize why he was hearing voices. When the voices didn’t go away, he attempted to hide their occurrence because deep down, he suspected what it meant. Mark had a schizophrenic uncle down in the skids, walking and mumbling to himself. Mark had watched his uncle deteriorate over the past ten years and didn’t want to end up like him. But in this case these thoughts did not persist. The situation was easily resolved with breathtaking simplicity, by suicide.

Schizophrenia is a pervasive phenomenon that affects one percent of the population. In general terms, it is a withdrawal disorder where the individual appears to move farther and farther away from their environment. The cause is still unknown but researchers believe it has a biochemical and/or genetic basis. Stressful life events are frequently associated with the onset and exacerbation of "symptoms". Approximately ten percent of schizophrenics commit suicide before age 30. Some are said to "recover" but others live a tortured life as they watch dreams turn
into remote memories of what could have been. Researchers have found ways to alleviate some of the symptoms but much more is required for this population.

A Changing Perspective

In the past, individuals diagnosed with schizophrenia were sent to institutions. Many lived out the remainder of their lives in isolation from the world. This segregation resulted from the stigma applied to schizophrenic people and fear that resulted from a lack of knowledge concerning them. These institutions also fulfilled a number of societal needs, the most salient of which was social control - the maintenance of order (Sarbin, 1991). These individuals were viewed as "insane", "crazy", or "wild" and deemed incapable of caring for themselves. Prior to the introduction of antipsychotic medication, schizophrenic people were physically restrained, either tied to beds or placed in locked rooms and submitted to appalling medical and surgical treatments whose main objective was social control. They were made into the "contaminated other" (Foucault, 1973) and kept well away from "normal" people who preferred not to have to engage with their "craziness". Surveillance and discipline was an outgrowth of "othering".

Earlier medications put them to sleep but did not control the symptoms. It controlled unacceptable and acceptable behaviour. It became a semi-conscious way of life.
Antipsychotic medication reduced symptoms for many but produced numerous other physical effects, some now known to be permanent. Individuals took on a zombie-like appearance. They did not appear able to care for themselves despite a lack of obvious psychotic symptoms. Fortunately, dedicated individuals continued to attempt to understand schizophrenia.

In recent years, a change in perspective has led to a tendency to "mainstream" schizophrenics into the community. There is a crisis in health care funding. An increasing emphasis has been placed on treating people in the community as a more economical means of preserving a financially stressed health care system. It has become too costly to maintain large institutions. Others question the "benefits" of such institutions. Critics like Illich (1977) have highlighted iatrogenesis, ailments induced by health systems. In other fields, architects, psychologists and others have shown how institutions, by their very existence, damage the physical and psychological health of the occupants (whether school children, workers, prison inmates or psychiatric patients). Foucault’s (1973) treatise on "madness" has had a significant impact and is often "blamed" for the current emphasis on deinstitutionalization.

The last three decades have brought about "improved" treatment modalities such as psychopharmacology and support
services that are said to enhance an individual’s ability to survive in the community. Schizophrenics, no matter how marginalized, are slowly being viewed by the rest of society as having a voice and entitled to the same rights as everyone else. Advocacy groups have helped press their rights. Finally, through education, the public’s awareness concerning the pervasiveness of mental illness has increased. Fears, myths and stigma associated with "mental illness" persist but are gradually being reduced. Today, most individuals diagnosed with schizophrenia are living in the community.

**Moving Towards A Community Focus**

In the mid 1980’s, the Government of British Columbia implemented the Mental Health Initiative. The focus of this document was to move individuals with mental health problems out of institutions and into the community. This initiative had enormous implications for schizophrenics. Riverview Hospital, British Columbia’s Provincial Mental Health Facility, once housed over 3000 people. At one time, the facility was self sufficient and a community in its own right. By 1993 the facility was treating approximately 800 individuals with plans to downsize even further in the near future.

Many schizophrenics have spent most of their lives in institutions which did not prepare them for life in the
community. In hindsight, the facility that was supposed to treat these individuals did more to impede them. It fostered dependency, a lack of confidence in personal abilities and generally disempowered an already marginalized group of people. Now, schizophrenics are suddenly expected to survive in the community after living in a structured, predictable environment. The change in perspective was necessary and timely. But extensive community support services were needed to assist these individuals with the transition. By 1993, the needed support did not exist.

Community mental health services in the City of Vancouver are provided by general practitioners, private psychiatrists, private psychologists and counsellors, hospital outpatient departments, a forensic clinic and nine mental health teams. There are a few advocacy and support groups to assist these individuals. There is minimal decent housing allocated to people with mental health problems. Demand far exceeds the available services. Those services already in existence were operating at maximum capacity prior to deinstitutionalization. Somebody apparently expected they could provide service to an even larger population. This was unrealistic. Funding is slowly increasing but not nearly fast enough to assist schizophrenic people faced with the stressors of daily life.
Schizophrenic people tend to migrate to larger cities like Vancouver where there is a chance they will secure access to services not available in rural communities. Many live on the streets, in cockroach infested buildings or in the skids. Some go to jail. Most collect welfare or a small pension that barely covers (or fails to cover) essentials. The thought of working or going to school becomes a broken dream. They are isolated by stigma. It is exceedingly difficult for these people to find a place with a minimal level of psychological and physical comfort.

Canadians may be thinking about the probability of acquiring HIV/AIDS, being hit by a drunk driver or felled by cancer. Most are blissfully unaware of the fact that many people have an excellent chance of being hospitalized for a psychiatric problem. Indeed, of the approximate twenty percent of Canadians that develop a psychiatric problem in their lifetime, one in eight will be hospitalized for that reason. Unlike heart disease and cancer, schizophrenia is largely ignored. For every person with cancer, about $400 is spent on research. For every person with schizophrenia, about $11 is spent on research (British Columbia Schizophrenia Society, 1992). The way a society treats "mentally ill" people is often cited as an index of its humaneness or maturity. Vancouver is considered an "innovator" in community mental health care in North
America. Despite this, many schizophrenics live a marginal existence.

It is essential that schizophrenics empower themselves and, as far as possible, become less dependent upon mental health services. Ironically, this idea is also very appealing to policy-makers desperately seeking ways to reduce the enormous expenditures of public money on health care. Learning, irrespective of how it is construed, is an essential prerequisite to and corollary of, empowerment. It is the mark of a humane and civilized society to learn about and assist its most tortured citizens who, through no fault of their own, live in a bewildering world of delusion, hallucination and social isolation.

**Empowerment and Learning**

The concept of empowerment has been applied to a wide variety of phenomena - the women's movement, the Black power movement, gay rights, people with AIDS, aboriginal peoples, to name a few. But what does it mean? Empowerment is difficult to define. It is easier to say what it is not: powerlessness, helplessness, hopelessness, loss of control over one's life, victimization, subordination, oppression, paternalism and dependency (Gibson, 1991). It is difficult to define because its meaning varies for different people and contexts (Rappaport, 1984). However, despite difficulties, there appears to be agreement that empowerment
is a transformation from an initial sense of powerlessness (Rappaport, 1984). Powerlessness combines self-blame, a sense of generalized distrust, a feeling of alienation, economic vulnerability and a sense of hopelessness in socio-political struggles (Kieffer, 1984). It follows that empowerment is the opposite of powerlessness. Hence, an empowered person is confident in their abilities to meet their own needs, solve their own problems and access resources which create a feeling of control over their life. Schizophrenic individuals experience a profound sense of powerlessness and loss of control over their lives. Empowerment is not an object to be given to someone.

Davis (1989) suggested that there are five elements to the empowerment process:

1) self-efficacy
2) accessing resources, knowledge and skills
3) authority and enablement
4) critical consciousness
5) multi-dimensionality.

These "elements" are further elaborated in Chapter Four however what appears to be implicit in these and the literature on empowerment is the notion that learning is a key factor. Saljo (1979) described five conceptions of learning differentially held by individuals:

1) a quantitative increase in knowledge
2) memorizing
3) the acquisition of facts, methods, etc. (sic) which can be retained and used when necessary
4) the abstraction of meaning
5) the interpretative process aimed at understanding reality.
These "conceptions" are explored further in Chapter Three. The author became aware when reviewing literature on schizophrenia research that there had been numerous studies related to cognitive ability, attitude and insight and compliance with treatment regimens. There had been few attempts to examine learning from the subjective viewpoint of schizophrenics. Most studies appeared to be impelled by an ideology of adaptation where there was a desire to "fit" the schizophrenic into "mainstream" society. This ideology of adaptation can also be seen in programs wherein schizophrenics "learn" assertiveness, stress reduction techniques and problem solving skills.

This study was informed by a more radical "change-oriented" agenda. It will not suffice to simply "fit" schizophrenics into what they perceive to be a fairly hostile and prejudiced society. Instead, they must learn to accomplish daily tasks but also organize to change their place within society. In the language of Burrell and Morgan (1979) what’s required is a "sociology of change", not a "sociology of regulation". It is this kind of idea that lies at the centre of a "radical humanism" (p.32). Schizophrenics need to deal with concrete realities in their current situation and health-care professionals need to know more about how the world appears from their perspective.
People tend to think of schizophrenia in relation to "symptoms" - delusions, hallucinations, disordered conversation. This is "our" abstraction. The person's context is not trivial but essential to understanding the meaning and nature of schizophrenia. If we avoid talking to schizophrenic people about normal aspects of their functioning, about their views of how schizophrenia has affected their lives, then this data is systematically excluded from consideration. When one asks a person with schizophrenia how their life has been affected, a clear response will be obtained. These people are generally aware of the limitations schizophrenia has imposed. They also take on an increased sensitivity to the suffering of others (Strauss, 1991).

Readers will recognize that this ideological perspective is quite congruent with contemporary adult education theory. Adult education literature has stressed the need to become learner centred (Knowles, 1980). An emphasis on the learner's perspective respects the person for their individuality and experience. It enables the people to become equal participants in the teaching-learning process and leads to empowerment as people take control over this aspect of their lives. In recent years there has been a growing preoccupation with critical theory (Little, 1992) and an explicit focus on power relations in educational settings. Feminists, people of colour, prison inmates
(Morin, 1981), indigenous and other marginalized people (Welton, 1990) have fueled this development.

**Purposes of the Study**

Having regard to the foregoing, Fig. 1 details the three classes of variables that framed this project. This diagram portrays the hypothesized relationship between the three classes of variables studied herein.

![Diagram](image)

**Fig. 1** Hypothesized Relationship between Conceptions of Learning, Elements of Empowerment and Dimensions of Living.
Schizophrenics, like other citizens, are involved with five "dimensions of living" (i.e. housing, income, social support, leisure, work/education). For them to successfully live in the community, they must dismantle their dependency on institutions and the helping professions. In short, they must become empowered. However, to do so represents a formidable challenge and considerable "learning". Learning is a corollary of and prerequisite to empowerment. Mental health professionals must understand the complexities of these relationships.

Any diagram or model is only a reified representation of reality. In Fig. 1, the "dimensions of living" overlap, and rightly so, because in "real life" they are a complex mixture of daily challenges. Saljo's five conceptions of learning and Davis' five elements of empowerment have been used as templates with which to analyze the data. While it was beyond the scope of this study, it appears that the most empowered individuals (i.e. those who possessed nearly all of Davis' elements) would manifest the attributes embodied within Saljo's abstracting and interpreting conceptions. In other words, empowered people should think abstractly, interpret meaning and subsequently change their perspective. The dimensions of living comprise the context within which schizophrenics undergo learning and empowerment.
Hence, there were two purposes to this study:

1) to interrogate Saljo's developmental model of learning conceptions from the perspective of schizophrenics;

2) to analyze the interrelationship between schizophrenic conceptions of learning and elements of empowerment.

**Definition of Terms**

For the purposes of this study, learning was defined as the process of making a new and revised interpretation of the meaning of an experience, which guides subsequent understanding, appreciation and action (Mezirow, 1990). Empowerment was defined as a social process of recognizing, promoting and enhancing people's abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives (Gibson, 1991).

Readers should note that in this study, the participants were referred to as individuals, interviewees, schizophrenic people or schizophrenics. There was a dilemma as to how to refer to these individuals collectively without appearing to disempower or marginalize them still further. As will be demonstrated in the literature review, there are numerous terms that refer to the various populations that utilize mental health services: patients, clients, mental health consumers. Each of these labels has advantages and disadvantages and several evoke "meanings" that denote disempowerment. In this thesis, although the term
"schizophrenic" was used, it was not meant to suggest that schizophrenics are undifferentiated or homogeneous. They are individuals, just like the rest of us. The term denotes a complex phenomenon. The author felt it was better to use this term rather than some euphemism like "user of mental health services", "consumer", "client" or "patient". Readers will also see reference to mentally "ill" people. The author was reluctant to use this terminology and, in doing so, was cognizant of the literature (e.g. Szasz, 1974) that claims mental "illness" is a myth, a social construct designed to buttress the power and influence of the "helping professions".

**Structure of the Thesis**

Chapter One has described the problem and purposes of this study. Chapter Two will present an overview of schizophrenia to familiarize the reader with the phenomenon. Special emphasis will be placed on the role of education in the treatment of schizophrenia and the collaboration between individuals and community mental health services. Chapter Three will present literature concerning adult learning theory that focuses on subjective experience, phenomenology and experiential learning. Chapter Four will review literature on empowerment particularly as it relates to mental health.
Chapter Five will introduce the reader to the methodology used in the study. The population studied, the design and the interview schedule are described. This chapter describes the management of the interview situation as well as methods used to ensure construct validity. Chapter Six presents a demographic sketch of the population interviewed. Vignettes of the twenty interviewees will be presented. Chapter Seven describes the preliminary analysis of the data using the matrix presented in Chapter Five. This chapter also presents the measures used to validate the author's judgments of conceptions of learning and elements of empowerment and discusses the responses of two individuals interviewed a second time to elicit their ideas about the interpretations made by the author.

Chapter Eight introduces the reader to elements of empowerment exhibited in the interview transcripts. Chapter Nine describes the conceptions of learning displayed by the interviewees. Chapter Ten speaks to the interrelationship between learning and empowerment with a focus on subjective and objective constructions that contribute to disempowerment. Chapter Eleven discusses the limitations of the study and ideas for future research involving schizophrenia and empowerment.
CHAPTER TWO
SCHIZOPHRENIA - AN OVERVIEW

Introduction
Anyone walking the streets of Vancouver will likely observe individuals huddled under bridges or in shop entrances with all their worldly possessions, isolated and frightened, talking and muttering. The sight of "street people" is becoming an all too familiar experience. Few people understand how these individuals come to exist on the streets but it is estimated that 30 - 40 percent have a mental illness, likely schizophrenia (Vanderstaay, 1992). Some individuals "choose" to live on the streets. But, to the average citizen, this barely constitutes survival.

The purpose of this study was to examine schizophrenic conceptions of learning associated with dimensions of living and personal empowerment. This chapter provides an overview of schizophrenia. The intent is to familiarize the reader with current thinking concerning schizophrenia.

Historical Perspective
Internal/Biochemical Perspectives
Schizophrenia was documented as long ago as 3400 B.C. Early in this century Bleuler (1950) described this many faceted phenomenon as a "splitting of the mind". He described four symptoms known as the four A’s: ambivalence, disturbance of
association, disturbance of affect, and a preference for fantasy over reality. This foreshadowed the commonly held view that schizophrenic disorders are an etiologically heterogeneous group with similar symptoms. At the same time, Freud (1911) believed the content of schizophrenic speech confirmed his theories of unconscious motivation of human behaviour and the stages of psychosexual development. Pavlov (1941) saw schizophrenia as a generalized inhibition or chronic hypnotic state arising from excessive stimulation of the nervous system weakened by hereditary or acquired damage. Internal, biochemical opinions on the etiology of schizophrenia, gained wider acceptance in the 1950’s with the initiation of antipsychotic medication as a treatment modality.

Some researchers suspect schizophrenia might be inherited. It was determined that children of a schizophrenic parent had a ten percent chance of developing schizophrenia as compared a "one percent chance" for the general population (British Columbia Schizophrenia Society, 1992). A specific contributing gene has not been identified. Although still considered relevant, this view of schizophrenia fails to ascribe sufficient attention to environmental factors and person/environment interactions.
Psychoanalytic Perspectives

Psychoanalytic theorists of the 1940’s tried to explain schizophrenia as stemming from disordered object relations. Analytic theory focused on the ability to cope with anxiety and depression leading to normal development. Within this theoretical perspective, emphasis was placed on disturbed family relations and communication. This more inclusive psycho-dynamic view also brought to the forefront the importance of the individual’s personal relationships with therapist and family. This view contributed to understanding yet was unable to account for all manifestations observed.

Environmental Perspectives

Meyer (1950) considered schizophrenia to be a reaction to a traumatic life event, a view basic to his psychobiological approach to all mental illness. Sullivan (1953) stressed deeply disturbed interpersonal relationships as the basis for schizophrenia, rather than the intrapsychic mechanisms emphasized by followers of Freud. Hartmann (1953) related schizophrenic psychopathology to severe conflicts over uncontrolled aggression, which can interfere with the development of autonomous ego functions and thus disturb perception and disrupt logical thought and human relationships. Menninger (1958) regarded schizophrenia as a reaction to stress rather than an illness. The removal of stressors would decrease symptoms.
Learning Perspectives

Another group of theorists claimed that schizophrenia is basically a cluster of "learned behaviors" and the symptoms (delusions, hallucinations) serve functional purposes. Semrad (1966) claimed the basic therapeutic attitude should involve an acceptance of the patient as he or she is, of their aims in life, values and nonpsychotic modes of operating. Semrad emphasized the importance of providing the person with a series of interpersonal experiences that would enable the person to differentiate between psychotic and socially appropriate behaviour. Thus, the development of interpersonal skills was seen as a necessary adjunct to dynamic psychotherapy. Social learning theory lies at the centre of this approach.

The Vulnerability Model

After first suggesting that biochemical, genetic, learning and environmental variables could all contribute to the etiology of schizophrenia, it became clear that no single model could explain all manifestations. Zubin and Spring (1977) elaborated a model which suggested an enduring vulnerability to schizophrenia resulting from interactions among various rather than any one single source. Individuals inherit a genetic vulnerability. The appearance of symptoms is a result of the vulnerable individual's inability to cope with stressors in the environment.
Vulnerability is manifested by the possession of a lower threshold for coping with stressful events. When stress is reduced, symptoms are reduced. This theory suggested that schizophrenia is not a permanent condition but that continued stress would evoke episodes.

The vulnerability model also predicted that indicators or markers can be found in individuals prior to and following episodes of symptoms as well as among their unaffected family members. A framework for examining a variety of probable behavioural and neurobiological indicators has subsequently been developed. Additional developments emphasized vulnerability as it pertains to the individual’s interaction with specific aspects of the environment and the presence of specific physiological signs that indicate vulnerability. Recently, the model has been modified by the introduction of a separate dimension that accounts for changes in tolerance to stress (Steinhauer et al, 1991). The tolerance dimension provides for the intervention of psychotherapeutic or biological treatments as a means of raising the individual’s threshold for coping above the usual or minimal level.

This overview is brief and in no way exhausts the literature concerning the etiology of schizophrenia. However, it highlights the ambiguity associated with schizophrenia and the fact little is known about it. Although a rich source
of clinical description and hypotheses, these theories have not convincingly explained the phenomenon of schizophrenia.

Clinical Manifestations

Contemporary practitioners and researchers tend to rely on the descriptive psychopathology defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised (DSM-IIIR, 1987), (Appendix B) to diagnose schizophrenia.

Schizophrenia is characterized by positive or active symptoms - hallucinations, delusions, disturbances in thought and changes in communication. There are also negative symptoms - blunted affect, poor self-care, altered judgment, inactivity and social withdrawal. Clearly defined, observable symptoms have allowed for the phenomenon to be studied internationally. Schizophrenia affects approximately 1 in 100 people worldwide and involves peoples of all socioeconomic and cultural backgrounds. Despite the positive aspects of criterion based research and practice, the phenomenon has been objectified and the subjective experience of these people has virtually been lost.

Cognitive Abilities

Cognitive Processes

Many have speculated about the cognitive structure and function of schizophrenic individuals. There is a wealth of
literature associating schizophrenia with information-processing and attention disorders. The significance of this research lies in attempting to discover more about schizophrenia and its impact on participation in educational activities and learning. Carr and Wale (1986) proposed an attentional model of schizophrenia in which disorders in the perception of information are related to dysfunction of preattentive processes. Certain symptoms such as hallucinations and delusions are seen as compensatory mechanisms of a disordered information processing system. The primary underlying abnormality is inability to attend to all stimuli with consequent disruption of information processing, both incoming information and outgoing or internal information. Much of the complexity and variability in the outward manifestations of schizophrenia may be regarded as secondary phenomenon attributable to the organism's regulatory or self-healing capacities. These can be viewed as operating to compensate for the inability to attend to all stimuli and thus to restore some internal equilibrium.

Using a variety of quantitative and qualitative measures to examine social competence, symptom status and social status, Allen (1990) reported that those who exhibited the greatest number and most severe symptoms had the worst employment histories. He concluded that impaired contextual processing appears to be related to current symptom status. If this is
the case, schizophrenic individuals will be more receptive and get more out of educational activities when symptoms are at a minimum than when symptoms are poorly controlled. Other results have suggested that those with the most psychopathological impairment have the greatest inability to think abstractly (Braff et al, 1988). Watson et al (1987) examined the intelligence and personality of 50 schizophrenic individuals and found that although there were no changes over time with respect to premorbid personality, there were observed changes in the arithmetic ability of intelligent schizophrenics. There was no significant decline in those with low IQ’s.

Cognitive Structure
Others have focused on the cognitive structures of schizophrenic individuals. Kelly (1955) postulated that a psychobiological disorder results when any personal construct is used repeatedly in spite of consistent invalidation. Psychological disturbances represent the apparent failure of a person’s construct system to achieve its purposes. Caught up in lack of capacity to predict, the disturbed individual may search frantically for new ways of construing the events or rigidly maintain a personal construct system despite repeated failures. In Kelly’s theory of psychopathology, dilation occurs when a person has no superordinate constructs to organize their perceptual field. Having abandoned or lost governing constructs, the
individual then attempts to broaden (dilate) their constructs and to reorganize them at a more bizarre and comprehensive level of plausibility.

Based on Kelly’s work, Bannister (1963) proposed a theory of schizophrenic thought disorder based on a serial invalidation hypothesis. In brief, this theory suggested that thought disorder is the outcome of being consistently wrong in one’s predictions, so that a gross loosening of one’s construct system is the ultimate form of psychological adjustment. Bannister and Fransella (1966) reported that the constructs of thought disordered schizophrenic individuals were considerably less highly interrelated and less consistent as compared to others with and without psychological disorders. A second experiment by Bannister and Salmon (1966) examined the question of whether schizophrenics were disordered across their entire construct system and found that although they did not differ from normal controls in their construing of objects, they were vastly less stable and consistent in their construing of people than were the ‘normal’ control subjects. They suggested that schizophrenic thought disorder may be particularly related to interpersonal constructs.

More recently, Cromwell (1991) proposed an alternative to the vulnerability model. He suggested that it is possible that uncertainty in conceptual structure (ie. personal
construct system) is a more potent contributory than is stress. Uncertainty would imply the lack of conceptual resources by which one could predict the outcome of one's own personal destiny in life situations. It might be argued that this notion was not much different from that usually referred to as "stressful." However, Cromwell argued that uncertainty is a particular kind of stress. It implies that one has difficulty in predicting the outcome of positive, as well as negative, life events. If such a formulation of schizophrenia is useful, it would place added emphasis upon the research and understanding of cognitive structure.

By no means conclusive, the literature on cognitive structure and function would seem to suggest that for schizophrenic individuals, there are "teachable moments". Liddle and Barnes (1988), using subjective and objective measures, found that most schizophrenic people were aware of their poor concentration, distractibility, absence of thought, speeded thinking, difficulty remembering, fatigue and abnormal experience. They concluded that the exploration of subjective experience offers the possibility of helping schizophrenic individuals to develop appropriate coping strategies.
Treatment Modalities

Psychopharmacology

Although there is no known cure, researchers have made progress in treating symptoms. In the mid 1950's, medication became the treatment of choice. It is not known exactly how neuroleptic medication works to control the positive symptoms of schizophrenia but there is evidence that demonstrates that medication reduces the chances of hospitalization. It has also been found that at least 50% of schizophrenic individuals do not take their medication or take it so sporadically that there is little effect (Angermeyer, Goldstein and Kuehn, 1989). Many of these individuals become part of the revolving door syndrome, frequently in and out of hospital living a chaotic and fragile existence. Acute care psychiatric hospital beds are in demand. Many schizophrenics are discharged to the community still experiencing symptoms. This is one of the reasons why readers will likely meet people talking to their voices on buses and in other public places. Moreover, some do not respond to medication and many side effects are permanent and irreversible. In spite of this, medication remains the treatment of choice.

Rehabilitation Models

An alternative to pharmacotherapy was behaviour therapy. Operant principles were applied to schizophrenic individuals in a systematic and comprehensive program known as token
economy (Kazdin, 1977). Aside from the ethical issues related to reward and punishment systems, it is exceedingly difficult to implement a token economy in the community because of an inability to control variables and context.

The basic principles were not completely dismissed and have been translated into the more contemporary skills training models. One of the most compelling arguments for skills training rehabilitation models comes from the failure of antipsychotic drugs to remediate the negative symptoms of schizophrenia, the serious side effects which often evoke noncompliance, and the fact medications cannot teach patients coping skills they require for survival in the community (Liberman et al, 1986). It is assumed that coping and competence can override stress and vulnerability, reduce relapses and improve psychosocial functioning.

Liberman and colleagues proposed a rehabilitation model consisting of four components: social schemata, social skills, coping efforts, and social competence. Basic psychobiological processes (perception, attention, memory, affect and concept formation); social cognitive processes (ability to regulate own behaviour based on the awareness of perceptions of others) and experience constitute an individual’s social schemata. A schemata enables an individual to make assumptions about events that occur in a particular situation (Glaser, 1984). Social skills are the
cognitive, verbal and nonverbal behaviours that must be used to survive and have a reasonable quality of life. Coping efforts are the individual’s attempt to put into practice the social skills that exist within their repertoire. The impact of the person’s social skills on the environment, favourable or unfavourable, defines that person’s social competence. A deficiency in any of the above components will result in an impoverished social schemata, lower skill level, impaired social coping and thus social incompetence.

This conceptual model stimulated both researchers and clinicians. It identified three major focal points for the design and testing of social skills training methods. The first is to "train" the basic psychobiological and cognitive functions that form the person’s social schemata. A second approach is to train the receiving, processing and sending skills of the individual. A third strategy is to change the individual’s environment such that skills, however well developed, can be supported and elicit a favourable response from others.

Psychotherapy
A third less acknowledged treatment is psychotherapy. In the nineteenth century, psychotherapy was the cornerstone of "moral treatment". The treatment called for understanding the person as an individual human being and where work and social relationships were encouraged as part of normal life
recovery rates for first admissions were 70 percent. The focus on medication has served to rationalize not having to understand the person. It has been argued that research shows that psychotherapy is not helpful with schizophrenic individuals. However studies have shown that psychotherapy alone or in combination with medication can bring about an earlier discharge from hospital, longer time out of hospital and improve thought disorders. More recently, it has been found that the extent of a "benefit" depends on forming a therapeutic alliance with a health professional (Karon, 1990). In spite of the mixed reviews that psychotherapy has received as a treatment for schizophrenia, it highlights the need to understand subjective experience.

Attitude and Insight

The research in this area is very limited and demonstrates the need for further investigation. After semi-structured interviews with 45 chronic schizophrenic inpatients, McEvoy et al (1981) claimed that most patients had no insight or "realization" concerning the need for medication. Medication use and improvement did not correlate with insight. This has been echoed by others who have used a variety of quantitative and qualitative measures to examine the beliefs, feelings and insights of schizophrenic individuals. Findings have neither been conclusive nor significant and may suggest that attitude and insight have
more to do with the trust involved in the therapeutic alliance with mental health systems rather than an effect of medication use.

