

RECOVERING FROM RECOVERY:
THE TEMPORAL MANAGEMENT OF DISORDER IDENTITY CAREERS

by

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ABSTRACT OF THE DISSERTATION

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Disorder Identity Careers

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This study examines the temporal dimension of subjective identification and disidentification. It is based on a qualitative analysis of the narratives of forty people who formerly identified with emotional disorder labels (i.e., anorexic, agoraphobic, bipolar, etc.) and no longer use the labels as a source of identity. I refer to this group as *de-labelers*. Using a grounded theory approach, my analysis of these narratives highlights three ideal-typical sub-narratives, each reflecting a different orientation toward autobiographical time, and consequently, a different attitude toward one's disorder identity: the *recovery narrative* (characterized by the optimistic *expecting orientation* that anticipates positive change), the *disability narrative* (characterized by the *accepting orientation* that assumes the status quo), and the *disidentification narrative* (characterized by ambivalence toward the disorder identity). Taken together, these three sub-narratives depict a chronology of the changing meanings of the disorder label over the course of the identity careers of eighty percent of these de-labelers. My simultaneous analysis of the existential, interactional, and cultural influences on

these temporal orientations (and their respective sub-narratives) suggests that individuals can exercise a significant amount of agency in *temporally managing* their disorder identities and may thus have considerable say in the meaning and duration of these identities.

Preface

My conscious interest in the themes that structure this study began several years ago in a therapist's office. I started seeing the therapist during my first year of graduate school because I was miserable: I was homesick, had few friends, worked incessantly, and obsessively questioned whether a future life as a sociologist would fulfill me. Seeing a therapist was not a new experience for me; I had depended on psychological treatment extensively during the preceding five or so years to help me overcome a debilitating anxiety disorder, agoraphobia, that had kept me largely bound to my home for a couple of years. What was new about this experience in the therapist's office, however, was that I was not there to seek help with my anxiety disorder. I had not had a panic attack in at least two years. And, even though I was currently 3,000 miles outside of my former "comfort zone," the help I needed in coping with this life transition had nothing to do with managing panic attacks. Given this context, both the therapist and I found it very curious when I told him one day that I wished I were still having panic attacks. After the years of effort to become free of the extreme limitations that such anxiety had placed on my life, it was unfathomable to hear myself wish for those shackles to return!

As I continued to tell the therapist about this wish, it became clear that what I actually desired was to have a condition that I *understood*. I knew agoraphobia inside and out. I knew its symptoms like my own name; I had an interpretation of its causes that made sense to me; and, I had honed a variety of cognitive-behavioral strategies that I trusted could recondition my emotional responses to stressful stimuli. Even though recovery had been a tremendously

difficult process, I also had the comfort of knowing that there were countless phobia support groups and treatment programs that I could call upon to help me through the psychological and social challenges that accompanied this condition. Affiliating with such a group during my recovery had been a profoundly helpful coping strategy. Even more important than providing me with social support and understanding, my affiliation with the recovery group also gave me a strong sense of identity as *an agoraphobic*. When I attended the group, I attended as an agoraphobic; when I called my friends from the group, I called them as one agoraphobic to another. When so much of my social identity had been stripped away by the limitations of the condition, my agoraphobic identity actually became a lifeline.

I gradually came to realize that telling the therapist that I wished I were having panic attacks again was not out of a masochistic tendency; rather, I was responding to my disorientation regarding my current state of misery. It was unlike anything I had known: I did not know how to define it; I did not know what had caused it nor could I relate it to any other experience; and I had no clue how to improve my situation or what to expect from it. I eventually understood that I was craving the *comprehension* of my former disorder, not the pathology itself.

For weeks afterward, I could not stop thinking about how close I had come to actively perpetuating a disorder that I had already overcome. What if I had in fact acted on my desire for a familiar way to comprehend my difficulties and searched the local newspaper for a phobia support group? Would I have begun to interpret my current difficulty as a remnant of “agoraphobia”? What if I had made new friends in the

group and began to spend time with people whose lives were focused around recovering from their phobias? Would I have been tempted to refocus my life on issues of anxiety, just when I had finally become well enough to direct my attention elsewhere? Fortunately, I was in a therapeutic situation that encouraged me to reflect on my attachment to my identification as “an agoraphobic.” But, what if I hadn’t been?

The question both haunted and intrigued me. On one level, this awareness of the fragility of my identity was extremely unnerving: I was confronted with the fact that, in a moment of crisis, I had been tempted to forfeit the new emotional freedom I had worked so hard to gain in exchange for a sense of familiarity and direction. On another level, though, I was fascinated. The more I thought about the impulse that had been pulling me to reinstate an outdated identity, the more curious I became about the process of exiting disorder identities. I wondered how other people decide when to discard their disorder identities and what factors might be involved in this decision. What role might social influences and a sense of personal identity play in one’s sense of wellness or illness beyond the influence of symptoms? And why, in all my reading about coping with agoraphobia and recovery in general, had I not seen anything about the process (or even the possibility) of letting go of identification with the disorder label, or alternatively, about a reluctance to letting it go? My pursuit of these, and related, questions through interviewing people who formerly identified with emotional disorder labels has led me to this analysis of the *temporal management of disorder identity careers*.

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* * *

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Chapter 1

Introduction: Temporally Managing Disorder Identity Careers

Change is central to the experience of self in modern times. Our lives are a series of active engagements with some identities and disengagements from others. We are busy becoming parents, board members, and vegetarians or ceasing to be students, pet owners, and state residents. The fluctuation of our identities is such a common feature of our lives that we often take it for granted. Yet, the very notion of identity change is analytically intriguing: we spend a portion of our lives knowing ourselves to be an “x,” relating to others as an “x,” making decisions based on the belief that we are an “