**Education and Schizophrenia**

Education for schizophrenics has largely been informed by a "top-down" institutional perspective oriented to management and efficiency. There has been no particular preoccupation with the subjective world of the schizophrenic. The prime motivation has been to "domesticate" the "patient" (or "client"). Much education is designed to ensure compliance to medication regimens.

**Medication Education**

Most educational efforts have been designed to ensure that schizophrenic people take their medication. There are numerous variables involved in the "decision" to take medication while living in the community. Researchers have cited insight and attitude, the client-therapist relationship, and cognitive abilities as good predictors of "medication compliance". Medication side effects tend to influence the decision to take medication. Women tend to take medication more frequently than men, require fewer hospitalizations and hospital stays are not as long (Angermeyer, Goldstein & Kuehn, 1989). It has been repeatedly shown that individuals who live with their families rather than on their own tend to have a higher rate
of compliance with treatment and require fewer hospitalization (Herz, 1986).

There is a discrepancy in the literature as to whether or not education promotes compliance with medication regimens. Several researchers have reported statistically significant results which suggest that participation in health education programs increases compliance for up to five months (Seltzer, 1980; Robinson, 1986/87; Eckman, 1990). There have been problems with the quasi-experimental methodology particularly where there are high attrition rates. Conversely, others have reported "no relationship" between education and compliance (Klein, 1974; Goldman, 1988). Klein suggested that giving information to clients tended to undermine their attitudes towards medication. Brown (1987) researched different techniques of instruction in a quasi-experimental design to demonstrate the effects of knowledge, side effects and compliance. He reported that while knowledge increased and negative symptoms decreased, there was no increase in compliance. There tends to be some consensus that education increases knowledge yet there appears to be no definitive relationship that exists between knowledge and compliance. Most of this research is done in hospitals, not the community.
Rehabilitation and Skills Education

There is less research relating education to behaviour and social skills therapies than to medication use. Literature tends to focus on the evaluation of education for family members rather than the education of the individual. This is not to say that educating family members has not had positive effects for both individual and family alike. Direct training of cognitive social skills has been restricted to single subject experimental designs. Research has confirmed the ability of regressed individuals to learn social responses under highly controlled and directive training programs (Wallace et al, 1980). These studies suggest that individuals could increase their repertoire of social skills as a consequence of initial training.

Vocational training is designed to assist the "mentally ill" to obtain and maintain employment. In a survey of 500 chronic Los Angeles mental patients living in the community, Lehman, Ward, and Linn (1982) found that lack of work was one of the greatest complaints related to poor quality of life. Sixty-five percent of participants in a Job-Finding Club successfully secured jobs or entered training programs. These individuals also demonstrated that they can maintain these positions for extended periods of time. Other studies have focused on training in recreational and leisure skills to reduce bizarre and deviant behaviour in unstructured free time.
Liberman (1986) summarized the results of these studies:

1) Psychiatric patients can be trained in behaviours that will improve their social skills in specific interpersonal situations;

2) Individuals show moderate to substantial generalization of trained behaviors to other environments however this requires further investigation particularly when it comes to generalizing more complex behaviour necessary for survival in the community;

3) Comprehensive, intensive social skills training can reduce symptoms and relapse.

He reported that the aim of rehabilitation is not to cure disease, but to enhance an individual's functioning, level of adaptation, and quality of life.

**Summary**

Despite all the good intentions, educational models have been developed without regard for the teaching-learning process. Somewhere along the way, the subjective experience of the individual has been lost and has ceased being the focus of the process. The process has become objective. By using such words as "disease", "deficiency", "directive training", and "rehabilitation", mental health professionals set up unequal power relations that may inhibit learning and empowerment. In doing this, they themselves become one less resource that the individual can look to for assistance.
The purpose of this chapter was to explore current literature on schizophrenia. It demonstrates that this phenomenon remains a mystery despite its pervasiveness and these individuals are destined to experience difficulty in the community. Therapies and education have been developed "for" rather than "with" the individual and are thus only marginally effective. Moreover, almost all programs of education for schizophrenics, like those for many other marginalized groups, are informed by an ideology of adaptation. The idea is to "fit" the schizophrenic into existing patterns of power and privilege. Few "professionals" set out to empower schizophrenics. The problem is that empowered people might challenge the fabric of privilege and prejudice that is part of the cycle of despair that perpetuates schizophrenia. Learning and empowerment are the keys to survival in and instruments for changing the community. By now readers will realize that the author has a point of view which ascribes considerable significance to learning and, its corollary, empowerment. Hence Chapter Three will review adult learning theory as it relates to schizophrenia and subjective experience.
CHAPTER THREE
ADULT LEARNING

Introduction

"Learning" is a corollary of survival. Like all people, schizophrenics have to learn. In earlier times when most lived in institutions "learning" involved knowing how to respond to health care providers' expectations, rules and regulations. Institutions provided structured, predictable environments where each day was much the same as the last. Educational efforts were directed at "training" and although skills learned may have been "useful", they were learned in a context much different from the community.

Now they live in the community and the need to learn is more pronounced. They have to distinguish "right" from "wrong", make complex decisions and be accountable for consequences that flow from their "learning" or lack thereof. Of course, anyone can be made to "learn", through a process of conditioning in a token economy or in some other controlled environment. But people do not become "empowered" in situations where there are profoundly unequal power relationships or "authorities" who deliver reinforcers. The author in no way discredits learning from role models (Bandura, 1977) or in response to reinforcement (Skinner, 1953), cognitive restructuring (Ausebel, 1968), stimulus/response relationships (Hull, 1943). However,
there is a socio-political subtext at the centre of this study. "Empowerment" is a corollary of learning. But, it also denotes a levelling of power relationships, the erosion of prejudice and stigmas that diminish the quality of life experienced by schizophrenics, a "new" attitude on the part of health providers, and increased participation and interaction by schizophrenics with their environment.

Therefore, the notion of "learning" as used here is as much political as it is epistemological and, because of these considerations, was anchored in subjectivist ontology. Readers might think that a focus on the subjective experience of schizophrenics is bizarre because, by definition, their subjectivity is "disordered". But, schizophrenics are adult learners and without understanding the way in which they "see" (i.e. find meaning in) the world, health "professionals" are blinded to their influence on these individuals.

For adult education research, this study is of considerable significance because although there has recently been a rash of studies concerned with "meaning" (e.g. Stalker, 1983; McLardy, 1991) many have been concerned with "normal" people. Adult educators must expand their horizons to look at people who are unlikely to participate in formal education and whose views are unlikely to be considered due to their marginal position within society. Their perspectives are valuable and by eliciting them, adult
education in a small but significant way may help empower these people.

Schizophrenics can and do learn despite the difficulties they experience. Mental health professionals view learning as paramount if individuals are to survive in the community and have introduced various types of educational activities "for" schizophrenic individuals. What they have failed to take into consideration is the subjective experience of schizophrenics. Few programs have involved schizophrenics in their planning. It is unclear as to why little investigation has occurred into the subjective experience of schizophrenics who can aptly describe their life, perceptions and needs. Educational experiences will be more personally relevant and effective if this missing knowledge, subjective learning experience, is incorporated into the planning and implementation of programs.

On a broader scope, literature on adult learning echoes this concern. The literature presented in this chapter grew from dissatisfaction with existing paradigms which failed to capture the very essence of learning; that is, the experience of learning from the individual's perspective. Although an attempt to present this literature in its entirety is beyond the scope of this work, a review of theoretical foundations is a necessary adjunct to examining
the conceptions of learning described by people with schizophrenia.

Subjective Experience of Learning

In the last decade, there has been a challenge to existing paradigms which viewed learning as simply an objective phenomenon that could be measured quantitatively. Marton (1976) demonstrated the importance of taking students’ perceptions into account when assessing the effects of instructional techniques. He reported that there were contrasting views of learning and called for a shift in paradigm to ensure explanations of student learning had ecological validity enabling researchers to make interpretations of the findings that do justice to the student’s own experience. Entwistle (1984) remarked that conceptions of knowledge have traditionally been quantitative and reproductive and tended to reinforce a give-take view of learning, limiting investigation into the process.

He wrote that most human learning depends on meaning and is directed towards it. The outcomes of learning are thought to represent qualitatively distinct changes in conceptions of real life phenomena. Learning itself can be defined as a change in conception. Entwistle contrasted two main categories: that which is meaningless and lacking internal structure and that which has an internal structure that can
be grasped and understood. Marton and colleagues (1984) suggested that learning should be regarded as that aspect of human life through which the environment appears with a higher degree of meaningfulness than before.

**Conceptions of Learning**

Interviews with adults in Sweden suggested there are differences between people who have extended education and those who left school early in the way they conceptualize 'learning' (Saljo, 1979, 1981, 1982). Individuals were asked "What do you actually mean by 'learning'?" The main distinction among their replies was between those who saw knowledge as factual or learning as memorization, and others who discussed alternative meanings of learning under different conditions or circumstances. Analyses of the interview transcripts produced what Saljo claimed were five qualitatively different conceptions of learning. Learning was seen as:

1) a quantitative increase in knowledge  
2) memorizing 
3) the acquisition of facts, methods, etc. which can be retained and used when necessary  
4) the abstraction of meaning  
5) the interpretative process aimed at understanding reality.

Research described how students move from a simplistic acceptance of facts presented by authority, to a period of confusion about the nature of knowledge and belief, to recognition of a shift that we need to develop a personal
philosophy of life built out of "interpretation" (Perry, 1978). It seemed to follow that observed variations in approaches would be linked to variations in conceptions of learning. Van Rossum and Schenk (1984) identified the five conceptions of learning but demonstrated that the first and last two conceptions were associated with surface and deep approaches respectively. They modified Saljo's (1979) suggestion of a dividing line between the third and fourth conception and suggested the third conception is a bridge between the others.

A sixth conception was also identified. This concerned learning as a process of self-actualization (van Rossum and Deijkers, 1984). Van Rossum (1988) described three views of learning - reproductive, constructive, and integrative. In a reproductive view of learning, the individual merely distinguishes between memorizing with and without understanding. In a constructive view, the process of learning is seen as a holistic, main-line directed activity. In an integrative view, the individual is concerned with understanding the author's intent and is able to take a critical standpoint in interpreting the material in the text. He demonstrated that understanding study texts is interpreted differently by students and that different interpretations seem to flow from logically corresponding conceptions of the nature of the learning process. In other words, the observations reveal a case of homogeneous thought
and action. Saljo (1982) argued for the existence of homogeneous thought and action patterns with regards to learning and understandings and proposed that the transition from one pattern to another must be seen from a developmental perspective. It begs the question as to what extent students' conceptions of learning and understanding can attain a more constructive nature by means of systematic training. Developmental research suggests that changes in the above mentioned patterns of thinking and acting occur slowly (van Rossum et al, 1985).

Approaches to Learning

The interviews by Saljo were part of a series of studies conducted in Gothenburg by Marton and colleagues which have shown how students' perceptions of academic tasks affect their approaches to studying (Marton et al, 1984). It seemed to follow that if outcomes of learning differed, then the process that led to the outcomes must also differ between individuals. As Marton did not view learning as lending itself to quantitative analysis, he tested this idea by performing rigorous qualitative analysis on extensive interviews with students describing their own study processes. The main concept emerging from this research describes approaches to learning. Differences in conceptions of knowledge and learning were linked with differences in approach to learning. Marton characterized the distinction between these approaches in terms of
intentionality (Marton and Saljo, 1984). A deep approach involved an intention to understand, while a surface approach described the intention to reproduce information in compliance with externally imposed task demands. Further attempts to impose a deep approach on students yielded contrasting results and indicated that students adopt an approach based on their interpretation of what is demanded of them.

Based on this previous research, Entwistle and colleagues, at Lancaster University, used factor analyses to identify groups of items within the dimensions of motivation and study methods to develop an 'Approaches to Studying Inventory'. Conceptual and factor analyses of the first pilot of the inventory (1979) demonstrated two concepts: deep approach, associated with organized, motivated study methods; and surface approach, associated with fear of failure and syllabus boundedness. Ramsden (1981) subsequently identified a third, strategic approach.

Another group of researchers carried out experiments to discover differences between student learning strategies. Pask and colleagues (1976) identified serialist and holist strategies. The serialist used a step-by-step strategy in which they used simple hypotheses. The holist used more complex hypotheses combining several properties simultaneously. Along with these two strategies, Pask
reported two major pathologies commonly found in learning: **globetrotting** and **improvidence**. Globetrotting was associated with a broad perspective, seeking interconnection with other topics and making use of personal and idiosyncratic analogies leaving examination for later. Improvidence was associated with a failure to use the valid and important analogies to interrelate elements of the topic. Pask reported that consistent use of one strategy was likely to show consistent pathology. He described **learning style** as a tendency to adopt a specific strategy. He differentiated **comprehension (holist like) learning** from **operation (serialist like) learning**. **Versatile learning style** was the ability to adapt the strategy to the task.

A question arose as to what extent the students' approaches to learning reflected the effects of assessment and teaching demands rather than representing relatively stable characteristics of the individual learner. Research had found that few students became deeply involved in a subject or critically evaluated it (Entwistle and Percy, 1974). The study showed limitations in the input-output model in thinking about higher education and demonstrated a need to investigate the process and context. Entwistle and Ramsden (1983) looked for explanations of emerging study orientation in terms of psychological theory. Holist like strategies could be seen as describing divergent thinking whereas serialist like strategies could be seen as describing
convergent thinking. Correlations between deep/surface approaches and comprehension/operation learning showed that styles rather than approaches were more closely associated with the psychological attributes.

Entwistle and colleagues interviewed students with extreme scores on approaches and revealed that categories exist within the deep and surface approach:

| deep approach | personal experience - integrating the task with oneself |
|               | relationships - integrating the parts into a whole |
|               | meaning - integrating the whole with its purpose |

| surface approach | unrelatedness - defining the task as separate |
|                 | memorization - defining the task as a memory task |
|                 | unreflectiveness - defining the task in an external way |

The investigators found that while the meaning of the deep-surface dichotomy was fundamentally the same in different subject areas, there were important variations in emphasis. Interview analysis confirmed the notion that six different departments provided very different learning contexts.

The Lancaster group also identified three categories of strategic study methods. Laurillard (1979) reported that students' study strategies and approaches were context dependent. The Lancaster investigators concluded that subject area and learning strategy were fundamentally related to the students' conceptions. Exploration of the
relationship between students’ perceptions of the context and their approach to the learning task demonstrated functional relationships.

It has been argued that the concept of approach to learning has been widely misinterpreted as a static individual characteristic (Ramsden, 1987). An approach to learning is a description of a relation between a learner and a learning task; the description of an intention and action. It is dynamic and implies change. To understand the meaning of the concept of approach in the way its originators intended, one must think about the process of learning holistically rather than focusing on its parts.

**Motivation to Learn**

Another factor involved in the complex phenomenon of adult learning is the relation between the learner’s motives and the way they go about learning. *Intrinsic motivation* appeared to be associated with a deep approach while *extrinsic motivation* was associated with a surface approach to learning (Fransson, 1977). It appeared that the observed variation in approach was linked with variations in the conceptions of learning held by participants. A distinct interplay between the content of the task, its organization with the student’s previous knowledge and approach to the task was identified.
Analysis of data from the 'Approaches to Learning Inventory' yielded further insight with regards to motivation (Entwistle and Ramsden, 1983). There were four distinct orientations associated with characteristic forms of motivation: meaning orientation - intrinsic motivation; reproducing orientation - extrinsic motivation and fear of failure; achieving orientation - achievement motivation; non-academic orientation - low intrinsic with high extrinsic and/or social motivation.

Higher motivation also seems to lead to better academic performance (Entwistle, 1987). This reinforces the idea that several dimensions of motivation lead to qualitatively different processes in learning and studying. Students have contrasting explanations for their past successes and failures. This proved to be a fruitful line to follow, moving research away from earlier mechanistic views of motivation as drive reduction and towards description of motives related to personal goals and intentions. The value of any potential reward or motivating influence is not from the learning situation or the assessment outcome itself, but the way a person interprets that situation or outcome in relation to their goals and priorities. In seeking to explain differences in the effort, or lack of effort, that people put into learning, an understanding of their emotional responses to, and rationalizations of, the outcomes of learning is essential. Entwistle linked the
common elements of recent research on motivation under four main approaches for research and practice: rewards, the learning context, motivating techniques and learning to learn. He concluded that bringing together these four approaches will improve the immediate outcomes of learning but the only lasting motivation is, after all, self motivation.

Process and Outcome
Research subsequently became directed at gaining insight into the relationship between the process and outcome of learning. Akin to deep and surface approaches, Svensson (1977) distinguished between holistic and atomistic approaches as the most crucial difference between interactions with complex learning materials. The difference was one of merely delimiting and ordering parts interacted with, compared to integrating parts by the use of some organizing principle. To be skilled in learning then meant to be deep, holistic and complete in approach and understanding. Skill in studying however is not equivalent to skill in understanding. It was found that students do not maintain material over time using a surface approach. This revealed a paradox in higher education. Students have difficulty balancing the need for learning with the demands of exams which tend to instill a surface approach.
A second pilot of the 'Approaches to Studying Inventory' by Biggs (1979) revealed four distinct factors: deep approach, akin to comprehension learning or meaning orientation; surface approach, akin to operation learning or reproducing orientation; organized study methods associated with achieving orientation; and stable extraversion. Entwistle and colleagues carried out the main study using the inventory with 2208 students from various departments and institutions. The results demonstrated consistent relationships in the expected direction between approaches to studying and academic progress and confirmed the research done by others using different methods.

Analysis of students' approaches to reading academic articles demonstrated predicted links between approach to learning and level of understanding and the extent of relevant knowledge retained (Entwistle, Hanley and Ratcliffe, 1979). Qualitative analysis showed distinct differences between deep and surface approaches. Students' comments showed a thematized interpretation of learning developed in higher education in which students recognize that their approaches are affected by assessment demands, subject content and level of interest (content and context).

Subsequent to his work on conceptions of learning, Saljo (1982) directed his research to studying what and how students learn from their reading. From reading, students
are expected to increase their knowledge of the world and conceptions in understanding and handling various aspects of reality. Encounters between learner and text in which different conceptions of the same phenomena are held or between different versions of the world may lead to new insights. He saw a need to look at internal relationships between approach and outcome by focusing on what the participants were doing in the particular situation and the assumptions they held about it. Analysis pointed to differences in conceptions of knowledge and learning which were linked to differences in approach: knowledge as offering improved understanding of reality through abstraction of meaning as opposed to knowledge as equated with information and facts. Saljo stated that content had to be considered in that academic reading material presents a particular reality of the world which may not be consistent with everyday experience.

It appeared that it would be educationally desirable if students could be taught how to learn. The effects of students' participation in study skills programs were examined (Ramsden, Beswick and Bowden, 1986). The intent of the study skills program was the development of awareness of different learning strategies, competency in selecting fitting strategies and provision of a repertoire of study skills. The researcher found that students who participated in the program increased their reported use of surface-
atomistic approaches and marginally decreased their use of deep-holistic approaches. The study cast doubt on the value of attempts to improve learning that does not take into account the students' perceptions of content and context.

Students actively and critically abstract from intervention programs what is useful to them which is a function of their perception of requirements. As long as variation in acts and outcomes of learning is seen to be the result of an interaction between content, context and student, then it is unwise to seek ways of improving learning by focusing on characteristics of students or teaching methods alone.

Findings confirmed previous reports that students adopting a surface approach were less able to retain, over a five week period, factual knowledge from an article they had read as compared to those using a deep approach. The research described study approaches and processes in terms of four dimensions: deep/elaborative, surface, organized and strategic/competitive. This research helped to differentiate the components of organized studying and active thinking in ways which facilitated future measurement of study processes and indicated ways of helping students to develop more effective methods of studying. The researchers stated that any attempt to modify students' study strategies are only likely to be effective if the learning environment is also changed.
Relevance in Learning

Much of the research pertaining to lectures has been conducted with an emphasis on the teacher's perspective. Qualitative studies examining students' perspectives give way to a wider concern with the teacher-student relationship. Hodgson (1984) reported that students were found to experience relevance of lecture content intrinsically, what it means to their own understanding, or extrinsically, in relation to assessment and course expectations. Subject relevance, the teaching-learning context and the students' background knowledge and familiarity were all found to influence the students' experience of relevance. Some students also revealed vicarious experiences of relevance linked to the lecturer's presentation. The study highlighted the important potential role of lecturers as facilitators of intrinsic experience of relevance. Vicarious relevance was seen as a pivotal or transition point in that a increase in vicarious experience led to a decrease in extrinsic and an increase in intrinsic relevance.

The Learning Context

Studies into approaches and outcomes demonstrated that learning is influenced by the context of the educational situation. Students conceptions of knowledge were found to be different in different departments. The studies provided
evidence of strong associations, across a spectrum of disciplines, between students' orientation to studying and their perceptions of workload, the quality of teaching and the degree of choice over content and study method. Questionnaire results revealed that students saw the process of teaching and learning in different ways in six different departments (Entwistle and Ramsden, 1983). Institutions appear to setup a conflict for the student between getting the grade and really learning something. It would appear that both approaches to learning are necessary. An intense effort must be made in course planning and assessment to avoid setting up learning situations that promote a surface approach.

Learning was not only found to be influenced by the educational context but also by the students' personal context. Educational orientation to learning encompasses the students' values, aims and purposes for studying. From this point of view, success and failure should be viewed in terms of the students' fulfillment of their aims. Approaches to learning and conceptions of learning can be linked to educational orientation to develop a conceptual framework grounded in the students' experience of learning. Studies at Surrey University and Open University revealed that educational orientation can be divided into four categories: vocational, academic, personal and social; and two forms, extrinsic and intrinsic (Taylor, 1981).
Extrinsic orientations involve looking towards the utility of qualifications and experiences, while intrinsic orientations concern different forms of internalized reward. Subsequent interviews by Taylor and colleagues (1983) involved comparisons between students at the University of Surrey and adults enrolled at the Open University. It appeared that school leavers were predominantly motivated by varying combinations of vocational, academic and social concerns, while the Open University students seemed to give personal development a higher priority in taking up studying again. The researchers found that students seldom display just one orientation but a combination of orientations and that lecturers were largely unaware of the complex mixture of reasons for continuing education.

Attempts were made to examine the influence of school environment on approaches to learning and the relationship between approaches and outcomes (Ramsden, Martin and Bowden, 1989). The researchers identified between school differences in perceptions and approaches. School environments offering supportive teaching, coherent structure, emphasis on autonomy and moderate stress on achievement were associated with learning involving an active search for understanding, organized study methods and avoidance of superficial approaches. Schools characterized by extreme emphasis on formal academic achievement, in which teaching was narrowly focused on examination success, was
associated with a tendency towards minimalist, reproductive and uncompromisingly competitive approaches to learning.

More recently, Entwistle and Tait (1990) performed two experiments with the purpose of explaining the relationships between approaches to learning, or study orientations, and perceptions of the academic environment. It was implied that perceptions of academic environment, rather than the environment in the objective sense, most directly influenced learning. Questionnaire responses from students of various institutions showed similarity to previous findings regarding the relationship between approach, orientation, motivation and style. The questionnaire asked students about their preferences for contrasting aspects of their perceived academic environment. Factor analyses found consistent patterns or relationships between study orientation scores and items describing study habits, evaluations, and preferences. The study showed that generally, students adopting a meaning or reproducing orientation also prefer methods of teaching and assessing which encourage those approaches to learning. Due to the substantial agreement about the facets of a particular environment, the researchers argued that the average ratings become more of an objective indicator of the environment and therefore, different patterns of causality can be inferred. Rather than a product of the learner's perception or attitude, approaches could be seen as reactions to the
environment provided by the department. Good teaching caused a deep approach and reproducing was seen as a product of workload and assessment procedures rather than being a facet of a particular conception of learning or an attitude toward studying.

Studies have demonstrated that for failing students, the usual linkages between approaches to learning and perceptions of the learning environment were rarely found (Meyer, Parsons and Dunne, 1990; Entwistle, Meyer and Tait, 1991). The lack of a similarly coherent structure among failing students, for their study strategies and perceptions of the learning environment, led to their patterns being described as 'disintegrated', compared to other students. They found interesting individual variations in the nature of the disintegration of perceptions. It still leaves a considerable gap in seeking to interpret the world view of failing students.

The Teaching-Learning Process

Students' perspectives of the teaching-learning process have largely remained hidden. Teacher-centredness has led to a focus on transmission rather than reception. Marton et al. (1984) argued that if our conceptions of learning are transformed by new knowledge then our conceptions of teaching must also undergo metamorphosis to an experiential conception of the teaching-learning process. The teaching-
learning process can thus be considered as a meeting of the minds where world views confront and collide rather than a matter of transmission. The success with which students achieve understanding may therefore depend on the capacity of the teacher to recognize and build from students' existing conceptions and to anchor new knowledge in a meaningful framework. Eliciting and exploring students' conceptions can become an integral part of the teaching-learning process.

The future of the psychology of learning and teaching is certainly not likely to involve grand general theories of elegant simplicity (Entwistle, 1985). Many mature students have had inadequate experiences of schooling. For them, the importance of re-establishing the conceptual bases of the discipline will be fundamental to future academic success. Mature students are more likely to seek personal meaning in their studying however they are also liable to poorly equipped from previous education to carry this out. Despite previous discouraging experiences with school, they will have continued to learn experientially. Such adults come into adult education with strong but narrowly focused motivation. They will want to gain personal understanding of the topics they are interested in but may have inappropriate conceptions of learning and poor study skills. The method of teaching will have to be carefully geared to provide strong initial support and guidance, together with
the freedom to pursue individual interests as skills and confidence are developed.

Summary
The research presented is a cumulative process. The ideas from Gothenburg were nourished in different research climates. Researchers could have produced separate integrations, organized around different salient features yet there is sufficient agreement to mean that the broad picture of adult learning emerging from the research would have remained much the same. Researchers were able to trace a chain of functional relationships that were not prescriptive but invite those involved in the teaching-learning process to consider interrelationships and possible consequences. Conceptions of learning and level of understanding have been linked to approach. The researchers have identified relationships between approach, strategy, orientation and style and have made further distinctions within these categories. The relationship between approach and outcome has been demonstrated. Differences in styles and approaches represent only part of the whole picture of student learning, content and context are prominent influences on learning and need to be taken into account. The research provides valuable insights into a learner centred in view of adult learning. It also brings to light the complexity of adult learning and the need to consider
these numerous concepts when analyzing an individual's learning.

The above research was carried out in academic settings with adults partaking in higher or continuing education. The context must be considered when applying these conceptual relationships to other learning situations. This does not, however, prevent these theoretical foundations from providing a reference from which to view adult learning outside of formal, institutional settings. Conceptions of learning from the perspective of the individual influence learning despite the context or circumstances. Saljo’s five conceptions of learning have consistently been revealed in analyzing students’ reports of their learning experiences. Conceptions of learning have a prevailing influence on adult learning and would appear to be the obvious starting point from which to analyze schizophrenic individuals’ experience of learning. To do so, Saljo’s five conceptions of learning were operationalized in the following manner which provided a template with which to view data in this study.

Conception 1 (C1) - A quantitative increase in knowledge
Learning is interpreted somewhat homogeneously as "getting to know all sorts of things". It is considered factual, taken for granted and unreflective.

Conception 2 (C2) - Memorizing and reproducing knowledge
Learning is characterized by a strong emphasis on memorizing material with the goal of being able to reproduce the knowledge. It is viewed as passive transmission.
Conception 3 (C3) - Knowledge for future use

Learning is viewed with the possibility of later using or applying what is learnt from before. Through this application, the individual gains rules and procedures, the ability to predict and test, similar to "trial and error".

Conception 4 (C4) - Abstraction of meaning

Learning is characterized by abstraction of meaning. There is a focus on a specific perspective that relates ideas together.

Conception 5 (C5) - Interpretation and understanding

Learning is aimed at a better understanding of reality. It involves making sense of a problem or an issue, being open to other perspectives, being critical and relating ideas to one's own experience.

There are wide range implications for future research. The long term aim of education should be directed to the more fundamental conceptual changes. Individuals should be encouraged to see learning as a reorganization and transformation of their understanding aspects of the real world. Mezirow (1990) defined learning as the process of making a new and revised interpretation of the meaning of an experience, which guides subsequent understanding, appreciation and action. It is not possible to understand the nature of learning or education without taking into account the role played by these habits in making meaning. Meaning perspectives refer to the structure of assumptions within which new experience is assimilated and transformed by one's past experience during the process of interpretation. Perspectives provide principles for interpreting. Emancipatory education is an organized effort to help the learner challenge presuppositions, explore
alternative perspectives, transform old ways of understanding and act on new perspectives. This view of adult learning is rooted in learning from the individual perspective and further confirms the need for adult educators to explore individual's conceptions and perspectives if they are to assist in learning. It is this view and attitude that is necessary if mental health professionals are to assist schizophrenic individuals to survive in the community and experience quality of life.
CHAPTER FOUR
EMPOWERMENT

The Concept
Recall that the purpose of this study was to examine the conceptions of learning held by schizophrenic individuals and analyze them within a framework of empowerment. The purpose of this chapter is to present current literature on empowerment and to demonstrate the significance of this concept for the lives of schizophrenics. "Empowerment" has become a loosely and overused term that has strayed from its origins in social action theory. It is used in conjunction with any individual or group with a cause. This popular word has been applied to a variety of phenomena from socio-political movements to individuals defined by their role or fight. The concept is rooted in social action ideology of the 1960's, self help organizations of the 1970's and the struggle to rid society of discrimination in the 1980's. As a result of these diverse applications and meanings, it is difficult to define.

It is easier to say what empowerment is not: powerlessness, real or imagined; learned helplessness; alienation; loss of control over one’s life (Rappaport, 1984). Gibson (1991) set out to define empowerment and determine if it had utility for nursing. A number of common characteristics were present. "Empowerment" had to be contextually
relevant; defined by those concerned; involve some kind of relationship; be multi-dimensional; proactive, focusing on solutions rather than the problem; dynamic; a process and an outcome; dialectical; developmental; revolutionary rather than reformist. In the end, Gibson redefined empowerment as "a social process of recognizing, promoting and enhancing people's abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives" (p.359). This definition recognized individuality and uniqueness of situations and stressed an interactive process within varying contexts. This is paramount when examining the relationship between empowerment and mental health.

Empowerment and Mental Health

Despite these conceptual difficulties, the notion of empowerment has considerable utility in the mental health system and, to a certain extent, has stimulated and guided mental health care and social policies (Rappaport, 1981). In translating the political ideology to the mental health arena, Rappaport outlined two requirements of an empowerment ideology:

On the one hand, it demands that we look to many diverse local settings where people are already handling their own problems in living, in order to learn more about how they do it...On the other hand, it demands that we find ways to take what we learn from these diverse settings and solutions and make it more public, so as to foster social policies and programs and make it more rather than less likely that others
not handling their own problems in living or shut out from current solutions, gain control over their lives. (p.15)

With respect to human services, in order to avoid being "one-sided", it is useful to attend to ideas and solutions developed by professionals and those developed by "successful" people living out their own lives. By understanding the different perspectives, we may be able to do more to provide alternatives to those who do not "fit in" rather than trying to force such people into limited options developed by professionals.

It is also necessary to distinguish between "prevention" and "empowerment" which are overlapping but distinct. Prevention is primarily concerned with a goal, empowerment with the process. Prevention has emerged as a competitor for resources that have been traditionally allocated to treatment programs within the paternalistic structure of human service delivery. Prevention has attained the status of a discipline with a body of literature, professional organizations, educational curricula and administrative offices. Many prevention professionals reflect the underlying paternalistic ideology in their attitudes and interventions (Swift, 1984). While many prevention practitioners subscribe to an empowerment philosophy, they are not required to do so by the underlying ideology. The processes may be left to expediency or the resources of the intervener: legislation (e.g. mandating seatbelts),
regulation (e.g. safety procedures for industry), or mediation (e.g. facilitating and enforcing agreements reached by opposing factions) (Swift, 1984). The pursuit is to eliminate the negative health or mental health outcome. Prevention implies stopping a series of events already in motion or reacting in advance to an expected event. Prevention creates images blocking, impeding, obstructing, terminating.

Empowerment is positive. Participation of people is a key theme and distinguishing characteristic of the empowerment process. Unlike some prevention interventions, it requires the participation of those affected by the intervention. It is a transformation from an initial sense of powerlessness. Empowerment may result from programs designed by professionals, but more often will be found in circumstances where there is collaboration among professionals and the supposed beneficiaries, or in settings where professionals are not the key actors. An empowered person has competencies learned through "daily living". Health care professionals cannot empower people. People must empower themselves.

The Individual Perspective

It has been suggested that the way to conduct research into empowerment is to find out how the phenomenon is
subjectively experienced by those people who express the sense that they are, or are not, in control of their lives (Rappaport, 1987). Attempts to understand factors that facilitate or impede personal empowerment, the influence of the context and the process of moving from powerlessness to control over one's life, should deepen our understanding of health promotion which is defined as "the process of enabling people to increase control over, and to improve their health" (WHO, 1986). This firmly plants empowerment in the realm of health and mental health, in particular.

**Individual-Agency Incongruence**

Some mental health professionals have a hard time realizing that their "clients" are often quite capable of meeting their own needs. The idea that professions are "disabling" (Illich, 1977) is controversial and generally brushed aside by health care workers whose critical perspectives are easily submerged by the day to day and night to night crises that characterize many health care environments. Professionals of all kinds (whether lawyers, accountants, teachers or nurses) claim to be in the business of "helping" but, from some perspectives, often appear to be serving their own needs more than those of their clients. The idea that individuals understand their own needs is not one generally shared by health and social service providers. Indeed, in some studies, those who achieved the greatest control in their lives refused to accept their situation and
kept questioning and searching for options (Lord and McKillop Farlow, 1990).

There is often a discrepancy between the perceptions of mental health service participants and providers in relation to factors and priorities associated with personal empowerment (Ridgway, 1988). Repeatedly, professionals felt that clients had a high degree of need for professional services, medication monitoring, individual therapy and episodic case management, whereas "clients" spoke of difficulties with transportation and finances. Several studies indicate that when individual and agency goals are incongruent, people do not profit from therapy, are disappointed with their care, fail to comply with treatment and terminate services inappropriately.

Concrete survival needs have consistently been identified by individuals as being more important than treatment needs. For example, Ridgway (1988) reported that the client’s focus on acquiring permanent housing was in contrast to problems identified by caseworkers. Studies of homeless individuals have identified housing, employment, food and social benefits, safety, dignity and self-respect as primary needs rather than the need for mental health services (Rosnow and Tucker, 1985; Ball and Havassy, 1984). In developing A Framework for Support for People with Severe Mental Disabilities, The Canadian Mental Health Association (CMHA)
Trainor and Church, 1984) reported that it is difficult for people with severe mental disabilities to have confidence and feel good about their lives because they frequently find themselves in crisis. These individuals experience problems in living that affect many different aspects of their lives. Although the needs varied, they were not hard to identify because we all share them to some degree. Participants identified the following as relevant:

1) Homes
   Housing which offers good physical conditions and serves as a base for privacy, relaxation and rejuvenation.

2) Work/Education
   Employment or educational programs which allow meaningful daily activity in a setting which promotes dignity and self-worth.

3) Social Support
   Personal relationships which facilitate companionship and caring.

4) Income
   Earnings and income assistance/subsidies that are adequate to purchase what is required for life in the community.

5) Leisure
   Recreational activities and opportunities for the development of personal interest which reduce idleness and provide a sense of personal meaning and enjoyment.

The need for mental health care only becomes a priority after the individual has appropriate housing, sufficient income, social support, work, leisure and opportunities to learn.
Context and Barriers to Empowerment

Individuals in the mental health system have no difficulty identifying barriers to empowerment. They lose control over their lives, become depersonalized, weak and dependent after being labelled "mentally ill" (Chamberlain, 1978). They lose trust in their own judgment, become indecisive, demoralized and overly submissive to authority. Hence, Leete (1988) described the process of disempowerment as follows: "In many cases, our weakest attributes are those we learned in the very institutions supposedly there to help us; i.e. withdrawal, dependency, fear, irresponsibility, lower self confidence, lost self esteem, and shattered personal dignity" (p.6). It is not surprising that individuals are looking for alternatives to the present mental health system which they perceive as creating and fostering disability. Individuals in the 1984 CMHA study described the mental health system as "fragmented, exclusionary, inadequate, discontinuous, segregating-isolating, controlling-lacking consumer involvement, custodial and stigmatizing" (Trainor and Church, 1984).

These perceptions arise from a larger context. A deep stigma and prejudice exists towards persons who experience mental illness. There is a general presumption of incompetence. Ill people are "othered". The system of care has historically relied on a paternalistic doctrine, acting as a surrogate decision maker, as the 'benevolent parent' to
the individual experiencing mental illness. Capponi (1989) clearly explained the effects of the paternalistic attitude:

When paternalism pervading the system is so strong that many consumers are not even informed as to their diagnosis, as to the effects, side effects, name and function of their medication they are asked to take, how can one expect that they would feel free and empowered enough to make out almost invisible connections between the big buildings. It will take time, effort and an atmosphere which fosters learning rather than one which criticizes gaps in knowledge. (p.8)

This legacy continues to have a profound impact on service planning and delivery. The "provider knows best" approach has also been perpetuated by "professionalism" and reliance on the notion that professionals possess specialized knowledge that cannot be understood by non-professionals. When mental health professionals presume that schizophrenics are incapacitated and unable to recognize their own needs, these presumptions often can limit, impair and harm individuals more than the actual illness.

Historically, the mental health treatment environment, whether hospital or community, has taken away the person's ability to make important life decisions. Ridgway (1988) described what happened when an individual passively adjusts to an environment that does not meet his or her aspirations. Such a situation is maladaptive and "leads to relinquishment of autonomy, submergence of competence, and weakening identity," and "frequently manifests in apathy, alienation, and physical and psychological symptomatology". People are
expected to conform to standardized programming and relinquish their values and decision making power.

A power differential exists between the mental health system and those it is supposed to assist. This inhibits personal empowerment and growth and supports the inequity and discrimination of the status quo. Church and Capponi (1991) wrote that emotional pain and powerlessness are present in all our lives but we must recognize fundamental differences between participants and providers in the way in which these experiences are lived out.

The mental health world contains different professions, status hierarchies and world views as well as a range of contentious issues. Participants and providers occupy different positions in the world. They are separated from each other by virtue of their experience of participation. If there is to be any empowerment, both must confront the differences in status within the system and not disguise them. Many who participate in the mental health system and attempt to work with professionals in partnerships feel as though they have landed on Mars (Church and Capponi, 1991). They find themselves in strange environments learning to live by strange words, practices and values that they may not necessarily share.
Mental health professionals act based on their knowledge, judgments and values. If they are wanting to facilitate empowerment of the people they are working with, should they set aside their own values and judgments and go with the will of the people or should they consider themselves an integral part of the system and allow their values and judgments to intrude? The degree to which a mental health professional should impose their values on a system is a matter of continuing concern, debate and study. The empowerment literature implies that life decisions should be left to the individual. This is not to say that the judgments of mental health professionals can't serve as alternate perspectives or resources for the person. In the end, should the person not be the judge of the success of the process?

The power of mental health agencies is enormous. They can choose whether or not to assist the referred individual. They can choose what form the assistance will take. They choose what rules come into play to maintain that service and it is likely that even the attempt to access the service was made from some other agency rather than the individual. Lord and McKillop Farlow (1990) reported that for most of the participants in their study, the longer they received mental health services, the greater their state of powerlessness. People with mental health problems spoke of being repeatedly drawn into the formal mental health system
and farther away from community life due to a lack of informal supports within the community. Both the research and the literature suggest that, ironically, many of the proposals and interventions aimed at providing solutions have served to perpetuate inequality and oppression.

The Process

Empowerment is a process; the mechanism by which people, organizations and communities gain mastery over their lives (Rappaport, 1984). However, the content of the process is of infinite variety and as the process plays itself out among different people and settings, the end products will be variable and inconsistent. The inconsistency is in the ends rather than the process. Despite the variability, an explanation or framework of the process is advantageous when applying the concept of empowerment to various situations.

A developmental perspective has been used to describe the process (Keiffer, 1984). He described empowerment as "a necessary long term process of learning and development." The sense of powerlessness is viewed as a construction of continuous interaction between the person and his or her environment. It combines an attitude of self-blame, a sense of generalized distrust, a feeling of alienation from resources of social influence, an experience of disenfranchisement and economic vulnerability, and a sense of hopelessness in socio-political struggles. Empowerment
is viewed as a process of becoming, an ordered and progressive development of participatory skills and political understandings. Empowerment then assumes a dual meaning. It refers to the longitudinal dynamic and to the attainment of a set of insights and abilities.

Keiffer provided a model of empowerment mobilized when there is a violation to the person’s sense of integrity. There are underlying themes associated with this developmental model. In the struggle towards empowerment, conflict and growth are inextrinsically intertwined. It is essential that individuals continue to experience conflict to sustain their emergence. In addition to the function of constructive conflict is the essential contribution of the dynamic of ‘praxis’. Praxis refers to the circular relationship of experience and reflection through which actions evoke new understandings. Experience is then at the core of empowering learning. The reconstructing and reorienting of deeply engrained personal systems of social relations and the building of skills progress only through repetitive cycles of action and reflection.

Those labelled "mentally ill" have generally experienced extended periods of powerlessness in their lives as a result of segregation, prolonged dependency and failures in community support services. Mental health professionals rarely seem to understand the dependency that they
encourage. Nor do they understand that mental health participants incorporate and internalize oppression which becomes part of their identity. It is not surprising that individuals interviewed described the process of empowerment as uneven and a continual struggle.

In analyzing individuals' subjective experience of empowerment, Davis (1989) detailed five elements of empowerment. These have been modified for the purposes of this study:

Element 1 (E1) - Self-efficacy

Empowerment involves the transformation from sense of self as helpless victim to acceptance of self as assertive and efficient citizen.

Element 2 (E2) - Resources, knowledge and skills

Empowerment involves accessing or developing needed resources, knowledge and skills to accomplish goals, as well as becoming aware of existing competencies.

Element 3 (E3) - Authority and enablement

Empowerment involves working to ensure that societal structures respond to the individual need to develop their potentials.

Element 4 (E4) - Critical consciousness

Empowerment involves understanding individual and societal factors which contribute to the marginalization of people

Element 5 (E5) - Multi-dimensionality

Empowerment involves individuals, but meaningful change can only occur when they work together to improve the quality of life for themselves, their group, their community or other social systems.
The process of empowerment begins with a motivational trigger (Lord and McKillop Farlow, 1990). Motivational triggers lead to change because individuals learn that they have a voice and that there are people who listen and appear to understand. The process almost always involves some alteration in the person's environment or context. As the process evolves, participants find that their growing consciousness of their own capacities and rights helps them to develop a sense of personal control and competence. Those who become the most empowered experience a shift in their perspective or framework.

For Gibson (1991), empowerment was seen as a composite of three primary factors: a) attributes that relate to the client, b) attributes that relate to the nurse, and c) attributes that belong to both client and nurse. The process entails a thorough assessment of the biopsychosocial factors in the health care situation and an identification of needs or problems therein along with the positive aspects of the situation. The process of promoting and enhancing people's abilities to meet their own needs involves helping the individual construct a critical awareness of the situation and a realistic plan of action. Although not prescriptive, these descriptions of the empowerment process provide a framework within which to view learning, which, of course, is an essential corollary of empowerment.
Implications for Mental Health Professionals

First and foremost, mental health professionals must recognize that individuals in the mental health system have a voice, knowledge and experience and are more in a position to define their own priorities than are professionals. "Clients" are able to systematically assess themselves on social adjustment (Glazer et al, 1982). Segal, Everette-Dille and Moyles (1979) found that clients direct assessment of the environment is pertinent in predicting social integration. Similarly, Coul tin, Holland and Fitch (1984) reported that clients' own judgment of fit between program and his/her own needs or preferences was a good predictor of successful functioning. Meeting the individuals concrete needs is a method of engaging the person and developing a trusting relationship which can subsequently be used as a base on which involvement with mental health services can be initiated. Instead of labelling individuals as 'resistant' or 'uncooperative' as a way of contending with poor fit between what schizophrenics want and what mental health systems have to offer, mental health professionals need to listen and acknowledge their perspectives.

Listening and consultation are only steps towards sharing power, not the real thing. Some might perceive that power is something that is taken; others might perceive that it is given. Empowerment is a dynamic. The powerful rarely have power taken away. Instead, the powerless usually exert
pressure which eventuates in the powerful giving some of their power away. If schizophrenics are to become empowered, professionals must relinquish power. Power and empowerment are dynamics and as such, require analysis from the perspective of the powerless attempting to take power and the powerful giving up power. Mental health professionals can begin the process of decreasing the power differential by sensitizing themselves to the marginalization of schizophrenics.

From the perspective of the mental health system, the aim should be one of collaboration and facilitation. Individual involvement and participation are at the centre of the empowerment process. Participation itself is both empowering and reinforcing and enhances self confidence and sense of personal control. It means accepting individuals unquestionably and believing in their abilities rather than focusing on "disability or deficiency". Facilitation requires that professionals change their views of themselves in order to change the intervention. Professionals should not seek to do for others what they must do for themselves. They should not focus on designing programs 'on behalf of' others. Rather, professionals must strive to collaborate with schizophrenics to develop emotional and practical resources. While professionals cannot stimulate or cognitively duplicate the fundamental dynamic of empowerment, they can actively facilitate individuals, or
citizen organizations, in their own critical and constructive examinations of their efforts towards changing social and political situations (Keiffer, 1984). People working in the field of health promotion need to think about participation and empowerment in broader terms. This includes learning from other areas of endeavour such as adult education and participatory research (Lord and McKillop Farlow, 1990). It means looking at the bigger picture, the individual's life and their perspective of that life and moving beyond clinic doors in our attempts to assist individuals to become empowered.

Summary

The present chapter has reviewed literature related to the concept and process of empowerment. Like other marginalized groups, empowerment is an issue faced by schizophrenic people living in the community. The literature has identified concrete needs such as homes, work/education, social support, income and leisure that schizophrenic individuals view as priorities for survival in the community and which are central to their becoming empowered. Various elements have been identified by the authors as crucial to the empowerment process. Davis (1989) provided a descriptive set of elements with which to analyze the empowerment process. These elements involve aspects of learning if individuals are to be successful in this process. To review, the purpose of this study is to
identify conceptions of learning held by schizophrenic individuals living in the community and to analyze these conceptions within a framework of empowerment. The following chapter describes the methodology for the study tying together dimensions of living, the process of empowerment and conceptions of learning.
CHAPTER FIVE

METHODOLOGY

Introduction
This was an ex-post facto study of twenty schizophrenic individuals living in the City of Vancouver and receiving services from Greater Vancouver Mental Health Teams. Readers should recall that the prime purpose of the study was to examine schizophrenics' conceptions of learning arising from "dimensions of daily living" and their need for personal empowerment. Due to the nature of the study, the participants involved and the theme of empowerment, a qualitative methodology was chosen. This chapter describes the methodology used, its suitability, the sampling process, the interview process, reliability and validity issues, and the treatment of the data. In this chapter, the writer discusses "issues" (ie. pertaining to sampling) and the strategy adopted to resolve or respond to them.

Suitability of Methodology
Issues
Learning is a corollary of empowerment. Professionals cannot empower schizophrenic individuals. Schizophrenics can only do this for themselves. However, professionals can facilitate the process of empowerment. If this is to occur, an awareness of conceptions of learning held by these individuals is a starting point on which to base new
knowledge in the struggle for personal empowerment and control. Conceptions of learning are subjective entities associated with the person's life experiences. These conceptions were not manipulated but described.

The researcher came to this study not as an objective or detached observer but as one who is part of the mental health system and therefore had a specific point of view. Having worked on the streets of Vancouver, the author felt that the 'system' was failing these individuals and that more energy should be devoted to understanding the schizophrenic experience. The central conceptual framework of this study was phenomenology. It is essential that the methodology reflect this epistemological stance. The focus of this study is the subjective experience.

Spending time and talking with schizophrenics is a worthwhile experience for both parties. Listening and understanding can reduce the inequity that exists between professionals and schizophrenics. The research process was therefore educational and political and had to be "enabling" those involved. Subjecting schizophrenics to paper and pencil tests may be enlightening but does not enhance or buttress empowerment processes. Hence, in choosing a suitable research methodology, it was imperative that the process not be disempowering for the interviewees.
The desired end product of this study was a rich, holistic description of schizophrenics’ conceptions of learning in relation to dimensions of daily living and personal empowerment. Such a description has the potential to generate hypotheses for future research and has considerable implications for the way in which practitioners interact with schizophrenic individuals. It followed that the required methodology produce a rich description of the data, the dimensions explored and the context.

**Procedure**
The research was an ex-post facto study involving conceptual analysis of transcripts supported by specific procedures to ensure the construct validity of data derived from interviews.

**Sampling Process**

**Issues**
The group under study consisted of twenty schizophrenic individuals living in the City of Vancouver and receiving mental health services from Greater Vancouver Mental Health Teams. Only mentally stable schizophrenics were candidates for the study as instability would limit the individual’s participation in the interview process. The individual’s "mental stability" was determined by the researcher when initially contacted. Individuals were determined to be mentally stable if they were:
1) residing in the community, 
2) their conversation could be understood by the researcher, 
3) symptoms (i.e. hallucinations and delusions) did not unduly interfere with the conversation.

Due to the nature of the study and the methodology used, participants had to volunteer for the study. It was important that the individuals not feel coerced to participate and that refusal to participate would not affect them in any way. There are biases associated with volunteer sampling however the nature of the study dictated that participants want to voice their perspectives and that this group of individuals would provide the richest description of their conceptions of learning. Besides, internal rather than external validity was of primary concern. The chief concern was with relationships between conceptions of learning and elements of empowerment (with respect to dimensions of daily living). The researcher was not attempting to generalize the findings beyond the particularities of the study population.

Particular attention was given to ethical concerns arising from the nature of the participants and the power issues involved. Some schizophrenics are very suspicious so it was necessary to ensure that consent forms describing the study, their rights, and measures to ensure confidentiality and anonymity, were clearly explained in plain language (Appendix C). It also required an assurance on the part of
the researcher that none of the information provided would be revealed to their therapists and that the study was in no way connected to their association with GVMHSS other than it was a criteria for inclusion.

Procedure
A purposive sampling strategy was used in order to select a population. All individuals had previous contact with the researcher in their association with Greater Vancouver Mental Health Service Society and a certain level of rapport had already thus been established. Potential participants were identified by reviewing assessments written by the researcher as a result of previous contacts over the past three years. Individuals between the ages of 25 and 50 years of age with a diagnosis of schizophrenia and two previous hospitalizations were included as potential participants. Individuals who did not meet this criteria and who were experiencing continuing problems with substance abuse, organicity or intellectual functioning and who could not fluently communicate in English, were excluded. Selected individuals were contacted either by telephone or in person at their place of residence to request their participation in the study, obtain informed consent and arrange an interview time and location suitable to them. No further individuals were sought after ten consenting males and ten consenting females had been found.
Interview Process

Issues
This section of the methodology chapter explores the issues related to data collection. The nature of the investigation and the participants involved were of primary concern when deciding on the interview format. The format of the interview had to encourage rapport and yet have enough direction to elicit information pertaining to the dimensions of interest. The questions had to have particular meaning for the schizophrenics and be worded in ways that would evoke a response. The format had to address the power differential that existed between the researcher and the participant as a result of previous contact within a different context. Participants were familiar with being interviewed for clinical and psychotherapeutic purposes. The format had to clarify for the individual, the research, information gathering focus of the interview rather than the type of interview that they were accustomed to so that expectations were clear.

When deciding on the logistics of the interview, it was necessary to take a number of factors into account. Many schizophrenics are maintained in the community on medication which has the potential to decrease concentration and attention span and produce restlessness and involuntary tremors. Limiting the length of the interview would increase the number of interviews that the individual had to
participate in in order to get the data. There was also the question of where to do the interview. It would have been convenient to interview people at their mental health team office but this would not conducive to a frank exchange and this idea was discarded. Interviews were mostly conducted in the interviewee’s home.

Due to the qualitative, inductive nature of the research, it was important that the interview process be recorded. It was critical that the data represent the interviewees’ own words and usages. Paraphrasing the interviewees’ accounts would mask, distort or replace connotations intended by the participants and would misrepresent the data.

Procedure
A semi-structured interview schedule was used (Appendix D). This provided for questions concerning dimensions of living and elements of empowerment yet was flexible, informal and provided the individual with some control over the process. The interview schedule was piloted on two schizophrenic who helped formulate questions and determine the appropriate length. Demographic data included: age, gender, living circumstances, number of previous hospitalizations, on or off medication, educational level, marital status, work or participation in educational activities. Individuals were interviewed at their place of residence. The purpose of the research was explained to the individual at the beginning of
each interview. Individuals were informed that they could stop the interview or go off the record at anytime. The interviews were audiotape recorded and people were aware that the interviews would be transcribed and tapes subsequently erased. Only the researcher and committee members would have access to the data and individuals would not be identifiable by demographic information or the transcripts.

Reliability and Validity

Issues
A common criticism directed at qualitative investigations is that they fail to consider issues of reliability and validity. This was even more of a concern for this study as many would ask how reliable or valid are schizophrenics’ reports. The purpose of this study was to delve into the schizophrenic experience and by questioning the validity or reliability of their experience, people contribute to their disempowerment. However, this kind of concern reinforces the need pay particular attention to questions concerning validity.

Reliability refers to the extent to which data are consistent over time. This poses a problem for studies concerned with naturalistic behaviour or unique phenomena and the issue has been posed as one involving the "trustworthiness" of the constructs and findings (Lincoln
and Guba, 1985, p.290). Would independent researchers discover the same phenomena or generate the same constructs in the same or similar setting? In the language of qualitative research, this is the problem of "consistency" (Lincoln and Guba, 1985). It also addresses the degree to which other researchers given a set of previously generated constructs, would match them with the data in the same way as the original researcher. This is another aspect of "consistency". Recall that in this study Saljo's model of learning was interrogated with conceptions of learning derived from schizophrenics. In plain language the question was - if the researcher thinks lines 3-9 of a transcript are evidence of Saljo's level 4, is this also the view of other "independent" judges?

Validity is concerned with the accuracy of the findings. Establishing validity requires determining the extent to which conclusions effectively represent empirical "reality" and whether conceptual decisions or constructs devised by the researcher represent or measure the categories of human experience that occur. Do excerpts from the transcripts represent conceptions of learning or elements of empowerment? In Lincoln and Guba's language (1985), this concerns the "neutrality" of the findings. The crucial issue in this study was concerned with construct validity.
Procedure
Three procedures were used to determine construct validity and are described in the following tables. All were part of an overall attempt to "triangulate" (Lincoln and Guba, 1985) on the data so as to protect the researcher from making "invalid" inferences concerning the meaning of the transcripts.

Concerning Conceptions of Learning (Inter-Judge)
Eight judges were given sample transcript excerpts of data that the researcher had previously categorized as evidence of Saljo’s different conceptions of learning and were asked to identify which conception(s) of learning the data exhibited. The judges responses were then compared to the researcher’s interpretation of the data to determine percent agreement. Data were arrayed in the blank table shown here (Table 1).

<table>
<thead>
<tr>
<th>Judges</th>
<th>% Agreement</th>
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<td>I</td>
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</table>

Conception 1
Conception 2
Conception 3
Conception 4
Conception 5
Concerning Elements of Empowerment (Inter-Judge)

Eight judges were given sample transcript excerpts that the researcher had previously classified as demonstrating each of Davis' elements in the empowerment process. Each judge was asked to determine which element(s) of empowerment the excerpt described. The judges' responses were then compared to the researcher's judgments of the data to ascertain percent agreement (Table 2).

Table 2
Inter-judge agreement concerning conceptual meaning (Davis) in sample transcript excerpts

<table>
<thead>
<tr>
<th>Judges</th>
<th>% Agreement</th>
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<tbody>
<tr>
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<td>I</td>
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<td>Element 1</td>
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<td>Element 4</td>
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<td>Element 5</td>
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</table>

Concerning Whole Transcripts (Researcher-Judge)

The next procedure used to address construct validity was to give two judges an entire transcript with operationalized definitions of conceptions of learning and elements of empowerment and request that they first circle relevant elements of empowerment with pencil and note the element beside the phrase e.g. E1, E2, E3 and so on. They were then requested to highlight those parts of the transcript that
demonstrated Saljo’s conceptions of learning and note the conception beside the phrase e.g. C1, C2, C3 and so on. This transcript was then compared to the researcher’s interpretations on the transcript.

**Concerning Construct Meaning (Researcher-Interviewee)**
The final procedure utilized to determine construct validity was to perform a second interview with two of the interviewees following data analysis to explore the researcher’s interpretations with them and to obtain their input regarding the validity of these interpretations.

**Treatment of the Data**

**Issues**
This section of the methodology chapter discusses the management of the data obtained and how it was analyzed. It was important that the data be managed in a systematic manner to ensure that confidentiality was maintained and that the data did not become too cumbersome that it made analysis difficult.

**Procedure**
After each interview, tapes were transcribed and printed. Participants were given a code number which was attached to their demographic and transcript data. Only the researcher was aware of which interviewees provided which data. The master list containing the interviewees names remained
securely locked until the end of the study at which time it was destroyed.

As each transcript became available, it was analyzed and influenced the direction of future interviews. Hence, the researcher was able to confirm or reformulate earlier interpretations of the data. Throughout data collection and analysis, the researcher kept a journal that described themes to be explored in subsequent interviews.

Saljo’s conceptions of learning and Davis’ elements of empowerment were used as a template to analyze and mark the transcript data. The data were arrayed in the following matrices (Tables 3 and 4) where "elements of empowerment" or "conceptions of learning" and "dimensions of living" were framing variables. Once a matrix was completed for both conceptions of learning and elements of empowerment for a transcript, the conception of learning matrix was placed on top of the element of empowerment matrix to provide an overall view of that particular interviewee akin to a template (conceptions) through which to view elements of empowerment.

Organization of the Results

By now readers are well aware of the fact the author interviewed schizophrenics in community settings. The context within which this work was performed is important
### Table 3
Framework for Organizing Transcript Data Concerning the Empowerment of Schizophrenics

<table>
<thead>
<tr>
<th>Elements of Empowerment</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
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<th>Dimensions of Living</th>
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<td>Home</td>
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<tr>
<td>Work/Education</td>
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<tr>
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<td>Income</td>
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<td>Leisure</td>
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<tr>
<td>Mental Health</td>
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</table>

### Table 4
Framework for Organizing Transcript Data Concerning the Learning of Schizophrenics

<table>
<thead>
<tr>
<th>Conceptions of Learning</th>
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<th>II</th>
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<th>Dimensions of Living</th>
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<td>Mental Health</td>
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</table>
and, in the following chapter, the author describes the socio-demographic characteristics of the interviewees and gives the reader a sense of what it was like to interview them. In Chapter 7, the author shows how the transcripts were interrogated in the initial analysis. In brief, a description of how data was transposed to a matrix not necessarily for "quantitative" purposes, but to provide a visual representation for the author as another means to interpret the data.

In Chapter 8, the author examines ways in which the elements of empowerment were nested within the dimensions of living. The concern here was with the element (i.e. critical consciousness) itself. Both the presence and absence of the element was noted. So, if a respondent felt he and she had or did not have "self efficacy", it was noted.

Chapter 9 describes the individuals' conceptions of learning with respect to the different dimensions of living. The conceptions of learning were not placed on a bipolar continuum as the elements of empowerment were. The fact that individuals did not voice one or more of the conceptions of learning did not lead to a conclusion that the individual did not possess that particular conception.

In Chapter 10, the author examines interactions between elements of empowerment and conceptions of learning in the
context of dimensions of living. In this chapter, there is a focus on the subjective and objective constructions of schizophrenia that lead to disempowerment.

Chapter 11 presents the limitations of this study and some of the numerous possibilities for future research that explores schizophrenia and empowerment.

Summary

This chapter has described the methodology used in the investigation. Issues related to the suitability of the methodology, the sampling process, the interview process, validity and reliability and the treatment of the data have been addressed. The following chapters describe the results of the data analysis.
CHAPTER SIX

THE INTERVIEWEES AND THE INTERVIEW

The purpose of this chapter is to introduce readers to the population studied: twenty schizophrenics living in Vancouver. Following a presentation of the socio-demographic characteristics of the population, the author discusses the interview process to give the reader a feel for what it was like to interview these individuals.

Socio-Demographic Characteristics

Overview

The 20 interviewees were all living in the City of Vancouver at the time of the study. Eight lived in supervised hotels in the downtown eastside/skid row area. Three lived in psychiatric boarding homes, four lived on their own, two lived at emergency shelters and three lived in the family home. The age range for males was between 25 and 44. The age range for females was between 26 and 49. Most interviewees had never married. All but one had worked previously but none were employed at the time of the study. Most interviewees had not completed high school and only four were attending educational programs at the time of the study. Two males and two females had stopped taking medication when interviewed. Half of the group had been hospitalized less than ten times; the other half, more than ten times. Table 5 provides an overview of the socio-
demographic characteristics of the interviewees. The reader is reminded that the population consisted of twenty individuals known to the author and can no way be generalized to the schizophrenic population at large.

Table 5
Characteristics of Schizophrenics Interviewed in a Study of Learning and Empowerment

<table>
<thead>
<tr>
<th>Socio-Demographic Characteristics</th>
<th>Clinical History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Sex</td>
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<td>25</td>
<td>M</td>
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<td>M</td>
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<td>25</td>
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<td>44</td>
<td>M</td>
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<td>M</td>
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<tr>
<td>44</td>
<td>F</td>
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<tr>
<td>26</td>
<td>F</td>
</tr>
</tbody>
</table>

Legend
M.S.- Marital Status (S=single, M=married, D=divorced)
Education - Past - (G=grade, C=college, U=university)
Present - Any education program (+=yes, -=no)
Work Experience - Past (+=yes, -=no)
Present (+=yes, -=no)
Home - (Apt=apartment, B.H=boarding home, S.H=supervised hotel, H=hotel, Fam=family home, E.S=emergency shelter)
Med - Medication Use (+=yes, -=no)
Hosp - No. of Hospitalizations (<10 vs >10)
Case Vignettes

PM1 was a 25 year old male, living on his own in a basement suite apt. on the east side of the city. He was diagnosed as schizophrenic almost four years ago and since that time had been hospitalized at least a dozen times for either self inflicted injuries or aggressive behaviour in the community. He frequently terminated involvement with the mental health system and questioned his need to take medication which he reported had only marginally controlled his voices and delusions and had given him uncomfortable side effects. He was not taking medication at the time of interview. PM1 had never had an intimate relationship with a female although desired this. He was well connected to support services in the community which he accessed when he needed to. He had a college education and planned to further upgrade with the goal of obtaining employment. He had not worked since his first hospitalization however was employed at various jobs prior to that. He was articulate and appeared excited at the opportunity to voice his opinions and views. During the interview, he was prone to go off on tangents however appeared to have no difficulty with the questions posed. PM1 was brought to hospital by police approximately two days after the interview and subsequently went to Riverview.

PF1 was a 33 year old female who recently moved to the 10 bed psychiatric boarding home where she then resided. She moved to get away from a noisy hotel in the skids. She was
not happy with her living situation. PF1 was diagnosed schizophrenia approximately 12 years ago. At that time, she was married and had a child. At the time of the study, she was divorced and estranged from the child. She had numerous hospitalizations resulting from self inflicted injuries at the direction of her voices. She was quite dependent on the mental health system, initiating contact frequently. She frequently experienced the negative symptoms of schizophrenia with extreme bouts of depression. PF1 was feeling depressed and hopeless when interviewed and voiced suicidal thoughts. She appeared to have difficulty responding to questions posed. PF1 related to author as therapist rather than researcher.

**PM2** was a 28 year old male who was recently discharged from hospital to the 9 bed, all male, psychiatric boarding home where he resided. This was his first boarding home experience, previously living on his own and employed. PM2 had been hospitalized six times in the last four years since being diagnosed schizophrenic. He was bright, articulate, talented and energetic. He had disengaged himself from mental health follow-up in the past as did not believe the diagnosis, did not want medication but was willing to accept same if for nothing else but to attain his goals of independence and employment again. He was quite aware of the stigma associated with mental illness yet had not incorporated this into his identity. He was playing tennis
with another resident when I arrived. He was enrolled to start a computer training course that week and was looking for part-time work.

PF2 was a 28 year old female who lived on her own in an apartment which was subsidized. She was diagnosed as schizophrenic about 10 years ago however she had received other diagnosis in the meantime. She had been hospitalized six times in the past ten years. She had numerous difficulties in personal relationships with family and males and desired to one day get married. PF2 was motivated and talented. She volunteered, playing guitar and singing at a hospital and continued to pursue her musical aspirations. When she spoke of herself, her self esteem was low despite her accomplishments. There were instances in the interview when she preferred to relate to the author as therapist rather than researcher.

PM3 was a 25 year old who had a seven year history of schizophrenia. He had been HIV +ve for the past five years. He had lived as a permanent resident at an emergency shelter in the city for the past three years. PM3 had been hospitalized five times. He generally took his medication as directed and attended his community follow-up. He presented as happy, go-lucky; at times, flirtatious, but always willing to get involved or assist others if he could. In any interaction, there was an underlying sense of
loneliness despite the facade. PM3's voices and delusions never went away but were pleasant. At times during the interview in his room, his fantasies would enter into the conversation but always within the context of what was being discussed. There was a point that PM3 was trying to make.

PF3 was a 30 year old female who resided at a supervised hotel in the skids where medication was dispensed by staff in the office. She had lived in boarding homes in the past but disagreed with the control exerted by staff and said she would never live in that situation again. She was diagnosed as schizophrenic approximately eight years ago. She had been hospitalized more than a dozen times for self inflicted injuries or setting fires at the direction of her hallucinations. PF3 was divorced. She had a four year old daughter who resided with her sister, adopted at birth. PF3 visited her daughter on a regular basis. When the author spoke with PF3, she reported recently being raped. This tragedy was overshadowed by her news that she was getting married in June and extremely excited about this.

PM4 was a 44 year old male who resided in a supervised hotel in the skids where medication use was monitored by a worker. He was diabetic. He was diagnosed at age 28 as schizophrenic and reported that his life had changed drastically as a result. He no longer saw the prospect of a girlfriend and was cautious about the possibilities of his
ever returning to the work force despite a desire to do so. He had been hospitalized over 10 times as a result of paranoid thinking and auditory hallucinations. He reported moving his place of residence at least twenty times in the past ten years due to his paranoid thoughts. His chaotic life had also forced him to live on the street on more than one occasion. He attended educational classes at the diabetic clinic. He freely articulated his ideas and opinions despite his belief that his performance was poor. He sought reassurance.

**PF4** was a 33 female living in a supervised hotel in the skids. She was diagnosed as schizophrenic ten years ago. She also had an extensive history of street drug use dating back to her time of diagnosis. She refrained from using drugs although admitted to having difficulty not returning to that lifestyle particularly because it was around her all the time. She had been hospitalized several times associated with her hallucinations and substance abuse. She wanted to have her own apartment and get out of the skids but didn’t see this ever occurring. She was hopeless and lost, lacked future plans and lived one day at a time.

**PM5** was a 44 year old musician who had resided at the emergency shelter as a permanent tenant for the past twelve years. He had lived on the streets for two years prior to going to the emergency shelter. He was moving into
subsidized housing in a month after being on the waiting list for three years. He was diagnosed as schizophrenic 16 years ago and did not agree with the diagnosis nor his hospitalizations. He took medication and attended the mental health team as a condition of his residence at the shelter. He had had a successful career in the music industry. Alcohol abuse among other reasons forced him to leave the band. Since that time, he had lived an isolative existence obtaining enjoyment only out of his music.

PF5 was a 49 year old female who resided at a supervised hotel where medication was dispensed. She was no longer taking the medication. She recently had been discharged from hospital adding to her more than twenty admissions over the years. PF5 had led a chaotic, nomadic life of moving frequently and living on the street in most major cities. Her paranoid thoughts and voices never went away leading her to an isolative life with minimal interactions with others. Her voices were present during the interview however did not appear to cause her distress nor interrupt her responses. She would lose her train of thought at times but in the end, she would answer the questions. She had no future plans.

PM6 was a 24 year old male living in a hotel in the skids. He recently had become a father but was estranged from the woman and child for reasons that he was unclear about. He was diagnosed as schizophrenic four years ago and had four
admissions to hospital. He frequently experienced voices and muddled thinking that would distress him to the point of thoughts about ending his life. He hoped to complete high school and go to college. He had worked full-time at various jobs after dropping out of school in grade 11. PM6 had a supportive family that he did not want to rely on. He had plans to move out of the skids into his own apartment.

PF6 was a 28 year old female living with her parents which was not a mutually satisfying arrangement. PF6 refused to move out on her own. She was diagnosed schizophrenic six years ago and had been hospitalized on a yearly basis related to voices that directed her to kill herself or bizarre religious delusions. She would stop medication shortly after returning home as did not believe that she required it. She spent her days chain-smoking and drinking coffee much to her parents dismay. Prior to her first hospitalization, she and a partner had a hair salon business that was quite successful. PF6 acknowledged her parents dismay and wanted to return to school or part-time work but felt that her concentration and abilities had deteriorated. She did not see her situation changing in the near future.

PM7 was a 32 year old male living in a hotel in the skids. He had been diagnosed as schizophrenic 8 years earlier. He described himself as a loner. As a youth, he dropped out of school in grade 10 as did not want to attend alternate
school. PM7 had had extensive legal involvement and insinuated that he had to move to B.C. for that reason. He had lived in Stanley Park for several weeks prior to getting a room at the hotel. He had lived on the streets many times in his life. He had been hospitalized twice for aggressive behaviour in the community. He had been connected to the mental health team and reported taking medication to keep him in control so that he didn't hurt people.

PF7 was a 37 year old female who had led a chaotic transient life in Vancouver for several years. She was diagnosed as schizophrenic at age 27 and experienced paranoid and persecutory thoughts, fearful that her life was in jeopardy. She was divorced, estranged from her daughter and had spent numerous occasions living on the street or at emergency shelters. PF7 was well connected with services and volunteered with a local advocacy group for people with mental health problems. She was articulate and concerned with "patient" rights and the improvement of services.

PM8 was a 30 year old male living alone in a hotel in the skids. He planned to move to a different hotel at the end of the month. He had been diagnosed as schizophrenic 8 years ago and had been hospitalized four times due to auditory hallucinations and disorganized, confused thinking. He attended the mental health team to receive his medication. He was bright and articulate. He had dropped
out of school at grade 11 but worked at several different jobs up until two years earlier. He spoke of how marginalized he had become. He wanted to find a job but didn’t have decent clothing to go for an interview. He was hoping welfare could give him some money for this.

PF8 was a 28 year old female who had been diagnosed schizophrenic four years earlier. She had been hospitalized yearly since that time due to voices that instructed her to take her life. She was living in a boarding home although desperately wanted to be on her own, go back to college and have a part-time job. She was frustrated with the mental health system as felt that over the years, she had gotten to know herself and symptoms and did not feel that they respected her enough to listen to her or allow her to participate in treatment decisions.

PM9 was a 32 year old male living in a supervised hotel in the skids. He was diagnosed as schizophrenic ten years earlier and had been hospitalized at least twenty times for suicidal gestures or aggressive behaviour in the community associated with his voices. He had had numerous dealings with the police in the city and had spent time in jail and the Forensic Institute. He had moved around a lot as was often evicted from apartments, hotels due to his behaviour. PM9 was content with his current accommodation. He had not worked for six years. He had no intention of returning to
school or seeking employment. He said that he really didn’t care what happened.

**PF9** was a 44 year old female who resided in the family home with her father. She had never married. Her mother had passed away several years ago and she spent all her time caring for her infirmed father. She was diagnosed as schizophrenic 20 years earlier. PF9 always stopped taking medication when at home as it made her feel too tired. She would take herself to hospital when feeling unwell, although always with physical complaints. She never agreed with the diagnosis that was given to her and refused mental health services in the community. PF9 was fortunate to have a fairly good network of friends in the community.

**PM0** was a 28 year old male who had spent more time in the Provincial Mental Hospital, Riverview, in the last ten years than he had in the community. He recently had been released from the hospital after a two year stay. He spoke about how difficult it was to adjust to community living. He was living in a supervised hotel however had been given an eviction notice for drinking alcohol which was against the rules. PM0 talked about his difficulties getting hooked up with welfare. He was participating in a educational/work program with the hope of future employment. He had worked as a janitor at Riverview for the last year. Despite support from his father and "minimal" support from the
mental health team, he did not believe that he was adjusting well and was feeling increasingly stressed. He said that he really wanted to make it in the community but was fearful that in the end, he would be back in hospital.

**PF0** was a 26 year old who had been diagnosed as schizophrenic three years earlier. She lived with her parents and siblings and had worked part-time in her father's business until he retired the previous month. She did not know what she was going to do and was finding the time quite long. PF0 was intermittently bothered by voices that made derogatory or frightening comments to her. She thought the voices might belong to the "Devil". Although supportive, she said that her parents had difficulty coping with her when she wasn't feeling well and that they didn't understand nor appeared to want to.

**Interview Process**

In most qualitative research the author does not go on at length about the interview process. It is usually dismissed as constant and readers are left to assume that what was supposed to be done (in the interview) was done. In this case, the author was interviewing schizophrenics and the ability of the reader to understand and use the results will be enhanced if he or she learns more (than is usually the case) about the interactions between the researcher and the respondents. Hence, in this section, the author presents
and summarizes some of her field notes so as to give the reader some of the "flavour" of the study, organized around four issues: context, current mental state, interview schedule, power relations.

**Context**

Individuals were interviewed primarily in their hotel rooms, apartments or the living room of homes/boarding homes. Attempts were made to interview individuals in a quiet, private area although this was not necessarily something that could be controlled. On several occasions, interviews were interrupted by other residents wanting to bum a cigarette or a light, noise from stereos or conversations between other residents in the hallway. Many of the hotel rooms had both poor ventilation and problems with heating. On more than one occasion, a cockroach on the table where we sat would become the focus of attention giving the interview a depressing yet amusing twist as the insects fate was decided between questions about learning and empowerment. A few individuals were pressed for time as had made other plans, had just received news about a function or had to attend somewhere to get a meal for that day. To a certain extent these factors interrupted the interview process. Interviews lasted from between 45 minutes and one hour.
Current Mental State

Interviewees were deemed to be mentally stable if the author could understand their conversation and their symptoms did not interfere with their ability to express themselves or manage an interview. On two occasions, interviews had to be discontinued as the interviewees became increasingly agitated and unable to focus due to auditory hallucinations and suspicious thinking. These individuals had been informed that they could stop the interview at any time however it was the interviewer who stopped the interviews in the end. One individual reported that she was feeling suicidal during the interview which ethically and professionally, the author could not dismiss and had to be dealt with. The individual’s mood at time of interview influenced responses to questions and the desire to elaborate on those responses. Some reports incorporated the individual’s delusional system or bizarre ideas as they elaborated on their response. This proved to be a rich source of data and forced the author to read between the lines when analyzing the transcripts.

Interview Schedule

The interview schedule was piloted on two individuals prior to the onset of data collection. These interviews were not included as part of the study data. Questions were revised based on these interviews. After the first five interviews in the data collection, the interview schedule was revised
slightly. Individuals appeared to have difficulty responding to the 1 - 10 scale although such a scale is commonly used in psychiatric mental status exams. The author suspected that the concept of control may have been difficult to apply to such a scale. The scale was revised to a high - low scale where interviewees were asked to place a coin between the two poles to demonstrate the amount of control that they felt they had with respect to the different dimensions of living. This proved to be a fruitful means of initiating the conversation when asked why they had placed the coin where they did.

Preliminary analysis of the first five interviews also demonstrated that individuals were more apt to discuss their conceptions of learning within the realm of work/education and that more of an effort had to be made to ascertain conceptions within the other dimensions of daily living. This was accomplished by adding more specific questions directed at learning in their daily lives (i.e. How do you learn how to panhandle? How do you learn to live on the street? How do you learn to survive?).

**Power Relations**

Interviewees had had previous contact with the author which was hoped to have positive effects on the interview situation as previously described. Regardless of position, nurse or researcher, a power differential existed between
the interviewer and interviewee from the start. The author had to wonder if responses would have been different if the individuals were not aware that the author was a nurse. When the interviewee chose to view the author as nurse rather than researcher, it tended to steer the interview into clinical areas where interviewees would seek advice. This would influence the interview. The author’s feelings of anger, disgust and empathy at the plight of these individuals influenced the line of questioning that was pursued. This is not to say that the data obtained was not valid or reliable. The interview schedule was followed but its semi-structured nature allowed for different lines of questioning to be pursued. A different interviewer may have chosen to pursue a different line of questioning.

Summary
Chapter Six has provided a description of the socio-demographic characteristics, case vignettes and the interview process from the perspective of the interviewer. By doing this, it is the hope that readers will become almost familiar with the interviewees as they read the following chapters which describe their learning and personal empowerment in their words. Chapter Seven will describe the initial stages of analysis and validation measures prior to exploring the results.
CHAPTER SEVEN
PRELIMINARY ANALYSIS OF DATA

The purpose of this chapter is to describe the initial stages of data analysis and the results of the validity and reliability procedures. Matrices were used to paint an overall picture of conceptions of learning and elements of empowerment. This was done on a case by case basis as each transcript was completed.

Analyzing the Transcripts
As transcripts were completed, they were analyzed using the operationalized definitions of Davis' elements of empowerment as presented in Chapter Four. The author noted the elements of empowerment and their mirror image ie. self-efficacy vs. powerlessness. When the author noted either positive or negative manifestations of a particular element, the transcript was marked "E1 or -E1". This was done on each transcript. For example, PF3 remarked, "People here have their own lives, independent, ya know." This statement was marked with an "E1". In PM4's transcript, he commented, "I feel like a failure you know." This was marked "-E1".

Once the transcript had been analyzed for manifestations of the elements of empowerment, it was reread, this time looking for conceptions of learning. This was accomplished by using the operationalized definitions of Saljo's five
conceptions of learning, presented in Chapter Three. If the individual’s statement reflected a conception or conceptions of learning, a notation was made on the relevant part of the transcript i.e. "C1, C2, C3, C4, C5". For example, PF2 stated, "I used to carry books home and just learn and study and get really good marks..." This reflected Conception 2 and was marked accordingly.

**Mapping the Matrix**

Using the matrices presented in Tables 3 and 4, each transcript was subsequently mapped. An empowerment matrix and a learning matrix were developed for each transcript. In order to map the elements of empowerment, the notations were reviewed so that elements were marked under the appropriate dimension of living. Because the dimensions of living were overlapping and influenced each other, interviewees frequently discussed more than one dimension of living simultaneously. When it was difficult to determine what dimension of living the individual was referring to, the author went back to the question to identify the context associated with the response.

Once positive and negative elements of empowerment were mapped on a matrix, the author returned to the transcript to identify excerpts that manifested conceptions of learning. A separate matrix of conceptions of learning x dimensions of living was completed. As it was not the author’s intent to
perform quantitative analysis on the data, the cell of the matrix was shaded rather than counting the number of instances that reflected a particular conception. For example, if the excerpt about housing manifested Conception 3, then that cell of the matrix would be shaded. The shading painted a picture of the conception(s) of learning predominantly used by the person in discussing their daily lives. The fact a person did not mention a certain conception of learning in no way meant that the person did not possess that particular conception. When a person manifested Conception 2 in discussing housing and not when discussing income, it was likely related to the questions posed not eliciting that conception rather than it not being present. Once completed, the shaded conceptions of learning x dimensions of living matrix was placed on top of the existing matrix of elements of empowerment x dimensions of living providing an overall picture of elements and conceptions for each dimension of living for that person.

**Issues of Reliability and Validity**

Three procedures were used to examine the reliability and validity of the authors judgments concerning manifestations of empowerment and learning. These procedures were presented in Chapter Five. The results of these validity procedures are discussed herein.
Conceptions of Learning

The researcher secured the assistance of eight judges. All eight judges worked in the mental health field - two from psychology, three from nursing and three from medicine. Four judges worked in hospital psychiatry and four worked in community psychiatry. All judges were currently working with schizophrenic people at some level. The eight judges were given the same sample of twenty transcript excerpts along with operational definitions and examples of the five conceptions of learning (see Appendix E). These excerpts had been previously rated by the researcher. Of the twenty excerpts the researcher had decided that three were manifestations of C1, five were C2, seven were C3, four were C4 and seven C5. The judges were asked to identify which conception(s) were manifested in each of the excerpts. The researcher utilized a score sheet where the 20 excerpts were listed in the vertical dimension (1 to 20) and the conceptions (1 to 5) were arrayed horizontally. In the first step the researcher circled C1, C2 or whatever other conception she considered was manifested in Excerpt 1. The same was done for the other nineteen excerpts. Next, she looked at the validation sheet provided by Judge 1. Beginning with Excerpt 1, the researcher noted where the judge's assignations agreed and disagreed with her own. Agreement was indicated with a tick and disagreement with a cross. These marks were made on a 5 (five conceptions) x 20 (excerpts) matrix making for 100 marks in total. The
researcher then did a separate count for each conception -
calculating the percentage agreement between her
assignations and those of the judge on, for example C1.
This process was repeated for C2, C3 and so on. Note that
agreement could be achieved in two ways - in the first, both
the judge and the researcher were agreed that, for example
excerpt 1 was a manifestation of, say, C1. Alternatively,
they could agree that it was not a manifestation of C1.
Hence, Judge 1 agreed with 85 percent of the researchers
assignations concerning C1, 90 percent of the researcher’s
assignation concerning C2 and so on. Table 6 presents the
percentage agreement with the researcher’s ratings of each
conception in the excerpts as well as averages for each
conception.

Table 6
Inter-judge agreement concerning conceptual meaning
(Saljo) in sample transcript excerpts

<table>
<thead>
<tr>
<th>Judges</th>
<th>% Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
</tr>
<tr>
<td>Conception 1</td>
<td>85</td>
</tr>
<tr>
<td>Conception 2</td>
<td>90</td>
</tr>
<tr>
<td>Conception 3</td>
<td>60</td>
</tr>
<tr>
<td>Conception 4</td>
<td>70</td>
</tr>
<tr>
<td>Conception 5</td>
<td>65</td>
</tr>
</tbody>
</table>

Average % agreement for Conception 1 = 82%
Average % agreement for Conception 2 = 86%
Average % agreement for Conception 3 = 65%
Average % agreement for Conception 4 = 74%
Average % agreement for Conception 5 = 62%
Agreement with researcher was relatively low for Conception 3 and Conception 5. As the reader will recall, Conception 3 refers to *knowledge for future use*. When examining the excerpts, judges tended to mark any comment that reflected knowledge, information or skills that might be used in the future whether the interviewee implied this or not. As such, all learning involves some form of praxis so judges who viewed learning in this manner tended to mark Conception 3 frequently rather than distinguishing it from the other conceptions. Conception 5 refers to *interpretation and understanding*. The low agreement may be the result of definitions and examples not being explicit enough or the interpretation of judges that the learning was not a personal experience. Although there was some disagreement concerning the meaning of certain statements in the transcripts there was sufficient overall agreement between the researcher and the judges to warrant continuing with the substantive analysis. This will be further explored in Chapter Eleven which discusses the limitations of Saljo's model.

**Elements of Empowerment**

The eight judges were given a new set of twenty different transcript excerpts concerned with empowerment. Operational definitions and examples of the five elements of empowerment (see Appendix F) were provided. These excerpts had been previously rated by the researcher as containing
manifestations of the elements of empowerment. Judges were asked to identify which element(s) were exhibited in each of the excerpts. The procedure was the same as that used for the validation of the conceptions of learning. Table 7 presents the percentage agreement with the researcher’s judgments concerning the meaning of each element in the excerpts.

Table 7
Inter-judge agreement concerning conceptual meaning (Davis) in sample transcript excerpts

<table>
<thead>
<tr>
<th>Judges</th>
<th>% Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
</tr>
<tr>
<td>Element 1</td>
<td>60</td>
</tr>
<tr>
<td>Element 2</td>
<td>90</td>
</tr>
<tr>
<td>Element 3</td>
<td>60</td>
</tr>
<tr>
<td>Element 4</td>
<td>90</td>
</tr>
<tr>
<td>Element 5</td>
<td>65</td>
</tr>
</tbody>
</table>

Average % agreement for Element 1 = 65%
Average % agreement for Element 2 = 81%
Average % agreement for Element 3 = 71%
Average % agreement for Element 4 = 80%
Average % agreement for Element 5 = 79%

The judges were least inclined to agree with the researcher about the presence and absence of Element 1 and 3. The reader will recall that Element 1 refers to self-efficacy. This element was defined explicitly but it is an abstract concept open to different interpretations. There was fairly high agreement concerning Element 4 which referred to marginalization. Marginalization is a corollary of powerlessness (the negative end of self-efficacy). Because
of this apparent intercorrelation between elements, judges were apt to check certain excerpts as being manifestations of both E1 and E4. Element 3 refers to authority and enablement which appears to overlap with Element 2, accessing resources. Many judges also thought some excerpts contained manifestations of both E2 and E3. In short, there was substantial agreement between the researcher’s and the judges’ assignations. This can be regarded as evidence of researcher/judge reliability.

These procedures preface a discussion (in Ch. 11) concerning the conceptual basis of Davis’ elements of empowerment. In this section we have mentioned the highly intercorrelated nature of the elements. In Chapter Eleven, the author returns to this and other issues.

Whole Transcripts (Researcher-Judge)
The second procedure to ensure validity was to provide two judges with an entire "typical" transcript and have them identify the conceptions of learning and elements of empowerment nested therein using the operationalized definitions in Chapter 3 and Chapter 4. Dan Pratt was chosen as one judge due to his familiarity with literature and assumptions concerning conceptions of learning and teaching, experiential learning and subjective ontology (see Pratt, 1992). Janice Johnson was chosen as the second judge because of (i) her knowledge of interpretivism (ii) the
expertise in her recently completed study on conceptions of teaching (Johnson, 1993) and (iii) her reputation for diligence. Pratt and Johnson were asked to circle phrases that were manifestations of elements of empowerment. They were then requested to review the transcript and highlight conceptions of learning. Their transcripts and classifications were then compared to the researcher's transcript.

As with the transcript excerpt validation procedures, there was more agreement with respect to elements of empowerment than with conceptions of learning. The researcher had identified fifteen conceptions of learning within the transcript. One judge only documented three conceptions within the transcript, only two of which agreed with the researcher. The other judge documented fifteen conceptions, ten of which agreed with the researcher i.e. 67% agreement. The low agreement with respect to the one judge was the result of disagreement in definitions of the particular conceptions of learning.

With respect to elements of empowerment, the researcher had identified 35 manifestations of elements of empowerment within the chosen transcript. The one judge documented eighteen elements of empowerment, ten of which were in agreement with the researcher. The other judge documented many more elements than the researcher. Twenty seven were
marked as the researcher had marked them on the transcript. Thus, the second judge agreed with 77 percent of the 35 manifestations of empowerment noted by the researcher. The discrepancy between the two judges and between the judges and the researcher can be explained in two ways. First, as discussed in the earlier validation procedures, the elements and conceptions overlap and certain phrases may be given one or more than one notation. The second concerned the actual procedure of marking the transcript. One judge tended to mark an entire response, apparently thinking in somewhat holistic or global terms, while the other judge marked various phrases within a particular response leading to more marks on the transcript.

**Construct Meaning (Researcher-Interviewee)**

The third procedure to ensure validity was to interview two of the individuals again to explore the researcher’s interpretations with them and to obtain their input regarding these interpretations. Following analysis of the transcripts, the researcher interviewed PF2 and PM2 again. The focus of the interview was to obtain their ideas about the relationship between learning and empowerment and to discuss interpretations of subjective and objective constructions of schizophrenia as they relate to learning and empowerment. This was accomplished by using Table 8 as a guide for the discussion. At the time of these "wind-up" interviews the data analysis reported in Chapters Eight,
Nine and Ten had been completed. These interviews were conducted at the very end of this study, a few weeks before this thesis was submitted in March, 1993. This was the researcher's chance to "test" the veracity of her interpretations. In a sense, it was an attempt to establish "face validity" - the degree to which the findings made sense to two schizophrenics.

PF2 and PM2 both agreed that learning and empowerment were related and that although learning was necessary for empowerment, empowerment facilitated or provided the "strength" and "motivation" to learn and participate in educational activities. PF2 commented that in the past when she had a "negative self image", she did not feel capable of learning and did not feel motivated to pursue any learning or educational goals. PM2 reported that people had to feel good about themselves in order to engage in learning for whatever reason, be it out of interest or goal directed for employment. PM2 commented that it was also necessary to be able to access the resources and that learning took place during this process. Both interviewees were interested in how the people interviewed compared to the general population with regards to learning. Although not the purpose of the study, the author shared information regarding the predominant use of conceptions and how it was speculated to compare to the general population. PF2 was surprised that the author believed that the conceptions
exhibited by the interviewees were probably quite similar to the general population.

When presented with the subjective and objective constructions of schizophrenia (Table 8) there was general agreement concerning the "soundness" of the analysis presented therein. PF2 and PM2 agreed that the media may "do more harm than good" by focusing on "the bad part of life" rather than showing that people with schizophrenia can live "normal lives like anyone else." PM2 commented "if that was the case, they probably wouldn't have any great story" and wouldn't bother. He pointed out that it would be better if the media just ignored people with mental health problems so they could live out their lives in peace as their broadcasts tend to give anyone associated with mental health, "a bad name".

There was general agreement with other subjective constructions at both the macro/micro level and micro level with a few exceptions. PF2 questioned the mental health systems' focus on biological disease. She had always been told that schizophrenia was "biological" and was unaware of other ideas about its etiology. PM2, on the other hand, was aware of this focus and how individuals "lose their identity" in the system, becoming a disease rather than a person. The implication is that all can be treated similarly with similar outcomes.
There was disagreement regarding the family’s role in alienating their children possibly because both of these individuals had fairly good relationships with their families. Both said they knew of other people with schizophrenia who were not so fortunate to have the support of family and that it made a big difference in their lives just knowing that their family was there if needed. PF2 spoke about how family members can trigger emotional crises for people with schizophrenia and how she and her mother have been through years of counselling to work out how to communicate more effectively with each other.

With respect to the objective constructions of schizophrenia, PM2 and PF2 agreed with the discrimination, marginalization, stigmatization and paternalism reflected in the actions of government, welfare, employers, "normal" people and authority figures. They were not able to comment about the objective constructions of mental health services and family because they had no "alternative" frame of reference. They had also not been exposed to ideas about the "productivity" of pharmaceutical companies or the possibility of families buying into the disease model. They were unaware of research agendas within the study of schizophrenia and underlying ideologies that nourish this research. Their reaction was not surprising given that interviewees were able to articulate their marginalization
yet this position tends to narrow rather than expand their view of the world.

Chapter Eight describes the extent to which the various elements of empowerment were arrayed and manifested in the twenty interview transcripts.
CHAPTER EIGHT
ELEMENTS OF EMPOWERMENT

The purpose of this chapter is to provide the reader with a sense of the level of empowerment or powerlessness expressed by the twenty schizophrenic people interviewed. This was accomplished using Davis' elements of empowerment as a basis for the interpretation of transcripts. Evidence for both the presence and the absence of the elements is presented. The chapter is organized within the context of the dimensions of living.

Housing

By far the most frequently and strongly expressed opinions and comments were in response to questions about housing and accommodation. This was not surprising given the fact that housing is a concern for anyone receiving income assistance and living in the city of Vancouver. There is not enough low income housing in the city and much of what is available is of poor quality. Emergency shelters are overflowing, particularly in the winter months when people attempt to get in from the cold, and there are 5-year waiting lists for government subsidized housing. In recent years, the provincial government has recognized the need for appropriate housing allocated to those who experience mental health problems but these projects are slow to get started and barely put a dent in the demand.
In the face of this grim picture, the interviewees expressed a generally equal number of both positive and negative statements with regards to their self efficacy and housing situation. For many, this was one area where they felt they had some control over the decision making process. In the end, the final decision was theirs to make and no one else’s.

PF1 "I wanted to move into a smaller place, that was my idea. Too noisy at the other place, slamming doors at night and stereos going."

PM4 "I was here for nine months and I went into a boarding home in New Westminster and I told them I just want to see how things go within the three months. At the end of two months, I phoned Robert and he said sure we’ve got a room for you."

In contrast, others manifested a lack of self-efficacy with respect to housing. For these interviewees, they perceived their accommodation as being determined by others. They lacked control.

PF4 "I don’t like this place. I got put here, had nowhere else to go. They say that I have too many problems but I don’t now."

PM6 "After I left UBC they put me in Lookout and then I was brought here. It was decided for me."

Most interviewees expressed feeling in control of housing in some respects and powerless in other respects. Although they felt that the decision of where they resided was their choice and responsibility, this decision was constrained by a lack of options.

PM5 "I don’t know what happened. I just refused to sleep in those cheap hotels, you know, like those sleazy hotels..."
that are really bad. Basically that's all it was. I could have gone, I didn't like the housing situation at all so I stayed out on the street."

For many, the end result of asserting themselves about housing was a period living on the streets with the resultant sense of disempowerment. Ten of the twenty people interviewed had spent some period of time without a roof over their head.

Interestingly, this did not appear to be associated with problems in acquiring resources, knowledge and skills. All participants appeared to have a good working knowledge of available resources and the processes by which different housing resources could be accessed. Again, the housing shortage, inadequate housing and lengthy waiting lists contributed to individuals being unable to get the accommodation they would like. Additionally, people could not acquire preferred accommodation because their incomes were either restricted or controlled by others.

PM6 "This one lady is trying to find a home for me. I don't know if it's a boarding home, MPA house, an apartment or Coast apartment or Kettle housing...she's gonna call Thursday for me to look at the place."

PF3 "Before I didn't know about the different places but now that I know, there are some places that I like better than others. I used to live in boarding homes. I don't want that anymore...too many rules."

Few interviewees voiced a sense of authority and enablement in relation to housing. Their difficulties were associated with government control and expectations from social supports. Interviewees reported difficulty working with the
welfare system. It was not enough to know the resources, the processes involved or be able to assert oneself to ask for the accommodation that would meet their needs. People reported that their requests were not listened to or acted upon. Once their control of their money was removed, interviewees were prevented from seeking their own accommodation without the "official okay" from the welfare service. This was not an easy task.

PF4 "Right now I get welfare and they don't let you do what you want even when you go and tell them that you want to move somewhere...Guess I'll just keep bugging welfare. I've checked out a few places on my own but there's always some catch or they don't have any room or welfare says no. I don't know."

Others' expectations also influenced access to preferred housing. Some talked about feeling obliged to take the advice of family and mental health professionals despite a deep seated desire to live on their own. There was a tendency to passively accept "suggested" accommodation because earlier struggles for "preferred" accommodation had usually got nowhere.

PM2 "He (the doctor) thought that I'd have more administrators or mental health workers here and that would be good for me. He thought that being around other people would be good for my mental health. My family advised it too. We had a bug family group meeting at the hospital, eleven to one. All eleven people just felt that I should come here."

In other circumstances, rules and regulations set by others determined the person’s eligibility pertaining to accommodation.
PF6 "I have to follow all the rules that my parents have written out or I have to move to a boarding home. I don’t want to live anywhere else just stay home."

PM5 "I don’t like being on psychiatric drugs, but I got no choice if I want to stay here I have to stay on psychiatric medication."

With respect to critical consciousness and the multi-dimensionality of empowerment, many interviewees voiced concern about the lack of housing but people with mental health problems are so marginalized that few see how they might improve their position.

PM8 "I wouldn’t let myself stoop that low to live on the streets. Lot of controversy over that these days. Mental patients coming out of Riverview, saying that they sleep on the street."

PM5 "They got no choice in housing. Housing is the biggest problem, it’s hard to keep them in a place. Most of them live in one room. They’d have much better control if they had decent housing. The whole thing is housing and money is pretty scarce these days and it takes money to supply the housing...the Bennett government wasn’t good at all but the NDP are all ears."

PF3 "The government needs to build better places for people to stay cause when you’re sick and they send you to these places they make you sicker. Too much stress in those places. The government people don’t see what happens and they don’t talk to anybody to try and make it better."

In summary, most interviewees felt powerlessness to direct or have control over their housing. Despite a feeling of having the final say in where they lived, this decision was influenced by a lack of choice or options and constraints placed on them by others.
Income

"I'm broke" became an all too familiar response from the individuals interviewed. Of all the dimensions of living, the lack of income appeared to be a significant disempowering factor. All interviewees were receiving income assistance (welfare) at the time of the study. Becoming part of the welfare system did not promote self-efficacy and contributed to disempowerment.

PF1 "I get $79 and that's it for the month...administered through St. James, Monday, Wednesday and Friday you get money...I don't see my cheque...you get $200 for that (clothes)...you have to give them receipts."

PM8 "Well not as much (control) as I'd like because like if I were to budget my money, like my mom taught me to, I'd be way better off if I could handle my own money, I just would be. It's administered by St. James Social Services and there's no reason for it. It made me feel a lot better and it gave me a lot more responsibility and freedom if I could handle my own cheque."

Most reported that their room and board was paid directly to the boarding home or hotel, restaurant or cafeteria. The remainder of the monthly cheque, approximately $80, did not come close to meeting personal expenses. Many had resorted to panhandling, searching the streets for dropped money and prostitution in order to supplement their income at some point in their lives. These interviewees frequently made self-deprecating remarks concerning these practices and felt that they had been forced to engage in such practices if they were to survive.

PM1 "Begging is not a crime. So I beg cause I'm the lowest of low in Canada. Basically, I'm a parasite on society."
Those able to acquire resources, knowledge and skills did so in an inconsistent fashion that met immediate needs but did not prepare them for future income crises.

PM4 "There's gonna be some extra work here once in awhile, cleaning the floors and the hallways, and by the tap early in the morning."

PF1 "You can get extra money but you have to go to the work program at Coast. You gotta sign up with them first."

Few interviewees had made plans to increase or supplement their income on a continual basis or had enrolled in training programs through rehabilitation/manpower services (that can result in increased income). Interviewees talked about how a lack of funds prevented them from meeting other needs. Yet, they appeared trapped within the "system" with few options.

Davis' third element concerns a sense of authority. This was notably lacking amongst this group of schizophrenics. People spoke of the constant struggle with welfare workers to regain control over their welfare cheques once that "privilege" had been taken away from them for unknown reasons. A few preferred to have their money managed for them instead of learning how to do this for themselves. Many viewed this lack of control as akin to being treated like a child. One person spoke of his continued struggle with welfare to get decent clothes so he might go for job interviews. As it stood, he had only the clothes on his back and although fairly clean, he did not view them as
suitable for job hunting. This contributed to his lack of self confidence.

A few schizophrenic interviewees were able to articulate the marginalization they experienced as a result of a lack of income. Their lack of money did not afford them the advantages of other citizens. Activities like going to a movie, which most citizens take for granted, were largely unattainable. Participation in many "normal" activities of daily living requires money which these people did not have. Their marginalization was deepened by the fact that "free" places to go and socialize were those mandated to provide services for people with mental health problems. Many wanted to go to a "normal" environment and be around "normal" people. Critical consciousness is necessary if people are to become empowered. All seemed to be able to make simple connections between their marginalization and their lack of income. Fewer were able to look at or analyze the larger socio-political context.

Many placed the responsibility for change on the government. Those involved with advocacy organizations saw that they had responsibility in facilitating these changes. People also recognized that a lack of finances was not solely a problem experienced by the mentally ill but also by other marginalized groups.
PM6 "The financial standard of living down here leads people to picking fights, drinking and smoking drugs. That's all they (Aboriginal Peoples) care about, it's not a life. They need schooling and jobs so they can have the money to get out of here. Gotta change the system, give people a break, let them prove they are worth something. Need connections with people in government so things can change."

PF7 "We need more organizations like the Mental Patients Association that can point people in the right direction so they can get on their feet. We need people who can help people get listened to by the government. We need to teach people not to be scared to say what is bothering them and stand up for their rights. They need to be given a chance to get out of the welfare system or a way to work and not have money taken away for doing that."

For the schizophrenics interviewed, money was a central issue with no easy solutions. Being hooked into the welfare system was viewed as frustrating and disempowering experience. To remain in the system meant continued frustration and disempowerment as it was generally believed that the system could not be manipulated or changed to meet their needs.

**Social Supports**

Schizophrenics are more successful at surviving in the community if they have the support of family members. The thought that someone actually cares is known to have a positive impact on sense of well being (Hogarty et al, 1986). Unfortunately, many schizophrenics have become alienated from their families. Hence, only three interviewees were living with their families. Twelve of the
twenty individuals interviewed had infrequent, tenuous contact or no contact with family members.

PF1 "I don’t exist, they don’t exist."

PF4 "I don’t see them that much. We’ve had an up and down relationship. They’ve tried to help me but I’ve let them down over the years. They don’t expect much of me anymore and I don’t expect much of them."

PM9 "I burnt my bridges with my folks. They just got fed up with me, giving me money and bailing me out of jail. I caused them too many problems so in the end I just stopped going around and I move too much so they don’t contact me."

PF5 "I don’t know where my family is, don’t care."

Self-blame rather than self-efficacy dominated these reports. There was little mention of attempting to initiate contact. Many had given up this idea. Others with tenuous contact spoke of continuing struggles with control issues and a failure to meet expectations.

PF2 "Well sometimes my mom can be controlling, but I think because I’m getting a lot better she’s respecting me a lot more. She worries about me, she wants me to do something with my life."

PF8 "Dad’s okay but Mom just upsets me to wanting to slash. Every time she calls, she gets on my case to get back to school. She doesn’t give a shit about how I’m feeling. She tells me to get a grip. I tell her that I didn’t ask to be schizophrenic."

Six people who reported having good relationships with family and friends viewed the relationship as significant, initiated contact and planned to spend time with family members.
Most interviewees appeared to live lonely lives. Only three reported having a 'significant other'. Only one person felt that they received support from the significant other. A desire to have a companion and intimate relationship was reported by fourteen of the twenty people. Many had given up hope that this would ever happen.

PF2 "I don't even think I'd be able to get married. I don't think I'm confident enough. I don't think I can handle it really...just don't trust."

PF6 "I meet a lot of jerks at the bar. I want a boyfriend even though my parents think it would be a bad idea. I gotta lot of guy friends but I want a boyfriend and to get married someday before I'm too old."

PM1 "I wanna get a wife so ah sexual, the joy of sex, not for the sex but the companionship and love and romance and a partner. Cause I think...humans were meant...are social animals."

Interviewees spoke about their loneliness and desire for a companion. They expressed a need to be able to share their lives, the good and the bad, with someone who would understand. Few had experience with intimate relationships and the need was balanced by genuine fear, lack of self-esteem and confidence.

Interviewees were largely unable to acquire resources, knowledge or skills that would permit them to meet potential partners. The idea of meeting someone and sustaining a relationship was a formidable challenge. Those who had assertiveness or social skills training were cautious about the benefits. Again, the lack of money was an issue.
attributing "unworthiness" to their poor financial status.
Where do you meet people? People talked about the risks and
difficulties of having a relationship with a person
vulnerable to mental health problems.

Social support was also provided by mental health drop-in
centres. These places were primarily managed by the users
of the facilities and offer a wide variety of services from
a place to socialize to more formal groups to opportunities
for work and education. Some of the interviewees were
members of various centres and reported degrees of
companionship and caring. Three interviewees felt they had
a sense of authority with respect to these centres, the
remainder did not actively participate in shaping the
mandate of these centres so as to make them more responsive
to their needs.

PF7 "This drop-in is for the people. Anyone who uses the
place can make suggestions for improving it, making new
programs. It's always changing, that's the way we want
it that way there is something for everybody. You can
come and do what you want."

Because a lack of support was such a prominent feature in
the interviews, it was not surprising to find that
interviewees' comments reflected critical consciousness with
respect to social supports. Alienation, social isolation
and the stigma associated with "mental illness" were
frequently mentioned in response to questions about social
support.
PM0 "First I lost most of my friends, they went on to live
their lives while I was in Riverview for a year. At
first they came to visit then it stopped. I was too
embarrassed to look them up again. Then my family,
they can’t look after me anymore. And now I’m in this
room alone. People are around but it’s not the same.
I think this happens to lots of people like me and then
it gets harder and harder to meet people and make
friends."

PF4 "I have a few (friends) but lost lots when I got into
drugs before. Some people aren’t really friends
especially down here. You talk but you don’t get to
know anyone really good cause that’s the way it is.
Usually people just want something from you. I don’t
want people to feel sorry for me or anything but
sometimes I still want someone to talk to and no one is
there."

PF2 "Sometimes I feel all alone, I feel something is wrong
with me but if I was with a bunch of people that have
the same thing I’d be able to accept myself more and
accept other people. I accept them, but the thing is
I’m really hard on myself and I don’t accept myself so
much because my family hasn’t always accepted me."

PM2 "Maybe they (friends) think that I don’t want to talk
about it or something, they might think that, but I
don’t know. I don’t really know, I’m willing to talk
about it. At first I felt awkward, but you sorta
adjust, they don’t ask, they’re busy people so they
don’t really pry into my personal life. I could easily
isolate myself from my friends. Like I’m living here
now and they won’t want anything to with me anymore so
I better not call them because I’m not up to par to
hang around them, they’re higher up than I am. I’m
down here and they’re up here now, so its not equal. I
don’t think that way and I don’t think they do either."

People were aware of their marginalization from family,
friends and society in general. An overwhelming sense of
loneliness and isolation was expressed by each individual to
a greater or lesser degree. This feeling was directly
attributed to their experience of schizophrenia and the
"consequences" of this experience.
Only two people made comments that reflected empowerment moving from the individual level to the group level or *multi-dimensionality* of this dimension of living. Both expressed similar views about educating the public about the myths and misunderstandings of schizophrenia with the hope that understanding will open the doors for schizophrenics to become more engaged in and with society.

PF3 "Lost a lot of my friends when I got sick. They didn’t understand and didn’t want to have anything to do with me. I think there’s a lot of people who don’t understand and get scared of people with mental problems. They need to find out about it so we don’t get treated the wrong way. It gets lonely sometimes especially when the voices bother me cause I can’t be around people then. I learned that’s it’s better for me to be by myself til it gets better but people don’t understand why I go on own. They just think I’m being weird or something."

One individual spoke about his effort to improve conditions for others that used the facility for support.

PM3 "I’m trying to make a better situation for all of us, so it’s nice to stay here and if you were in trouble, I’d even offer my hand. I’d let you share the simple things I have because it just adds to more."

Social support or lack thereof was a major concern of the individuals interviewed. Those who received support from family appeared to have a brighter outlook on life. All experienced difficulties in finding a companion and intimacy. As a group, they were aware of their marginalization but did not have many ideas about how to improve their support systems.
Work/Education

All interviewees had been employed some time in the past. At the time of the study, none were employed. Many of the interviewees expressed a desire to work again but only two were actively participating in an educational program with the goal of subsequent employment. Thirteen of the twenty had not completed their high-school education. There was an equal number of positive and negative responses related to self-efficacy and work or education.

PM2 "Full-time (work) I'd have to pay $750 a month to live here. I can't afford that. I'm taking a computer course starting next week for six months at the Vocational Institute and I'll get a job placement. So I figure 6-8 months and I'll be out of here."

PM0 "Like I was working as a janitor for a year when I was at Riverview so it wasn't bad that's why I'm taking this janitor course through Coast. It'll be done in a few weeks then I'll get a job placement to see how it works out. It's mostly night work which is better for me and not so many people."

Others questioned their ability to learn or work and viewed these as remote possibilities for the future.

PM7 "I tried going back, it's too hard to study. I went to try a GED test and failed so didn't bother anymore."

PF2 "It makes me really sad because I really like learning. I would like to go back to school but I can't do it right now. I'm wondering when, who will be able to help me or what's going on. I feel like maybe some people think I'm stupid or something."

PF8 "I tried taking some college courses ya know. I didn't know what I wanted to do but it didn't matter cause it got too tough, the voices kept interfering and I couldn't concentrate, had to leave. The voices aren't there all the time now but I'm afraid to go back cause they'll probably come back."
There were many such examples that demonstrated a lack of self-esteem and confidence. Similarly, there were mixed responses related to acquiring resources, knowledge and skills with respect to educational activities or work opportunities.

PF7 "If people check into it, there’s lots of things that they can do if they want to go back to school. If you call MPA or Coast, they’ll tell you where to go. They won’t do it for you though, you gotta go to the place on your own. There’s lots of courses at night school or the colleges or high-school upgrading stuff that people can try out and sometimes you can get them paid for by welfare or unemployment and it gives people something to do and helps them improve themselves."

PM4 "I’m thinking of BCIT, or something like there, over by the park there. I’d like to see if I could take some upgrading and then maybe to a, I’d never be a chef I’d be too old to be a chef, but if you could get into it and get a short order cook you know, there’s always a demand for cooks."

In many cases, people voiced frustration but could not get resources required to change their current situation.

PF4 "Tried to go back later but couldn’t learn...just didn’t seem to make sense. Kinda seemed pointless cause I was already out on my own and it seemed like I’d have to go to school forever if I wanted to do something and I didn’t know what I was gonna do anyways."

PF3 "Like there’s programs but I don’t like the ones I’ve tried and nobody seems to know about the other ones. None of them will help you get a job."

It was not surprising that people were having difficulties making the system work for them. Despite the fact that the interviewees could list numerous different programs, many did not meet their needs for a variety of reasons. Timing, transportation, money, lack of interest, rules and
regulations associated with housing, welfare and medication regimens all interfered with their ability to participate in education or work. Lacking a sense of authority and enablement, interviewees were disillusioned about ever returning to education or work.

PM9 "It’s hardly worth it in the end. If you make more than $100 a month then they (welfare) start taking money off your cheque. For one thing, most people aren’t making enough to live on, they’d make more on welfare. Secondly, most people can’t handle the stress of working full-time and there aren’t too many part-time jobs that you could live on so it’s better to just stay on welfare. If you’re lucky and know someone you might be able to get some money under the table."

PM4 "I’ve got to rearrange it, I thought it was coming back in the evening but he stuck me on coming in on days. I don’t like going during the day, I’d rather go in the early evening, so convenient for me, less people. Getting up and going at that time of the morning, some people can do it but not me, too tired from the medication."

PF1 "If you want to get new clothes you have to go to a work program. And it’s not that I don’t want to go to a work program, Jack figures I want to get out of the program, but I feel like I’m not ready for it yet."

Comments deemed to reflect or pertain to critical consciousness and multi-dimensionality in relation to work/education were briefly touched upon in the interviews but not nearly to the extent found in discussions about housing or social supports.

PF3 "Don’t know what I’d do cause I never trained for anything and now people look at me and think I’m not capable. If people find out that you have a mental problem they think bad things and don’t give you chance but they shouldn’t do that cause they really don’t know you and they don’t know that the problems aren’t always there, only sometimes. I think that I could work on good days but there are no jobs like that."
PF6 "People look at you differently once you’ve been in a mental hospital. Like I had my own business ya know doing hair and I was making money and then this happened. I could probably still cut hair and everything but who’s going let me do that now. What do I tell them when they ask why I haven’t worked for the last five years or why I still live with my parents. People find out even when you try to hide it."

PM0 "It’s a drag when it’s easier to do things when you’re in Riverview than when you’re out. It took months to get into the program. When I tried to look for work, people just give you weird looks, he’s nuts or something they think."

Work and education did not appear to be a major priority as compared to housing, income and social support. There were two interviewees who were actively pursuing education and employment but the remainder had virtually given up on this idea. Future plans were non-existent and attention was focused on getting through the present.

Leisure

Interviewees fell into two groups. First, there were those who engaged in numerous recreational and personal interest activities which provided a sense of meaning and enjoyment. These interviewees demonstrated self-efficacy with regards to leisure. At the other extreme were those who reported doing little with their "spare" time, feeling alone and isolated, ruminating and preoccupied with their thoughts. It was rare to experience pleasure and enjoyment.

PM5 "I spend a lot of time in my room by myself, I play my guitar a lot.

PF3 "I get up and figure out what I have to do that day. Maybe get some food and look in stores. I walk a lot."
I like to see what other people are doing. I might work on my knitting."

PF2 "I go for long walks. Go to prayer meetings sometimes, play the guitar or piano, or go visit a friend, or just go for a walk or a coffee or read the Bible or maybe try to get into another book."

PM1 "Talking to people, reading. Tai chi, martial arts, running, jogging, ah getting into trouble."

PM3 "I used to go bowling. I like going swimming once in awhile. We watch videos and we take it easy and try not to play too hard on each other because times are hard. I go to Coast cause they have a pool table."

PM2 "I went for a bike ride, I like to exercise early in the morning before I shower. I usually figure out something to do for an hour and half."

PM7 "Sleep. I sleep a lot cause I'm taking chlorpromazine, it's a heavy duty tranquilizer. I just watch TV or listen to my music."

PF6 "Most of the time I just smoke, drink coffee and watch TV. Sometimes I go out with my friend but I don't have enough money to do it very much."

There appeared to be a general lack of interest in and motivation for leisure activities. For these interviewees acquiring resources, knowledge and skills that would assist them in meeting their needs for enjoyable activities was irrelevant because it was not identified as a need. Some claimed that drop-ins and gathering places for people with mental health problems did not meet their need to socialize with others. Those who demonstrated self-efficacy did not have problems accessing the resources they required.

There were a few interviewees who had or were volunteering at drop-in centres but continued to feel isolated and had
difficulties interacting with others. There was no sense of authority and no attempt to adapt these centres to meet the needs of people using them. Likewise, there were few comments in relation to critical consciousness or multidimensionality with regards to leisure. Several interviewees felt marginalized as a result of their lack of money and subsequent inability to engage in pleasurable activities like going to a health club or to a movie. A few others felt that attending community social events, particularly as a group, drew stares from other people in attendance. This reduced their confidence to engage in "normal" activities.

Mental Health Services

All twenty individuals interviewed had reasonably strong opinions about mental health services. Being deemed "mentally ill" had a great impact on their lives. Each individual had different experiences with the mental health system yet all spoke of being powerless to a greater or lesser degree. Comments primarily focused on a perceived lack of self-efficacy within the mental health system.

PM8 "Doctors supposed to know me and all this, I don’t know if they do or not. I’m just trying to take their word for being true and I’m just wondering cause I’m into so much trouble in my life."

PF4 "I know they want to help and sometimes they do but other times, they don’t understand and send you away when you don’t have to go. I don’t think they should be allowed to do that."
PM6 "They take control over the patients. Give them more medication. They drugged me up good, I couldn't even walk."

PM7 "Leave them (people) alone and mind their own business.

PF9 "When I was in the hospital, they made me take the medication. I didn't have a clue what they were giving it to me for. I was fine, still am. Stopped taking it cause it made me too tired. I still go to the team once in awhile cause I like talking to my worker and she helps me with my Dad so I don't get run down like before."

PM0 "I go there and end up listening to everything they have to say but I never get to talk. Same thing every time, pretty stupid. I go cause if I don't take the medication I might go back to Riverview and I don't want to do that. That's what they told me anyway."

PF5 "I go now but I'll probably stop cause I don't believe what they tell me and I don't like taking injections. They get mad at me. They don't believe me when I tell them I don't need it."

People complained about a lack of involvement in plans made concerning them. They reported feeling a lack of opportunity to voice their concerns and feelings of being "over-powered" and "misunderstood". A decision to assert themselves was seen to create difficulties in their relationship with the mental health service. Many viewed the treatment regimen as an all or nothing phenomenon. They feared that questioning any aspect of the plan, ie. the need for medication, would jeopardize any perceived positive benefits from the mental health team such as group involvement.

Despite the more negative comments related to self-efficacy, interviewees spoke positively about their ability to acquire
resources, knowledge and skills through the mental health service.

PF2 "I go there for counselling and recreation."

PM0 "They helped me get things sorted out with welfare and get this place. I couldn't do it on my own."

PF7 "Contact with the mental health team programs is important. They helped me get my life sorta structured and get me stable."

PM1 "I don't take advantage of the resources that are there but I will use the resources that are available to me in a positive way."

A sense of authority with respect to mental health services was rarely commented on by interviewees. They reported neither being "asked" for their input regarding mental health services nor feeling they had a forum to express their ideas about improvements that they recommend. Many seemed to place the responsibility of those "in power" to initiate this process rather than themselves. This perceived lack of authority was related to the extreme sense of marginalization they experienced as a result of receiving mental health services. Every individual interviewed made comments that reflected critical consciousness.

PM1 "I think you can make a comparison between psychiatric hospitals and concentration camps in the sense that the person, if they are formally committed, have no rights and they're at the mercy of the psychiatrists."

PF4 "People don't think you can do things anymore for yourself and when you try you end up failing so they still look at you that way, look down on you like you're not good enough anymore cause they don't understand."

PM8 "Riverview is the kind of place that when you're in there they don't really appreciate you feeling too
well, they mainly want to label you this and that and
they try to observe you to what makes you feel good and
they try to take the good away, that’s what I think.
They try to deny you the feeling of whatever makes you
pleasurable in your life you know. Thoughts or
whatever."

PM2 "I met this guy in hospital and he became very dependent
on the hospital and I think they sent him to Riverview
because of that, I don’t really think he belonged
there, he was just being lazy, he just gave up on life,
just sort of let it go, let it slide...He just didn’t
have the confidence and stamina to do it."

PF3 "Nobody listens to them cause they think they’re stupid
or something but they don’t have to live in these
places. They need to get people out of bad areas."

PM4 "I look at people like today, I was looking at people on
the street they’re all watching me or something. It
annoys me."

PF9 "They had no right to give me a label schizophrenic or
anyone else for that matter. It doesn’t really affect
me cause I live with my Dad and look after him but it
could ruin your life, make it hard to get a job or
worry for no reason."

PF7 "I never quite understood but my life just keeps getting
worse since I first went to hospital. I would have
never thought back when I was married that I would end
up on the street ya know, everything has changed. When
people label you it’s like a kick that you never get up
from. Every time I go to hospital I have to start all
over again and that’s not easy to do."

People spoke about how being labelled "mentally ill" or
"schizophrenic" impacted every aspect of their lives. For
many, the resultant oppression was internalized and
contributed to their further marginalization. Those able to
externalize the marginalization had suggestions for
improving their situation and were actively participating
with others to do this.

PF8 "It’s hard for people to stand up for their rights but
they have to if they want to change things like better
housing. The more people that stand together, the more the government will listen."

PM9 "I went to City Hall with everybody from Lookout to fight for the Drop-in cause of the zoning. We won. We even got all the other people in the place to clap and stand up for us cause it was really important that we have a place to go. They were really nice, they let all of us go up and speak, that's what did it."

PM8 "He's been in the news a lot. Well he was pushing for a little bit of lee-way on patients, certain type of respect between the staff, or gap or whatever, between the staff and the patients right."

PM3 "I think they're doing a lot more than I even thought. People work together and that way they achieve a lot."

Summary

If we were to look at the overall view of empowerment depicted by the twenty transcripts, one is left with a general impression of powerlessness. Interviewees did not perceive that they had control over dimensions of daily living and they experienced difficulty accessing resources or making the system work for them. The schizophrenics in this study experienced extreme marginalization throughout their lives and were faced with the day to day struggle of dealing with life in face of this blatant segregation and isolation.

This chapter has presented interviewees reports of empowerment or lack thereof. Empowerment must start with the individual. However, there is ample evidence in the transcripts that an individual's disempowerment occurs within the context of society. It is not a static
characteristic that can be attributed to the person nor can sole responsibility then be placed on these people to empower themselves. Citizens, families, societal authorities and organizations, and the government, to name a few, all contribute to the disempowerment of people with schizophrenia. Interviewees will not become empowered until social structures are changed and schizophrenia is constructed differently. This will provide the environment in which schizophrenics can become empowered and all can learn. The purpose of the next chapter is to provide readers with a view of these interviewees' conceptions of learning in relation to their daily lives.
CHAPTER NINE

CONCEPTIONS OF LEARNING

The purpose of this chapter is to present an analysis of the interview transcripts that emphasizes the conceptions of learning manifested by the individuals interviewed. The reader will recall that the other purpose of the study was to interrogate Saljo's five conceptions of learning. The operationalized definitions of conceptions of learning presented in Chapter Three were used to analyze the transcripts. As in the previous chapter, this chapter is organized around the dimensions of living which provide the context the individuals' learning. Readers should note that the researcher was not concerned with attempting to ascertain the extent to which each conception was present or absent. If there was nothing in the transcript that suggested an interviewee learned by "rote" (C2) it did not mean that the individual did not possess this conception of learning. The context or question may not have elicited a response that dwelt on learning by "rote". The researcher was only concerned with whether a conception was present in the transcripts.

Housing

By far the most frequently manifested conception of learning was C3, knowledge for future use. Interviewees reported using knowledge from previous housing experiences to assist
them in making decisions about their current living circumstances. For many who had lived on the streets, this involved learning how to survive in the skids and learning to be street smart.

PM3 "I never had a clue about Emergency Services. I called the Housing Board cause I needed a place and they told me."

PF3 "Well I think I learned the hard way but you just learn by watching everybody and everything and by talking to the other people about what happened to them so you know what to do and who you should stay away from" (discussing how she learned to become street smart).

PM7 "I lived on the streets for two years. I used to live down on the River hills, so with my camouflage net and my green tent, it was easy to hide. I took hunter’s training, how to survive in the bush."

PM1 "What’s it like living here, it’s far superior to MPA, Satellite housing, it’s far superior to 3/4 way housing. It’s far superior to boarding homes although I’ve never lived in them but I would say that."

Because housing was such a prominent issue, many voiced a personal and specific perspective. In elaborating on what housing meant to their lives, they provided many instances embraced by Conception 4, abstraction of meaning.

PM9 "It’s like this, you have to way all your options and figure out what will be best for you in the long run. Where you decide to go affects your money, where you’ll eat, who you end up hanging around with. Like as much as I try to stay out of places where there’s lots of drugs and alcohol, it’s hard to do that cause they’re cheap that way I have money left over."

PF3 "The government needs to build better places for people to stay cause when you’re sick and they send you to these places they make you sicker. Too much stress in those places."

PM4 "I learn different things. Like I said this isn’t the best part of the city. I don’t go down by Pigeon Square or the Balmoral and some of those places at
night cause you have guys thrown out, they've been kicked out and then they take it out on you. This kind of stuff so I just watch it."

Many individuals, along with abstracting meaning and connecting several ideas together in discussing their perspective on housing, spoke about this dimension within the larger context of many different perspectives.

Conception 5, *interpretation and understanding* was revealed in statements about the overall housing crisis for people with mental health problems and the possibilities for or barriers to improving this situation.

PF6 "It's a real problem. When I was in the hospital, there were so many people who didn't have anywhere to go. There wasn't a place and keeping them in hospital wasn't fair cause if they had a place to go they'd do fine. Then you have people who are on the street who could probably use a stay in hospital to help them and they can't get into the hospital cause there are no beds. It's a no win situation."

PF9 "I think people are finally realizing that this is a problem. There's been lots in the paper and on the news about it. Maybe with more media attention, the government will put more money into housing for mentally ill people."

PM5 "Like people if they had a choice of where they could it would be much better. The whole thing is housing and money is pretty scarce these days and it takes money to supply the housing, it's pretty difficult. It took Lookout ten years to get the Deputy Ross Residence going...and they were really trying. The Bennett government wasn't good at all but the NDP's were all ears."

PM6 "The patients need connections to do that" (change the system).

These individuals had gone beyond learning as related solely to their personal perspective and had related the problem to the socio-political and economic dimensions of society. In
doing so, they had a more inclusive understanding of the housing crisis faced by people with mental problems.

Income

In talking about their financial situation, many remarks reflected Conception 3, Conception 4 and Conception 5. Phrases reflecting the first two conceptions were not found in the transcripts. The most prevalent manifestation was concerned with Conception 3, knowledge for future use. This learning involved finding ways to make money or managing what little money they had.

PF4 "I just watched. It seemed kinda simple, just stand there and ask for money. You have to learn where to go cause some places are better than others so you try a place and if it doesn't work then you move on."

PF3 "People tell you and there's signs like downstairs that tell you where you can get a free lunch or supper. You just ask, people will tell you where to go. Then if you can't get money for a few days you can plan out where to get your meals that way you don't go to the same place all the time cause I don't think they like it."

PM4 "Stand on the corner, spare change, spare change, sir. I did that a couple of times. I got $11 one day.

PM7 "I used to do a lot of B&E's with friends, we had probably more money than everybody else. I would steal jewelry and sell it. Make more money doing that than working."

PM8 "Well not as much as I'd like because if I were to budget my money, like my mom taught me to, I'd be way better off if I could handle my own money."

PM5 "I've learned to manage my money. Like I can save money, if I got a reason to save money I go right hog wild you know I pinch every penny till it screams."
PM6 "My dad gives me suggestion, he doesn’t want me to smoke cause it costs too much money. He says I can barely survive."

PF5 "You have to learn to watch your money, every single penny. Find places where there is cheap food and tobacco. I pick up a few odd jobs from the nuns sometimes, collect cans and bottles in the alleys. Sometimes they feed me, sometimes money."

There were fewer responses that reflected Conception 4, abstraction of meaning with regards to income.

PM6 "How do you learn to manage your money? You have to be independent, you have to be responsible, that’s how you take care of your money. Balance it out. Work, after that you get money, you get paid, how can I say this. Independent on your own, do things, work."

PM9 "The welfare system is difficult to work with but if you don’t have a job, you don’t have a choice. There’s a lot to find out like some people just get plain welfare and some get handicap and there’s $100 difference but they don’t tell you these things that way they can keep more money and it doesn’t coast them as much."

PM0 "I had a real hard time getting a welfare cheque. They won’t give you a cheque til you have an address and you can’t get an address til you have a downpayment. Doesn’t make much sense and just stressed me out. They don’t understand how difficult they make it on people like me. I don’t want to go back to hospital."

When talking about income, the interviewees did not generally speak in ways that reflected the meaning of Conception 5, interpretation and understanding. The fact that there was so much control over this aspect of their lives may have contributed to a focus on a personal perspective. They were not inclined to look at the current state of the economy, the recession and government priorities all of which influence social service programs.
Social Supports

Within this dimension of living, individuals talked about learning associated with interactions with family, friends, support organizations and society. Companionship and caring were important issues. Learning how to gain support in the face of mental health problems, changing relationships and social isolation was a struggle for many. The transcripts uniformly reflected Conception 3, Conception 4, and Conception 5.

All but one of the interviewees appeared to have used Conception 3, knowledge for future use, in developing social relationships and the support connected to them.

PF2 "MPA is good too, if you come into contact with someone who doesn’t have anything to do or someone to talk to tell them to godown to MPA, cause there’s always someone there and something to do, they care."

PM8 "My mother wrote me a letter in the hospital, she said life is more than just doom and gloom, there’s flowers and everything else. What she said there I really remember that and can look back on it, it’s like a reflection. I like reflecting back on what my mother used to tell me."

PM0 "My dad has always tried to teach me to become independent. He gives me advice to use. His life wasn’t like mine is but the things he tells me helps sometimes cause I remember what he said so I know what to do."

Many of these individuals had abstract ideas about the learning that occurred in relation to their interactions with people. They went beyond viewing learning as reproductive in nature and tended to have a specific
perspective about learning. This learning appeared to assist in organizing their context. This perspective permeated this and other dimensions of living.

PM8 "Mother's are a big contribution to what the child can learn especially later on in life after adolescence cause my mom, I used to go up and see her and she'd talk to me and tell me a few things. Mother's can have a really big impression on the kids, I think. Especially males cause mother's are a lot more learned or something. They’re older or something. Like I’m not sure if this is for all Canadians or what."

PM5 "You have to learn to get along with everyone else, that’s all. I do a lot of biting the tongue. It’s quite hard like there’s two groups of people here. There’s the emergency clients and there’s the tenants. I’m a tenant. Sometimes the clients hell is pretty heavy around here, they only stay for a couple of weeks but they’re pretty well lost. You get a lot of alcoholics and a lot of drug addicts, hookers, two shooters downstairs that are wired to heroin, they’re stoned every day."

PF3 "Part of it is my problem and whether I want to be with people. I keep in contact with my family cause they’re important. If I don’t like some then I’m not going to spend time with them. That happens around here a lot. People like to use people so you have to learn to who is just going to use you and who is really a friend."

PF6 "It’s a give and take thing with my family and with other people I guess. They’re only going to take so much of my shit. I’ve learned that some of the things that I’ve done have really pissed people off and then they don’t want to spend time with me. It’s a respect thing. If I respect them and show that I care and everything then they respect me."

Four of the individuals interviewed described experiences associated with Conception 5, interpretation and understanding. These individuals incorporated the perspectives of others in making sense of their social support system.
PF6 "Lots of people have difficulty understanding schizophrenics and for that reason shut them out like they don't belong. They're just regular people who sometimes have voices or talk different. They don't realize that even when you're sick you're aware of the way people treat you or stay away and that's when you need someone the most. My family has learned that I need to know they are there for me even when I'm sick and might say the wrong thing cause I can't help it."

PM4 "Yeah, I mean, just gotta learn to mind your own business, that's about it. I'm really trying to work on it, mind my own business. When I do get paranoid then I think they're talking behind my back and the whole bit and they're not they're talking about something that's got nothing to do with me. Dan introduced me to the Reverend Gary Patterson and was something in my past...I went through hell in my mind for over 30 years over that problem, worse than the thing that happened. Now with the Reverend's confidence, I trust him, I can work on it."

PF8 "I'm sure lots of people told you about being lonely. The voices stop you from talking or doing things with people. People that don't have voices can't understand. It's like having a three or four way conversation going. The thing people don't realize is that most people don't have it happen all the time. It creates a barrier.

Work/Education

By far, most comments associated with learning were made in connection with work and education. The author speculated that this was the result of the fact many interviewees associated learning with schooling or job training. Responses to questions about learning within this dimension appeared less difficult to respond to than in other dimensions. Approximately half of the interviewees talked in ways congruent with Conception 1, increase in knowledge.

PM2 "I think when you're younger, even kids are a lot sharper when they are younger, I'm not that old, but I think kids pick up things a little bit quicker than adults."
PF4 "I dunno, maybe just remembering things, doing things, figuring things out."

PF5 "Learning, ah well, like everybody does that. In your life you learn lots of things."

These responses reflected an undifferentiated, "getting to know all kinds of things" view of learning. Although present in ten transcripts within the dimension of work/education, it did not predominate the transcripts. There were far more incidences of Conception 2, memorizing found in the transcripts particularly associated with education.

PF4 "Tried to go back later but couldn't learn, think I messed my brain up with drugs. Couldn't remember, couldn't concentrate and didn't really like it."

PM1 "I could go to college and take maybe three or four courses and read the material and remember it and pass the course."

PM9 "You learn by remembering and I'm not that good at it anymore. You read things but you don't learn it until you know you remember it. Then you know you know it."

Most of the excerpts concerning learning about work and education were congruent with Conception 3, knowledge for future use. All the schizophrenics interviewed used this conception within this context.

PM6 "How do you learn something? Practice. Keep reading after that a couple of months you've learned something. Study. Practice. Do things that you've learned and keep practicing."

PF9 "I guess I learn the things that I have to. There are some things that there would be not point in me learning because it's not part of my life. I learn what is going to help me. Like taking care of my dad."
PM0 "When I was a Riverview, I went to the programs that I could use when I get out."

These individuals spoke of obtaining personally relevant knowledge in a rather technical way that could be used in the future. There was more of a practical component to the conception of learning not necessarily found in previous conceptions.

Others voiced more abstract ideas about learning. They attached specific meanings to learning.

PM1 "Philosophically to learn is to me to live, to learn is to experience, to learn is to love, to learn is to have emotions...to learn is to me to be happy and to do what is right morally."

PF8 "Learning is part of life. It’s part of growing and becoming a person. People grow and learn all their lives."

PM3 "It was educational and it proved well because I’m getting to the part where all my knowledge is coming forth. Real verbal communication its worth itself because everything was lost in different ideas and to actually communicate you’d have to understand who you are."

PF7 "Learning is done everywhere. You don’t just do it in school. You’re learning all the time in your dealings with other people, reading, talking, doing. It happens whether you’re conscious of it or not. It’s part of life."

These individuals had a particular perspective about learning and had connected learning to life, growth, and various forms of communication and interaction.

In sixteen of the twenty transcripts, evidence of Conception 5, interpretation and understanding was noted.
"Learn from listening to older people. I’ve done a lot of things that people wouldn’t agree with anymore. They learn from me as well cause I’ve got the experience and they don’t."

"You learn something and then it affects your life and it makes things easier or it helps you make the decisions you have to make."

"I think learning is putting it into our life, just applying it to your life, daily life and letting it become a learning experience in a living way."

"Formal education all it does is propagates a certain belief, certain cultures... All I’d be doing is learning what somebody else had thought, what the instructor thought or the author thought."

"Changes your life. It develops, I develop. And with my character, I develop. It’s inspiring. New ideas."

These are but a few of the excerpts that reflect Conception 5. All interviewees spoke of learning in experiential terms: personal development, change, directing, exchanging ideas and opening oneself to new ideas. Learning was viewed as a continual, transformative process that changed their life.

Leisure

Leisure was defined as recreational activities and opportunities for the development of personal interest which reduce idleness and provide a sense of personal meaning and enjoyment. Many interviewees had difficulty talking about "leisure". They appeared to do little with their time and spent several hours a day on their own, usually in their rooms. Many did not have any ideas about leisure other than
watching TV or listening to music which they did not consider learning experiences.

PF4 "Somebody usually tells me about outings or they put a list in the lobby."

PM5 "Watch TV. No, don’t learn anything from it cause I don’t pay much attention to it."

PF5 "Don’t really have any interests. Just stay in and listen to music or watch TV. Don’t learn anything from that."

Learning in relation to leisure was viewed in general terms by these individuals. Some interviewees explained the role of memorization (C2) in activities they engage in.

PF2 "I remember everything that I have to get done, or everything throughout the day, except when I read I can’t retain it. But everything else exterior like outside of that I can remember."

PF6 "There’s lots of things that I’d like to learn how to do but if it takes too much concentration or memorizing then I get frustrated with it and give up like when I was trying to learn how to knit last year."

PM9 "I guess some people have to learn things for some activities and not for others. Like you gotta remember the rules for some games but not if you’re just going to work out."

PM6 "Memorize, that’s right. If you play sports, memorize the play, keep memorizing the play until it’s down pat."

Conception 3, knowledge for future use explored learning for leisure with the intent of applying this knowledge sometime in the future.

PM0 "When I was at Riverview, I would watch for awhile and see if I could figure it out and also see if it was something that I wanted to do. I tried to look for programs or things that I could do when I got out but it didn’t really work out."
PF3 "I might work on my knitting. (Learned that) at OT but mostly by myself. I just practiced and corrected my mistakes. I like it but can't do it when the voices bother me, can't concentrate."

Those who expressed ideas that reflected Conception 4, abstraction of meaning, did so in relation to a specific leisure activity that they engaged in. For example, PM1 compared literature he had reviewed but did not talk about how this learning personally affected him.

PM1 "The criticism of Shakespeare is that he only wrote what was already known as thoughts, the thoughts of man, which everybody knows. But Omar Kiam actually wrote more, he was way before Shakespeare, but actually the greatest poet of all is Jehovah and the Bible poetically is superior to any book I've read."

Similarly, this person spoke of the meaning she attributed to her art work.

PF0 "Almost everyday I do drawing. I think everyone needs something they can do to relax. For me, it's drawing, other people listen to music or go for walks. I like drawing cause it's something you can do anywhere, anytime. Sometimes I draw when I don't want to talk about things.

Using Conception 5, interpretation and understanding, this individual spoke of the difference that leisure would make to his life.

PM8 "I'm trying to get out more often, I gotta wait til the bus pass gets here, then I'm gonna be going out a lot you know everyday. Once you get a bus pass, you can get on any bus, skytrain or anything you know, take rides around and go places. That would open up my life a bit more. When you have the chance to move I think you should appreciate that type of inner knowledge that you have about that. That you're making a good move."
The lack of response by individuals regarding leisure activities was indicative of their isolated and marginalized state, the apathy and monotony of their lives.

Mental Health Services

This was certainly one of the dimensions that those interviewed had something to say about. Each individual had different experiences with the mental health system. The group was split in relation to previous hospitalizations; half had been hospitalized less than ten and half more than ten times since being diagnosed schizophrenic. All had been admitted involuntarily (committed) to the hospital in the past. In general, individuals voiced mixed reviews about the mental health system. There was general agreement that improvements were required. Conceptions of learning ranged from Conception 2 to Conception 5.

In Conception 2, memorization, individuals focused on remembering their medications or advice that their mental health worker had given them.

PF3 "I learn about my pills but still like that they have staff here cause there's too many to remember and sometimes I feel like overdosing so they give them to me. I know most of the names and some of what they do but it's confusing."

PM8 "I remember what my therapist was telling me and stuff like that. I kind like what he said and remember it."

PF0 "I always have to write down the names of the pills and the times so I can remember them. I forget sometimes when I'm supposed to take them."
Many individuals spoke of difficulties remembering their medications, when they were supposed to take them or why they were taking them. Interviewees also spoke of tiredness, blurred vision and decreased concentration and memory associated with the medication they were taking. Some spoke of the information or skills that they had received from the mental health service that they could subsequently utilize. This included altering medication regimens to see what would happen, trying suggested coping methods or just being aware of resources that could be accessed when required in the future (Conception 3, knowledge for future use).

PF1 "Getting my mood stable. I’ve been working on it, my anxiety, but I’m not getting anywhere."

PM4 "I was stubborn about it, but I finally got it down, I didn’t believe it, kept sometimes going off my insulin altogether just to prove I’m not that bad. I went off for a couple of days and it seemed that everything was going wrong. I’m more stable with the medication."

PM1 "Well just trial and error, I know they’re there if I need them and I’ve used a lot of them. I don’t take advantage of them, I don’t take advantage of the resources that are there, but I will use the resources that are available to me in a positive way."

PF4: "Yeh some like I went to skills group and can do some of the things okay but other talking groups are too hard. Everybody talks about their problems, it’s depressing and nobody has any good ideas how to solve things so it’s kinda wasting my time."

The schizophrenics interviewed related numerous ideas about the mental health system. They expressed these ideas in an abstract manner (Conception 4). However, their
perspective was narrow and they did not necessarily relate these ideas to their experience.

PM2 "I met this guy in hospital and he became very dependent on the hospital and I think they sent him to Riverview because of that, I don't really think he belonged there, he was just being lazy, he gave up on life...if he really wanted to he could pick himself and do these things, but he just didn't have the confidence and stamina to do it. I think that's why they don't publicize it (services) too much."

PM6 "Changes, to not drug up the patients, give them a little bit of medicine, what they need for their illness and how they should cope. The doctors have to talk to the patients then the social worker who will help them find a home."

PM9 "It's complicated but that doesn't really matter when they commit you, you lose all your rights so why bother trying to figure it out. There's no point fighting them. They say it's for the best, ya right, so you play the game and then they let you out."

PF8 "If they really want to help then they have to start listening to people instead of doing all the talking. Like I tell them what's wrong but they don't listen. Why do they bother asking then?"

These individuals frequently voiced dissatisfaction with mental health services when asked. They had learned the "system". In their anger, their perspective of the system was narrowly focused on medication, control and hospital.

Interviewees who reflected Conception 5, interpretation and understanding spoke of personal learning with respect to the mental health system. Within this dimension they described various aspects of learning as well as their personal experience with the mental health system.

PF6 "I've been in hospital a lot cause I used to always go off my medication cause I didn't think that I needed
it. Now I know that I do better on it than off it. The other thing is that I finally got a therapist that I can work with. She listens to me, we talk. I guess that I learned to trust their judgment and consider what they say probably because they listen to me too.

PM1 "It's been over three years that I've had a mental illness and now ah I was terrified mainly from my first delusion...and after that the delusions get continuously less terrifying. Nonetheless they are quite spectacular delusions in the sense of being totally out of reality."

PF7 "I know there are times when I really needed to go to hospital but when it gets to that point, I just don't want to go. I've learned through MPA that we have rights and we are entitled to a review panel. I try and stay out of hospital as best as I can. The team is just doing what it's supposed to when it put me away not that I agree with that power. I heard that there's going to be new legislation and the law changed so people's rights are taken away. More people need to know about their rights."

PF0 "I know that they've helped learn to live with my voices and not get so scared. I used to get so scared but now I have a positive attitude and they don't bother me as much. Everybody is different and they have to look at everybody's problems differently."

PM8 "I wouldn't let myself stoop that low to live on the streets. Lot of controversy about that these days. Mental patients coming out of Riverview, saying that they sleep on the street and everything else, but I cared enough to get myself out of Riverview. I went to the lawyer's office many times and made friends with them. They learned to trust me and I learned to trust them so they let me out."

Summary
This chapter has presented an overview concerning the various manifestations of Saljo's conceptions of learning expressed by schizophrenics with respect to dimensions of living. Although more difficult to express than elements of empowerment, these individuals spoke about their learning in the various contexts. All conceptions of learning were
voiced to some extent but most "learning" excerpts were congruent with Conception 3, 4, and 5. The author suspected that this was quite similar to the general population. The transcript data suggested that the interviewees apply the knowledge they gain, think abstractly and incorporate learning into their life, helping them to better understand their world. However, most of the interviewees did not perceive themselves as having the ability or potential to learn - like many "normal" adults. Often, they made self deprecatory statements with regards to their ability to learn, engage in educational activities or train for employment. This was viewed as yet another response to their disempowerment. Although the interviewer probed with questions concerned with "learning" the answers frequently dwelt on disempowerment. For these people learning is not a neutral or benign process but one deeply connected to their sense of powerlessness. It became evident that empowerment was both easier to discuss and a topic that interviewees wanted to pursue.

Chapter Ten will focus on the relationship between learning, empowerment and context. Despite being able to learn, all interviewees felt disempowered to some extent. Their disempowerment largely results from the social construction of schizophrenia.
CHAPTER TEN
CONSTRUCTING DISEMPOWERMENT

The purpose of this chapter is to explore learning and change in the context of disempowerment. When the author began this study she assumed there was a linear relationship between learning and empowerment. This assumption was based on "common sense knowledge" (Luttrell, 1989) and the empowerment literature. It seemed to follow that if schizophrenics exhibited "low" conceptions of learning then they probably would not be empowered. This did not appear to be the case. The interviewees displayed a range of conceptions with a predominant use of Conceptions 3 to 5, similar to what might be found if the author had interviewed a group of bus drivers, secretaries, labourers or teachers. But, although apparently able to test reality, think abstractly and look beyond their own perspective, almost without exception, they felt disempowered. The purpose of this chapter is to explore questions surrounding this issue, particularly structural factors that foster disempowerment.

Impact of Structure
"Structures" occur at a macro, macro-micro and micro level. At the centre of the following analysis is the notion that each set of structures creates "subjective" and "objective" constructions. Hence the approach taken in this chapter is "constructivist". The objective "realities" of
schizophrenia (poor housing) are disempowering and difficult to deal with but no worse than the subjective constructions (e.g. schizophrenics as "weirdos") of "normal" people. The issues to be discussed are represented in the following table.

Table 8. Disempowerment by Subjective and Objective Construction of Schizophrenia.

<table>
<thead>
<tr>
<th>Level</th>
<th>Author</th>
<th>Subjective Construction</th>
<th>Objective Construction</th>
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<tbody>
<tr>
<td>Macro</td>
<td>Media</td>
<td>Sensational &quot;weirdness&quot;</td>
<td>Gov't</td>
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<td></td>
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<td>Reinforce &quot;children of society&quot;</td>
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<tr>
<td>Macro/Micro</td>
<td>Mental Health</td>
<td>Biological &quot;disease&quot;</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Social Services</td>
<td></td>
<td>Helpless &quot;dependent&quot;</td>
<td>Social Services</td>
</tr>
<tr>
<td>Employer</td>
<td></td>
<td>&quot;incapable&quot;</td>
<td>Employer</td>
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<tr>
<td>Education</td>
<td></td>
<td>&quot;disabled&quot;</td>
<td>Education</td>
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<tr>
<td>Micro</td>
<td>Citizens</td>
<td>Distance by &quot;fear&quot;</td>
<td>Citizens</td>
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<tr>
<td>Authority</td>
<td></td>
<td>Label or ignore</td>
<td>Authority</td>
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<td>Family</td>
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<td>Alienate</td>
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<td>Schiz</td>
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<td>Internalize Oppression</td>
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Table 8 distinguishes subjective from objective "constructions" of schizophrenia. These ontological positions bind or otherwise limit what is possible for schizophrenics living in the community. The objective "facts" of their existence - the shortage of money, the difficulties associated with housing, the lack of jobs - all reinforce their feelings of disempowerment. However, they are not more or less corrosive than the subjective constructions of schizophrenia created by the media, mental health professionals and ordinary citizens.

If the media constructs schizophrenics as "weird" and, in implementing mental health "policy" the government makes them into children, the ontological basis of these constructions doesn't matter much. However, for present purposes it helps to distinguish so-called objective "facts" that materially effect schizophrenics from the subjective "meanings" ascribed to them by macro, macro/micro and micro-level "authors".

In this analysis an "author" can virtually be any one person or group, organization or system, or structure of influence that either through their ideas or actions have an impact on schizophrenic people.
Macro-level subjective constructions

As the reporter reads a hand-written letter whose rambling contents describe having murdered someone and attempting suicide at least four times, a bare-foot, dishevelled, poorly clothed man walks across the busy street in the cold of winter. The power of the media is phenomenal. Their goal is to present a subjective construction, an image, of people’s lives and although life consists of both joy and tragedy, the media is prone to present the negative side of life. Recently, the plight of people with mental health problems has been the focus of the local and national news (e.g. Globe and Mail, 6 March, 1993) not that their plight, homelessness or deinstitutionalization are new phenomena. In attempting to increase the public’s "awareness of" and "empathy for" the difficulties experienced by those who are schizophrenic, they perpetuate stigma, fear, myths and misunderstanding and in the end, accomplish the opposite of what they set out to do. By "sensationalizing" their lives, they construct schizophrenics as "weird" and thus contribute to their disempowerment.

A recent headline in the 6 March, 1993 Vancouver Sun newspaper described the Vancouver Canucks hockey team as "schizophrenic" in a discussion of their winning and losing streaks (Appendix G). So what did he mean? He, like many others in society, still view schizophrenia as "split personality", a Dr. Jekyll and Mr. Hyde phenomena.
Schizophrenics are constructed as unpredictable, bizarre, and evil. They cannot control themselves. This "othering" disempowers them by highlighting the fact they are "different". It questions their ability or need to learn by perpetuating a view of a disordered, chaotic life, the person lacking control of the brain.

A recent B.C.T.V. interview with a "schizophrenic" focused on his inability to get back into the institution where he had spent much of his life. Instead of focusing on disempowerment in the community, the interview portrayed the individual as helpless, hopeless and somebody who could not care for himself. As constructed on television this person could not learn to take care of himself. Viewers "reading" this broadcast would feel pity for this man. Through an editing process that focused on the "pitiable" aspects of this man, viewers were invited to assume that all schizophrenics are like this. Pity does not empower and in this case, further marginalizes.

Macro-micro level subjective constructions

Macro-micro level structures consist of specific "mid-level" groups or organizations which have a particular mandate or role within society such as mental health services, social services, the employment/labour market, educational institutions. These groups contribute to the marginalization of schizophrenics by their subjective
constructions of the phenomena. Mental health services are staffed by people from varying disciplines and theoretical backgrounds and as such, hold no one view. However, mental health services contribute, sometimes in pronounced ways, to the continued disempowerment of these people.

Schizophrenia continues to be primarily viewed as a biological and possible genetic disease entity by mental health professionals. Unlike other "diseases" with obvious and overt, often physical, manifestations, "diseases" of the brain are not simple to investigate or manipulate and therefore do not lend themselves to scrutiny by others. The professionals are considered the "experts" and it is assumed that they know what they are doing when treating schizophrenia. The individual schizophrenic is often viewed not as a person but a disease. The focus becomes one of treating the disease rather than helping a person who is experiencing an emotional crisis. Individuality is lost within a myriad of terms used to describe speech and behaviour and names of medication whose action is never quite explicit. Problems with housing, income, support or jobs become secondary. If experts can "fix the brain", the person will be able to function like "the rest of us."

The focus on the "broken brain" rather than on the person has a significant impact on learning and empowerment. Can somebody learn if they have a "broken brain"? Learning is
associated with brain activity. Many lay people and medical "experts" think not. Certainly, the schizophrenic could not learn enough to make them functioning members of society. Professionals have to be aware that individuals can only empower themselves. Setting up clinics, drop-ins or supervised housing tends to segregate these individuals from the rest of society. The people interviewed stated that they did not want places specifically set aside for individuals with mental health problems. They wanted to be with "normal" people and be treated in the same way.

Social services perpetuates stigma and marginalization by their subjective construction of schizophrenics as helpless and dependent on society. Once labelled, it is extremely difficult for these individuals to become anything but dependent on society. They force segregation by only affording them enough money to barely survive in the roughest, economically deprived areas of the city. No one wants to live in the skids but schizophrenics can't afford to get out. The social service system is a complicated arena of rules and regulations which lacks consistency and discourages people from finding out anymore than necessary. Learning how the system works is a formidable task. Attempts to get out of the system or question it are considered as disruptions to the overall process.
Unemployment services view schizophrenics as virtually unemployable. Potential employers in the community view these individuals as incapable. They are left with few options and only given chances by "friends or family". The welfare system prevents these people from making more than $100 without taking it off their cheque. Many do not feel capable of full-time employment, at least to start off with and if they were to gain full-time employment, the minimum wage would be the most that they would make due to their lack of education or skills. For many, the diagnosis of schizophrenia came at a time when they were making career plans, completing high-school or attending post secondary institutions. A select few are given the opportunity to train. These individuals tend to live in supervised housing and agree to take medication.

Educational institutions subjectively construct schizophrenics as yet another marginalized group along with the physically challenged, people who are blind or have difficulties hearing. There is not the same stigma attached to these other groups as there is to schizophrenic people. As such, efforts are made to mainstream these other groups into the educational system. Similar endeavours will not work for schizophrenic people for several reasons. Most educational courses that offer credentials are offered within large institutions. This means large classes and usually costly fees. Schizophrenics, many of whom have been
away from the formal educational setting for some time, are intimidated by the institution and large classes. To create special classes for these individuals would mean drawing even further attention to a marginalized group who want to be considered normal. The individuals interviewed addressed the lack of educational and training opportunities and the stress associated with pursuing this possibility. Strauss (1991) captured the distress experienced by one individual who tried to go back to university:

I'm schizophrenic, still, I'd like to go to school. I've read a lot, took a course in parapsychology. The course in witchcraft, metaphysics... Had to stop, the voices were learning what I was learning, it was coming back to me in a disorder. I was taking a course in astrology and had to stop it, I was teaching the voices too much... I know this sounds crazy. (p. 85)

They did not have the money needed for private tutoring that would help them regain their confidence prior to engaging in more formal educational activities.

**Micro-level subjective constructions**

Micro level structures mostly consist of people that schizophrenics come into contact with on a daily basis - other schizophrenics, family, citizens, people in the neighbourhood and authority figures such as police. The general population, people on the street and in neighbourhoods, stigmatize these individuals because their conversation and behaviour don't necessarily fit prevailing norms of what is appropriate behaviour. They distance
themselves because they are afraid and do not understand schizophrenia. People on the street either look the other way for fear of making eye contact or stare and laugh. How many people would strike up a conversation with these people while waiting in a line? How many neighbourhoods have opposed housing projects dedicated to people with mental health problems? How many slaps in the face do schizophrenics receive before they begin to question themselves as individuals with the same rights and needs as other citizens?

Authority figures such as police officers construe these individuals as "loons" or "mental." Quite apart from the derogatory and prejudicial nature of these constructions, they blame the victim and label them "irresponsible." As a result, schizophrenic people "learn" to fear the police and other authority figures. PM1 and other interviewees spoke of being hassled by the police for no other reason than sitting on the street. Schizophrenics do not believe that they receive the same treatment as other citizens in society. Unfortunately, many police officers and other authority figures reinforce the stigmas exhibited elsewhere in society.

It is commonly thought that schizophrenics create problems for themselves by alienating their families and friends. Regrettably, much of this alienation stems from the families
and friends who misunderstand the behaviour. Expressed emotion, guilt, poor communication and conflict with family members are known to trigger increased difficulties for schizophrenics (Miller, 1989). By withdrawing their support and not acknowledging responsibility, families and friends further marginalize the individual. What does the rest of society learn from families pushing their loved ones away?

Schizophrenics internalize the oppression that pervades their lives on a daily basis. They question their worth, their abilities, their place in society. Stigmatization and marginalization are difficult to deal with. Schizophrenics have an even greater difficulty when they are attempting to cope with delusions and voices. This disempowers them for several reasons. The stigma they sense from others deters them from interacting with "normal" people. The perceived marginalization does not provide an environment that would encourage interaction with others. This in turn isolates them, perceived by others as bizarre, unusual behaviour. The lack of interaction leads to misunderstanding and speculation. Schizophrenics disengage from society. This disengagement becomes yet one more behaviour viewed as a symptom of disease rather than the result of treatment by an oppressive society.
Macro-level objective constructions

Government bodies reinforce the idea that schizophrenics are "children". They are treated as children on one hand and as a "special" group on the other. In both instances, they are governed by the benevolent parent legislated to take responsibility for these "disadvantaged and impaired" individuals and to take control over them when it is deemed that they meet criteria developed by the government. Special treatment segregates them from the rest of society.

Observers would be forgiven for thinking that governments are primarily in the business of "managing" schizophrenia. Schizophrenics have little political power, a schizophrenic is not likely to show up as an M.L.A., M.P. or cabinet minister. Despite the occasional fulminations of advocacy groups schizophrenics are not sufficiently well-organized to engage in the kind of activity or party politics. For example, in ten years persons-with-AIDS have made a significant impression on governments and yet AIDS was not "discovered" until 1983. Schizophrenia has been a "recognizable disease" since about 1911.

Governments are charged with securing and distributing resources and there is no way in which they become involved with the uncertainties and pain of these individuals. Occasionally a particularly effective movie or popular novel can move politicians but, in general, there is no
significant social force capable of eroding or changing the notion that schizophrenics are like "children". There is not likely to be a schizophrenic Rick Hansen or Terry Fox who changes public consciousness and thus the thinking of government.

Macro-micro level objective constructions
Psychiatrists justify their existence by continuing to use the label "schizophrenia". Some propose that it is a biological/genetic disease whose etiology and cure are just around the corner (Torrey, 1993). Biologically-based psychiatric constructions of schizophrenia attract the largest amount of research funds. Psychological or "talking therapies" that have had a demonstrable impact on schizophrenia (see Karon, 1990) do not enjoy the same kind of support. The belief in a biological disease entity has also stimulated the "productivity" of pharmaceutical companies as medication becomes the treatment of choice despite controversial evidence concerning side effects and minimal long-term improvement as compared to other interventions. Schizophrenia has become big business. Drug companies and dealers profit at the plight of these people.

The mental health profession also influences society's view of schizophrenia as these are the "experts" speaking. As an "authority" on mental health, they are seen by society to possess knowledge and expertise. Society turns to its
experts for answers. Unfortunately, much of society is receiving a very biased view of schizophrenia which leads to a narrow perspective and further marginalization.

Social services control the "objective" or material conditions of these individuals. They remove from the individual all that makes the person an adult in the eyes of society. They take away their right to manage their own financial affairs. Money is dolled out like a teenager's allowance. For some, the decision of where to reside is taken away and unless these individuals can find other funds, they are forced to comply with the wishes of those holding the money. They intervene with hotel and apartment managers and thus reinforce the idea that these people are not responsible adults.

Employers discriminate against schizophrenics along with other marginalized groups. They contribute to an image of incapability by not giving these people a chance to prove themselves. Many of the interviewees had lost hope of ever being employed again. They had lost a sense of self as being employable and productive.

Educational institutions have been forced to adapt their architecture, libraries and other facilities to the needs of visually impaired, people in wheel chairs and others with obvious physical disabilities. It is relatively easy to respond to the needs of "physically disabled" people. There
is little evidence to suggest that the "average" teacher, instructor or professor could adapt to and cope with the needs of a person who periodically experiences delusions, hallucinations and profound states of distress. Particularly talented teachers might welcome the challenge but, a climate of cutbacks and insecurity, educators are not likely to willingly undergo the learning that would result from teaching classes containing schizophrenic people. Moreover, those who view institutions of "higher" learning as elitist organizations would not be likely to adapt curricula, teaching or counselling techniques to the needs of schizophrenics who, as noted above, would likely find present arrangements (in most formal educational settings) too stressful.

Micro-level objective constructions

"Normal" people contribute to disempowerment not so much by what they do but by what they don't do. Schizophrenics experience a profound lack of support. What would be the impact of a situation where they felt cared about and included? What could these individuals accomplish for themselves and others, if they had the support of "normal" people who demonstrated genuine caring rather than fear and disgust?

Not all families have alienated their schizophrenic children. However, many who claim to support their children
have rallied together but uncritically "bought into" the biological disease theory. As such, they have inadvertently contributed to their children's demise. It has given them the justification for submitting their children to treatments which reinforce helplessness. They have perpetuated the vicious circle by contributing to biological and pharmaceutical research. As a group, they have done more to lobby for themselves as family members than for the individuals experiencing the difficulties.

Authority figures (e.g. police) reinforce the status quo by either ignoring these individuals or fitting them into existing structures (i.e. hospitals and jails). They are imprisoned or hospitalized because of nameless, meaningless or highly pejorative "diagnoses" e.g. "danger to self or others", "just crazy". What message do authorities give to the rest of society by treating these individuals like this?

Schizophrenic people are disempowered and although learning is a corollary of empowerment, it did not appear to enhance empowerment for the people in the study. People must empower themselves, but to accomplish this, social structures have to change. To create an understanding society, schizophrenics will have to be involved in the process of shaping society. This will involve learning on their part as they become increasingly acquainted with existing socio-political and economic systems that serve as
a starting to point for change. This vision also has significant implications for all the "authors" of the various constructions of schizophrenia.

**Implications for Change**

Readers will recall that this study was directed by a commitment to a "sociology of change" rather than a "sociology of regulation." (Burrell & Morgan, 1979). The schizophrenics interviewed in this study experienced an extreme sense of disempowerment that cannot be explained by a limited discussion of the interviewees alone. Their disempowerment can be attributed to their difficulties with the existing structures in society. The limited self-efficacy of these individuals was not surprising when considered in the context of their repeated marginalization by almost every person or organization they came into contact with. They seemed acutely aware of their marginalized status within society.

Ultimately, individuals have to overcome their oppressors. Empowerment may begin at the individual and move to a collective level. However, at present, there isn't much hope of making significant progress unless social structures change. This change involves learning by individuals, groups, organizations and influential structures in society.
Government bodies must open their eyes to other perspectives rather than a paternalistic doctrine of control and management which is by far an easier route to take than trying to understand. To understand, the people in these positions of influence will learn that these individuals are capable, functional and attend therapy sessions like many professional people who are experiencing difficulties in their lives. They must come to recognize that there is a thin line between what is and what is not "crazy". They must work to eliminate the gap that exists between schizophrenics and the rest of society and in doing so, involve schizophrenics in the process of change at all levels. The BC Provincial Government recently introduced health care legislation whereby a third of government bodies will be comprised of lay people. Who will ensure that schizophrenics are represented? They are not likely to participate without a specific invitation to do so. The government will have to get closer to the people instead of distancing themselves as they have done.

The media who pretend to present authentic constructions of people's reality must acknowledge that they are part of the status quo which tends to marginalize these people. They are more than aware of the number of people they have the potential to influence. Responsible journalism would present a multitude of perspectives with which the audience could draw their own conclusions. Instead, they
sensationalize lives and draw attention to people who prefer to be left alone to live a "normal" life. Through education, the media needs to be sensitized to their use of stereotypes and myths they inadvertently propagate. Other marginalized groups would not put up with such derogatory comments.

Mental health services are reactive rather than proactive. Unlike other areas of medicine of which psychiatry includes itself, mental health has not jumped on the health prevention and promotion band wagon. In most cases, service is provided once the person has been hospitalized and on the referral of some other organization. Self referrals for counselling are placed at the bottom of long waiting lists and it's only when a "crisis" happens, as diagnosed by the professional rather than the individual, that any action results. By the time professionals attempt to assist, the person has virtually been labelled and marginalized. Certainly, services are in demand and a lack of funding is blamed but other areas of medicine are showing the benefits of health promotion and prevention. Mental health organizations can learn from other areas of health and plan to manage funding more effectively. This is essential because future funding is not expected to increase.

Mental health professionals also have the responsibility to continue to increase their knowledge and open themselves to
perspectives that challenge the orthodoxy of the medical/biological model. Organizations must provide both the incentive and the opportunity for their employees to participate in continuing education. This includes providing an environment in which professionals and schizophrenics can explore these perspectives together.

Social services and employment agencies need to learn about the role they play in marginalizing schizophrenics and keeping them in this disempowered state. How many financial aid workers know about the lives and struggles that these people face on a daily basis? Rather than viewing them as helpless people whose hands are always stretched out for more, they must develop programs that allow schizophrenics to save face and become active citizens in the community. This involves programs for education and training, employment opportunities that don't take away financial benefits as the person adjusts to being part of the work force again.

At a micro level, citizens can help schizophrenics become part of the community. Everyone has busy lives but how much time does it take to read or learn about schizophrenia? How much effort would it take to say hello instead of turning away? How much time would it take to investigate the successful housing projects in other neighbourhoods? A little effort would make a big difference.
Authority figures can be role models for citizens. Police are reporting increasing interactions with the "mentally ill". They attribute this to the downsizing of institutions, lack of homes, lack of treatment, among other reasons. Although possibly placing the blame where it should not be, they are taking an active role in educating their members about mental health and how to more effectively intervene in crisis situations.

Families need to learn about their impact on schizophrenics. Education should be directed to include alternatives to the biological model of schizophrenia. More importantly, they need to find out that they can provide one of the essential factors that can contribute to empowerment; that is, a sense that the person is cared for, belongs and is understood. To accomplish this, education must be directed to understanding the person’s struggles and learning to communicate effectively.

Lastly, there are implications for schizophrenic individuals themselves. Despite what they may think about their abilities to learn, the interviewees demonstrated that they do learn. Learning will have to continue to be part of their lives if they are to become empowered. To become empowered, they will have to transform their self perception and their perception of the world. Advocacy groups of
"survivors" are probably the most helpful in accomplishing this yet there are few who come out of the "psychiatric inmate" experience unscathed. Not many are left with the energy to fight for something better. These people need to be provided with the opportunity to tell their story to others who can learn from their experience of rising from a dark, lonely, misunderstood existence.

Summary
By and large the twenty interviewees were disempowered and this chapter had discussed societal factors that contribute to this situation. Schizophrenics can learn, but no amount of learning will assist these individuals in becoming empowered unless there are concurrent changes in society. There are implications for public policy, for increased responsibility on the part of support services and the media and changes at a personal level. All involve education and learning.
The purpose of this chapter is to describe limitations of this study and implications for future research. The chief limitations concern criteria used to analyze the transcripts, namely, Saljo’s conceptions of learning and Davis’ elements of empowerment. To a certain extent both "models" are flawed and this impeded the analysis of transcripts and validation of the author’s judgments concerning their meaning. Each model will be discussed in turn.

**Saljo’s Conceptions of Learning**

Recall, Saljo’s five conceptions of learning:

1) a quantitative increase in knowledge
2) memorization
3) the acquisition of facts, methods, etc. which can be retained and used when necessary
4) the abstraction of meaning
5) an interpretive process aimed at understanding reality.

In order to use these conceptions to analyze the data, they had to be elaborated and put into plain language. This was attempted by reviewing Saljo’s work as well as others who had since built on it (e.g. van Rossum, 1988).

Saljo’s conceptions were based on his work with university students and perceptions of what they get from their course reading materials. This is a far cry from schizophrenics
talking about their daily lives. Yet it is believed that these conceptions of learning are universal and have been tested by others who confirm the first five and have since added a sixth conception.

Saljo (1982) claimed that his was a developmental model. As learning becomes more "sophisticated" people pass through level 1 (learning "facts") to level 5 ("interpretation and understanding"). However, there does not appear to be a consistent underlying structure that strings the conceptions together. Conceptions 1 and 5 appear to relate to outcomes or goals while Conceptions 2 and 4 speak to how one might reach these learning outcomes. Saljo has conceptual apples in the same bag as conceptual oranges. Conception 3 appears to combine Conceptions 1 and 2 with praxis. The fact Conception 3 is concerned with "... methods etc" suggests that even the author was not sure about what should and should not be included in this conception. Imagine if a biologist distinguished between fauna and flora etc. Or, imagine Eysenck claiming people were introverted or extraverted etc? Conception 3 is viewed as a transition point because of the inclusion of praxis. This explanation does not suffice as praxis, the "application" of what is learned, is involved in all learning no matter what the conception. Even simple "facts" - such as knowing the UBC bus leaves from Broadway - leads to "action" (such as getting on this bus). In retrospect, a good argument could
be made for using other models. For example, Gagne's five types of learning outcomes (verbal information, intellectual skills, cognitive strategies, attitudes and motor skills) vary with respect to only one dimension - learning outcome. Saljo's model is conceptually muddled in that different elements are packed into each level. Hence, statements in the transcripts often reflected several conceptions and, despite attempts to formulate exceedingly concrete definitions of what appeared to be the central meaning of each conception, there were instances when it was difficult to separate conceptions as they tended to build upon each other.

Besides, most interviewees appeared to be anchored in Saljo's conception 3 - the acquisition of facts, methods etc for later use - and, in this regard, are probably no different than the bulk of the adult population. In some respects Saljo's model was too crude to analyze the learning of schizophrenics which, as indicated in the previous chapter, is overwhelmingly shaped by their feelings of marginalization and disempowerment. By definition, schizophrenics have disordered cognitive processes but, to dig further into the matter, future researchers will need a more sophisticated model of learning (and accompanying theory) than that provided by Saljo. Because of the importance of social structures and their role in disempowering schizophrenics it will be important to
distinguish the "learning process" from the need to create optimal "conditions for learning" (Gagne, 1977).

**Davis' Elements of Empowerment**

Recall that, for Davis, an empowered person has:

1) self-efficacy  
2) an ability to access resources, knowledge and skills  
3) authority and enablement  
4) critical consciousness  
5) multi-dimensionality.

Davis' work does not constitute a model. At best this is a list of elements - characteristics that we'd expect to be found in an empowered person. Presumably a semi-empowered person would manifest only some or moderate amounts of each element. The problem is that each element is nested within an ideology of individualism, even though there is occasional or oblique reference to structural factors - access to "resources", the idea of empowerment as "multidimensional".

Unfortunately, the exact meaning of each element is not clear and the author had to elaborate the elements in order to make them work in this study. Judges asked to identify Davis' "elements of empowerment" in the transcripts were unable to use the elements until concrete examples were attached to them. As such, the transcripts were open to interpretation by those who examined and rated the excerpts.
Although Davis' elements of empowerment were developed from a group more closely linked to schizophrenics than were Saljo's conceptions, these elements required reformulation in order to make them operationally useful. Each element was a process in its own right and implied a positive direction - e.g. will have "self efficacy". In order to use these elements with schizophrenics who were severely disempowered, they had to be conceived as bipolar (with a positive and negative end). The author noted evidence for the presence and the absence of the element. Judges asked to validate the author's ratings had to be provided with concrete examples of both poles of the element.

**Ideology of Individualism**

Probably more significant than the semantic difficulties that arose from Saljo's and Davis' work is that both formulations are based upon an ideology of individualism. Schizophrenics cannot be held responsible for their position in society nor for the societal changes required to improve their lives. As such, individualism does not take into account the societal structures that contribute to their marginalization and oppression and prevent empowerment. Changes in the socio-political and economic environments must occur from the individual level to government. It involves schizophrenic people but it also involves all the other people they come directly or indirectly in contact with every day of their lives.
There appears to be a need to distinguish schizophrenic learning from the creation of optimal conditions for schizophrenic learning. The former falls within the realm of psychology and has been approached from psycho-linguistic and cognitive perspectives. Creating optimal conditions for schizophrenic learning falls within the realm of education. The schizophrenic people interviewed appeared to learn in much the same way as others but lacked the social environment or sense of empowerment necessary to take advantage of or to create new opportunities for education.

The transcripts proved to be a rich source of data and the experience of interviewing these people was both challenging and enlightening for the author despite working in mental health for several years. Throughout the study, it was more difficult to maintain a focus on learning and easier to focus on empowerment because this is what the interviewees wanted to talk about. Disempowerment was their primary concern. Future attempts to understand schizophrenic learning from standpoints similar to that taken in this study would probably produce little valuable information due to the individualist ideology at the root of subjective ontologies of learning. What seems more important is the individual sense of empowerment and their position in society. The literature suggests that learning is a corollary of empowerment. This study suggests that
empowerment is a corollary of learning. The two concepts move side by side. Therefore, it would seem more prudent that future research focus on empowerment.

**Cross-sectional**

This was a cross-sectional study. Even during the short time period in which this study was carried out, the author became aware that a few interviewees ended up in hospital, jail or on the street. Their lives are far from static and for this reason, a longitudinal study in which individuals check in with the researcher once a week over the course of a year, and keep a personal diary of issues associated with empowerment and learning would probably be a good source of information concerning the lives of these individuals.

**Need for Experimentation**

The current obsession with post-positivist epistemology should not blind future researchers to the power of experimentation. In the past there have been experimental designs created to examine outcomes of educational activities provided for schizophrenic individuals. Few if any have been carried out from an empowerment perspective. It might be possible to set up an experimental situation in which one group of individuals is exposed to a buddy system with a psychiatric survivor who has been through it or exposure to a learning environment outside of the
institutionally developed programs and compare them to a group of "control" individuals.

**Similarities to Other Groups**

A much more manageable means of approaching schizophrenic empowerment is through conceptual analysis. Other groups in society have been marginalized and share some of the same concerns as schizophrenic people. In future research it would be enlightening to analyze literature that pertains to the "othering" process and ways in which social structures maintain the status quo by delegitimizing and marginalizing schizophrenics.

**Professional Practice**

Yet another area that requires further investigation is the practice of mental health professionals. Schizophrenics' reports about interactions with their environment are valuable. They provide such a common set of themes across time and societies that one ignores them at great risk (Strauss, 1991). The interviewees could readily articulate their disempowerment and their experience could be placed within specific categories of self efficacy, critical consciousness and so on. The categories that arise from their experience can be used as a framework with which to develop education for mental health professionals so that they are aware of these individuals' needs and can direct their practice accordingly.
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Discharged psychiatric patients are in a terrible bind. They may be unhappy living in homes with poor care, but they are even more fearful of having no home at all.

BY JOCK FERGUSON
The Globe and Mail
Toronto

THOUSANDS of elderly and handicapped residents of Ontario rest and retirement homes are in a terrible bind — and increasing — risk of being dumped on the streets. They may be unhappy living in homes with substandard care, but they are even more frightened by the prospect of having no home at all.

The homes — legally defined as "board and care" homes — are not covered by the provincial landlord-tenant Act or rent control regulations. Thus, rates may suffer arbitrary rent hikes and summary evictions. Moreover, the homes are often run by unscrupulous, profit-driven owners who may evict residents for any reason, including refusing to pay their rent. This is reflected by the number of elderly residents living in the worst homes, many of whom are in a state of chronic depression and anxiety. It also means that residents have no recourse under the law to challenge their eviction. And because the homes are often run by unscrupulous owners, they are not subject to the same standards of sanitation, nutrition, and good care as licensed nursing homes. Thus, residents may suffer from a lack of basic hygiene and care.

In addition, residents are often threatened with eviction if they complain or try to improve conditions in their home. This is reflected by the large number of residents who are afraid to speak out for fear of being dumped on the streets. In some cases, residents have been evicted without notice or compensation for their belongings.

The problem is made worse by the fact that many residents are on limited incomes and have no options if they are evicted. They may be forced to live on the streets or in temporary shelters, which are often even worse than the homes they were forced to leave.

For example, Mr. Zaraldo, a resident of the Ouellette Avenue Home, was evicted from his home and was forced to live in a temporary shelter. He was forced to leave his belongings behind and was left with no options but to live in a space that was not fit for human habitation.

This is a growing problem in Ontario, and it is one that needs to be addressed. The government must take action to ensure that residents have a right to a safe and healthy home, and that they are not subject to arbitrary evictions.

In conclusion, discharging psychiatric patients are in a terrible bind. They may be unhappy living in homes with poor care, but they are even more fearful of having no home at all.

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Diagnostic Criteria for Schizophrenia

A. Presence of characteristic psychotic symptoms in the active phase: either (1), (2), or (3) for at least one week (unless the symptoms are successfully treated):
   (1) two of the following:
      (a) delusions
      (b) prominent hallucinations (throughout the day for several days or several times a week for several weeks, each hallucinatory experience not being limited to a few brief moments)
      (c) incoherence or marked loosening of associations
      (d) catatonic behavior
      (e) flat or grossly inappropriate affect
   (2) bizarre delusions (i.e., involving a phenomenon that the person's culture would regard as totally implausible, e.g., thought broadcasting, being controlled by a dead person)
   (3) prominent hallucinations [as defined in (1)(b) above] of a voice with content having no apparent relation to depression or elation, or a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other

B. During the course of the disturbance, functioning in such areas as work, social relations, and self-care is markedly below the highest level achieved before onset of the disturbance (or, when the onset is in childhood or adolescence, failure to achieve expected level of social development).

C. Schizoaffective Disorder and Mood Disorder with Psychotic Features have been ruled out, i.e., if a Major Depressive or Manic Syndrome has ever been present during an active phase of the disturbance, the total duration of all episodes of a mood syndrome has been brief relative to the total duration of the active and residual phases of the disturbance.

D. Continuous signs of the disturbance for at least six months. The six-month period must include an active phase (of at least one week, or less if symptoms have been successfully treated) during which there were psychotic symptoms characteristic of Schizophrenia (symptoms in A), with or without a prodromal or residual phase, as defined below.

   Prodromal phase: A clear deterioration in functioning before the active phase of the disturbance that is not due to a disturbance in mood or to a Psychoactive Substance Use Disorder and that involves at least two of the symptoms listed below.

   Residual phase: Following the active phase of the disturbance, persistence of at least two of the symptoms noted below, these not being due to a disturbance in mood or to a Psychoactive Substance Use Disorder.

   Prodromal or Residual Symptoms:
   (1) marked social isolation or withdrawal
   (2) marked impairment in role functioning as wage-earner, student, or homemaker
   (3) markedly peculiar behavior (e.g., collecting garbage, talking to self in public, hoarding food)
   (4) marked impairment in personal hygiene and grooming
   (5) blunted or inappropriate affect
   (6) digressive, vague, overelaborate, or circumstantial speech, or poverty of speech, or poverty of content of speech
   (7) odd beliefs or magical thinking, influencing behavior and inconsistent with cultural norms, e.g., superstitiousness, belief in clairvoyance, telepathy, "sixth sense," "others can feel my feelings," overvalued ideas, ideas of reference
   (8) unusual perceptual experiences, e.g., recurrent illusions, sensing the presence of a force or person not actually present
   (9) marked lack of initiative, interests, or energy

Examples: Six months of prodromal symptoms with one week of symptoms from A; no prodromal symptoms with six months of symptoms from A; no prodromal symptoms with one week of symptoms from A and six months of residual symptoms.

E. It cannot be established that an organic factor initiated and maintained the disturbance.

F. If there is a history of Autistic Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present.

Classification of course. The course of the disturbance is coded in the fifth digit:

1-Subchronic. The time from the beginning of the disturbance, when the person first began to show signs of the disturbance (including prodromal, active, and residual phases) more or less continuously, is less than two years, but at least six months.

2-Chronic. Same as above, but more than two years.

3-Subchronic with Acute Exacerbation. Reemergence of prominent psychotic symptoms in a person with a subchronic course who has been in the residual phase of the disturbance.

4-Chronic with Acute Exacerbation. Reemergence of prominent psychotic symptoms in a person with a chronic course who has been in the residual phase of the disturbance.

5-In Remission. When a person with a history of Schizophrenia is free of all signs of the disturbance (whether or not on medication), "in Remission" should be coded. Differentiating Schizophrenia in Remission from No Mental Disorder requires consideration of overall level of functioning, length of time since the last episode of disturbance, total duration of the disturbance, and whether prophylactic treatment is being given.
Appendix C. Consent Form Used in Study of Learning and Empowerment in Schizophrenics

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CONCEPTIONS OF LEARNING AND EMPOWERMENT

Principal Investigator: Dr. Roger Boshier, Professor, Dept. of Adult Education, University of British Columbia. Phone #822-5822

Co-Investigator: Colleen Price, M.A. Candidate in Adult Education, University of British Columbia. Phone #822-5822

The purpose of this research study is to ascertain your views about learning as it pertains to your life in the community and personal empowerment. As a participant in this study, you will be interviewed by the co-investigator for a one hour duration. The co-investigator may request a second interview within one month to validate ideas that arise from the study. The interview will be tape recorded so that your ideas are recorded accurately. Following transcription of the interview, the tape will be erased.

Participants will in no way be identified; names will not be used. Confidentiality of interview data will be maintained and interview transcripts will be destroyed at the end of the study. Only research committee members will have access to the interview transcripts. Your participation in this research is voluntary. Your refusal to participate will be respected and you will not bear any repercussions as a result of making this choice. You may go off the record or stop the interview at anytime without consequence.

It is the hope that the information you provide will help increase understanding of your life and what might be done to assist your survival in the community.

If you have any further questions, you are encouraged to contact either investigator at the above contact number.

I,_________________________, consent to participate in this research study and have been provided with a copy of this consent form.

Signed:__________________________
Date:_________________________
Appendix D. Interview Questions Used in a Study of Schizophrenic Learning and Empowerment

CONCEPTIONS OF LEARNING AND EMPOWERMENT

HOME

1) How long have you lived here?
2) How did you get this place?
3) What is it like living here?
4) Do you like it?
5) Do you see yourself moving to other accommodation in the future?
6) How would you do this?
7) Would this be done on your own or does it involve other people?
8) Has there ever been a time when you haven’t had a roof over your head?
9) What did you do?
10) How did you know to do that?
11) Why do you think this happened?
12) On a scale of 1-10, 1(low personal control) and 10(highest control), where do you place the amount of control that you have over housing?
13) Who has the control?
14) Do you see anyway of changing this situation?

WORK/LEARNING

1) Can you tell me about your experiences going to school?
2) What prevented you from furthering your education?
3) Are you participating in any educational activities, groups, workshops, now?
4) If so what? If not, why not?
5) Can you tell me about your work experiences?
6) Are you working now? At what? If no, why not?
7) Would you like to be working or attending an education program? Why?
8) What would assist you in either attending an education program or seeking employment?
9) Do you see either as a possibility in the future?
10) What does it mean to you to learn?
11) How/when do you know that you are learning?
12) Has the way that you learn changed over time?
13) Do you think that you learn any differently now than before?
14) On a scale of 1-10, 1(low personal control) and 10(highest control), where would you place the amount of control that you have over your ability to work or participate in education?
15) Who/what do you associate as having control?
INCOME

1) Where do you get your finances from?
2) Do you get money from any other means?
3) Does it cover your monthly expenses?
4) What about clothing?
5) Do you ever use some of the soup kitchens, food bank or coffee drop-ins?
6) Where do you go for this?
7) How did you find out about it?
8) Have you ever run out of money?
9) What did you do?
10) How did you know to do that?
11) On a scale of 1-10, 1(low personal control) and 10 (highest control), how much control do you have over your financial situation?
12) Why is that?
13) Who/what has the control?

SOCIAL SUPPORT

1) Do you have family in the city?
2) Describe your relationship with them?
3) Has it changed over time? In what respect?
4) What about friends?
5) What do you do with your friends?
6) If you had some good news, who would you share it with?
7) If you had a problem, who would you turn to?
8) Do you ever feel lonely? When, under what circumstances?
9) What do you do?
10) Why would you do that?
11) Have you noticed any changes in the way you get along with other people?
12) Are you involved in any community or support groups?
13) What does participation in that group do for you?
14) Or..Have you ever considered joining a community or support group? If no, why?
15) On a scale of 1-10, 1(low personal control) and 10(highest control), how much control do you feel that you have over relationships with others?
16) Would you want that to change?
17) How might you about doing that?

LEISURE

1) Tell me about a typical day for you?
2) What activities do you get the most enjoyment from?
3) Where do you do those things? Are other involved?
4) How do you feel after doing that?
5) Do you have any other personal interests or hobbies?
6) What about in the past?
7) Is there anything that you would like to do but that
you are not able to right now? Why is that?

8) On a scale of 1-10, 1(low personal control) and 10(highest control), how much control do you have over leisure/recreational activities or opportunities for personal development?

9) Would you like to change that?

10) How would you change it? What would you do?

MENTAL HEALTH SERVICES

1) How long have you been attending the mental health team?

2) Why do you go there?

3) Tell me about a typical appointment at the mental health team?

4) Do you attend the team for any other reasons?

5) Do you find attending the team helpful?

6) In what way?

7) If not, why?

8) What other types of services do you think they could provide?

9) Have you ever been asked by anyone for your opinion about mental health services?

10) If given the chance, what would you say about current mental health services?

11) Why do you say that?

12) Who do you think controls mental health services?

13) Who do you believe should have control of these services?

14) Are there any changes to the system that you would like to see? Can you describe them?
Appendix E. "Conceptions" Validation Procedure Used
In a Study of Schizophrenic Learning and Empowerment

Thank you for agreeing to help us with validating judgments derived from interview transcripts. C1, C2, C3, C4, C5 represent conceptions of learning. You are asked to review the conceptions, C1, C2, C3, C4, C5, as described below. Then read each of the following quotes and circle which conception or conceptions you believe the quote describes.

Operational Definitions

Mark C1 when the statement reflects the kind of learning that is just "facts", "information" and not a process.
   i.e. "Getting to know all sorts of things."
   "I've learned a lot of things at the team."
   "I know my medication name."

Mark C2 when the statement reflects the kind of learning which involves "reproducing facts", "memorization" or is associated with "school" or "education".
   i.e. "Learning goes into the memory bank."
   "I used to learn but I can't remember anymore."
   "I could take the course and pass it."

Mark C3 when the statement reflects the kind of learning where the information gained is actually used by the person.
   i.e. "I watch people then I know what to do when I'm in that situation."
   "I know all the resources and will use them if I have to."

Mark C4 when the statement reflects that the person thinks abstractly, relating several ideas together but does not relate learning as a personal experience.
   i.e. "Learning is to grow, learning is to love, learning is to live."
   "People learn by talking, by watching, by listening, by experiencing, by doing."

Mark C5 when the statement reflects the kinds of learning that helps the individual to better understand their world. Ideas are related to one's own experience.
   i.e. "I used to think that way but I learned from the other people that it wasn't really true so now I think that..."
   "When I learn, I develop as a person and cope better."
Excerpts

Excerpt 1:

"Even reading the paper, you learn things. I mean sometimes you forget it, but when you're flipping through the paper most people stop at the articles that interest them the most. Different articles interest other people in different ways."

C1  C2  C3  C4  C5

Excerpt 2:

"I think kids pick up things a little bit quicker than adults. They learn a little bit quicker."

C1  C2  C3  C4  C5

Excerpt 3:

"Everybody I know has a computer, I don't even know how to work one. You get into a certain program, but I don't know how to program a computer, so that's what I want to learn how to do."

C1  C2  C3  C4  C5

Excerpt 4:

"Mental patients coming out of Riverview, saying that they sleep on the street and everything else, but I cared enough to get myself out of Riverview. I went to the lawyer's office many times and made friends with them. They learned to trust me and I learned to trust them. so they let me out."

C1  C2  C3  C4  C5

Excerpt 5:

"I myself was thinking that if I did ever go back to Riverview I'd be at least ten times better off you know because I've been through a lot of things and like living situations and I can sort of look at one and say well that incident might be better that this incident."

C1  C2  C3  C4  C5

Excerpt 6:

To learn it's been such a judgment on me that in the past well to learn I've always thought that I needed a
change in my life before I can start learning or something."

Excerpt 7:

"I think you can only learn from memory. If you memorize something, but I think parents are the best for that. Mother's are a very big contribution to what the child can learn especially later on in life after adolescence cause my mom, I used to go up and see her and she'd talk to me and tell me a few things."

Excerpt 8:

"My mother sent me a letter in the hospital, she said life is more than just doom and gloom, there's flowers and everything else. What she said there I really remember that and I can look back on it, It's like a reflection. I like reflecting back on what my mother used to tell me."

Excerpt 9:

"Once you get a bus pass, you can get on any bus, skytrain, or anything you know, take rides around and go places. That would open up my life a little bit more."

Excerpt 10:

"Well not as much as I'd like because like if I were to budget my money, like my mom taught me to, I'd be way better off you know if I could handle my own money."

Excerpt 11:

"Getting to know the area, know some people, getting to know where stores are, getting to know where this and that is."
"I learn different things. Like I said this isn't the best part of the city. Learn to watch what you say and do on the street in this area."

Excerpt 13:

"Memorize, that's right. If you play sports, memorize the play, keep memorizing the play until it's down pat."

Excerpt 14:

"I remember everything that I have to get done, or everything throughout the day, except when I read I can't retain it. But everything else exterior like outside of that I can remember."

Excerpt 15:

"Formal education all it does is propagates a certain belief, certain cultures...All I'd be doing is learning what somebody else had thought, what the instructor thought or the author thought."

Excerpt 16:

"Well I think I learned the hard way but you just learn by watching everybody and everything and by talking to the other people about what happened to them so you know what to do and who you should stay away from" (discussing how she learned to become street smart).

Excerpt 17:

"Like people if they had a choice of where they could it would be much better. The whole thing is housing and money is pretty scarce these days and it takes money to supply the housing, it's pretty difficult. It took Lookout ten years to get the Deputy Ross Residence going...and they were really trying. The Bennett government wasn't good at all but the NDP's were all ears."
Excerpt 18:

"Well not as much as I'd like because if I were to budget my money, like my mom taught me to, I'd be way better off if I could handle my own money."

Excerpt 19:

"I had a real hard time getting a welfare cheque. They won't give you a cheque til you have an address and you can't get an address til you have a downpayment. Doesn't make much sense and just stressed me out. They don't understand how difficult they make it on people like me. I don't want to go back to hospital."

Excerpt 20:

"It's a give and take thing with my family and with other people I guess. They're only going to take so much of my shit. I've learned that some of the things that I've done have really pissed people off and then they don't want to spend time with me. It's a respect thing. If I respect them and show that I care and everything then they respect me."
Appendix F. "Empowerment" Validation Procedure
Used in a Study of Schizophrenic Learning and Empowerment

Thank you for agreeing to help us with validating judgments derived from interview transcripts. E1, E2, E3, E4, E5 represent elements associated with empowerment. You are asked to review E1, E2, E3, E4, E5 as defined below. Some of the elements can be viewed as continuums. We are concerned with any statement that reflects the element no matter where it might be on the continuum. Then read the quotes below and decide which element or elements the quote describes and circle your response.

Operational Definitions

Mark E1 when the statement reflects helplessness, low self esteem, lack of confidence, control by others, or feeling in control, decisive about one's life, feeling good about oneself.

i.e. "I've decided that I'm going to move next month."
"They control all my money."

Mark E2 when the statement reflects ability or inability to access resources, increase knowledge or develop skills.

i.e. "I don't know how to find a girlfriend."
"I'm going to welfare to get some money."

Mark E3 when the statement reflects ability or inability to work with systems in society so that needs are identified and responded to.

i.e. "Welfare keeps giving me the run around so I'll have to just keep bugging them."
"They'll show me around til I find a place I like."
"They don't listen to me."

Mark E4 when the statement reflects feeling marginalized, isolated and segregated and contains some insight concerning why this is.

i.e. "People don't give you a chance when they find out you're schizophrenic."
"I would rather be with normal people than go to the drop-in."

Mark E5 when the statement reflects working on their own or with others experiencing mental health problems to improve their quality of life.

i.e. "I volunteer at the MPA to help other people find out about services and get adjusted to being out of hospital."
"I try to make this place better for everyone."
**Excerpts**

**Excerpt 1:**

"This one lady is trying to find a home for me. I don’t know if it’s a boarding home, MPA house, an apartment or Coast apartment or Kettle housing...she’s gonna call Thursday for me to look at the place."

**Excerpt 2:**

"I don’t like being on psychiatric drugs, but I got no choice if I want to stay here I have to stay on psychiatric medication."

**Excerpt 3:**

"I get $79 and that’s it for the month...administered through St. James, Monday, Wednesday and Friday you get money...I don’t see my cheque...you get $200 for that (clothes)...you have to give them receipts."

**Excerpt 4:**

"I wanna get a wife so ah sexual, the joy of sex, not for the sex but the companionship and love and romance and a partner. Cause I think...humans were meant...are social animals."

**Excerpt 5:**

"Maybe they (friends) think that I don’t want to talk about it or something, they might think that, but I don’t know. I don’t really know, I’m willing to talk about it. At first I felt awkward, but you sorta adjust, they don’t ask, they’re busy people so they don’t really pry into my personal life. I could easily isolate myself from my friends. Like I’m living here now and they won’t want anything to with me anymore so I better not call them because I’m not up to par to hang around them, they’re higher up than I am. I’m down here and they’re up here now, so its not equal. I don’t think that way and I don’t think they do either."
Excerpt 6:

"It's hardly worth it in the end. If you make more than $100 a month then they (welfare) start taking money off your cheque. For one thing, most people aren't making enough to live on, they'd make more on welfare. Secondly, most people can't handle the stress of working full-time and there aren't too many part-time jobs that you could live on so it's better to just stay on welfare. If you're lucky and know someone you might be able to get some money under the table."

Excerpt 7:

"We need more organizations like the Mental Patients Association that can point people in the right direction so they can get on their feet. We need people who can help people get listened to by the government. We need to teach people not to be scared to say what is bothering them and stand up for their rights. They need to be given a chance to get out of the welfare system or a way to work and not have money taken away for doing that."

Excerpt 8:

"Full-time (work) I'd have to pay $750 a month to live here. I can't afford that. I'm taking a computer course starting next week for six months as the Vocational Institute and I'll get a job placement. So I figure 6-8 months and I'll be out of here."

Excerpt 9:

"I go there and end up listening to everything they have to say but I never get to talk. Same thing every time, pretty stupid. I go cause if I don't take the medication I might go back to Riverview and I don't want to do that. That's what they told me anyway."

Excerpt 10:

"This drop-in is for the people. Anyone who uses the place can make suggestions for improving it, making new programs. It's always changing, that's the way we want
Excerpt 11:

"People look at you differently once you’ve been in a mental hospital. Like I had my own business ya know doing hair and I was making money and then this happened. I could probably still cut hair and everything but who’s going let me do that now. What do I tell them when they ask why I haven’t worked for the last five years or why I still live with my parents. People find out even when you try to hide it."

Excerpt 12:

"They got no choice in housing. Housing is the biggest problem, it’s hard to keep them in a place. Most of them live in one room. They’d have much better control if they had decent housing. The whole thing is housing and money is pretty scarce these days and it takes money to supply the housing...the Bennett government wasn’t good at all but the NDP are all ears."

Excerpt 13:

"The financial standard of living down here leads people to picking fights, drinking and smoking drugs. That’s all they (Aboriginal Peoples) care about, it’s not a life. They need schooling and jobs so they can have the money to get out of here. Gotta change the system, give people a break, let them prove they are worth something. Need connections with people in government so things can change."

Excerpt 14:

"Tried to go back later but couldn’t learn...just didn’t seem to make sense. Kinda seemed pointless cause I was already out on my own and it seemed like I’d have to go to school forever if I wanted to do something and I didn’t know what I was gonna do anyways."
Excerpt 15:

"I met this guy in hospital and he became very dependent on the hospital and I think they sent him to Riverview because of that, I don't really think he belonged there, he was just being lazy, he just gave up on life, just sort of let it go, let it slide...He just didn't have the confidence and stamina to do it."

Excerpt 16:

"I don't even think I'd be able to get married. I don't think I'm confident enough. I don't think I can handle it really...just don't trust."

Excerpt 17:

"Sometimes I feel all alone, I feel something is wrong with me but if I was with a bunch of people that have the same thing I'd be able to accept myself more and accept other people. I accept them, but the thing is I'm really hard on myself and I don't accept myself so much because my family hasn't always accepted me."

Excerpt 18:

"I'm trying to make a better situation for all of us, so it's nice to stay here and if you were in trouble, I'd even offer my hand. I'd let you share the simple things I have because it just adds to more."

Excerpt 19:

"It makes me really sad because I really like learning. I would like to go back to school but I can't do it right now. I'm wondering when, who will be able to help me or what's going on. I feel like maybe some people think I'm stupid or something."

Excerpt 20:

I went to City Hall with everybody from Lookout to fight for the Drop-in cause of the zoning. We won. We even got all the other people in the place to clap and
stand up for us cause it was really important that we have a place to go. They were really nice, they let all of us go up and speak, that's what did it."
Schizophrenic personality means Canucks are going Nowhere fast

HOCKEY

NOTES & QUOTES

- Canucks defenceman Robert Dolt is the top regular as he sub-
  fused bruised ribs in the second period Saturday when
  crashed into the boards by New Jersey winger Joe Day.

- Right winger Jim Sandtak is feeling fine after an automatic suspen-
  sion for 10 games after being hit by Sergei Gonchar.

- Left winger Gennady Nemov has no goals in 11 games and
  only two assists going into the final game of the season.

- "Our defencemen right now are in the twilight zone and our
  forwards don't score. That doesn't help any," — Canuck
  boss Pat Quinn.

- "We needed to have a better game and have a bounce-back game
  against the Penguins," — Canuck coach Alain Vigneault.

- "Our defence is still better than the Penguins' defence," —
  Canuck centre Mats Sundin.

- "I don't know what the score is, but I know we're winning," —
  Canuck goalie Darcy Tucker.

- "Our defence is still better than the Penguins' defence," —
  Canuck forward Trevor Linden.

- "Our defence is still better than the Penguins' defence," —
  Canuck forward Trevor Linden.

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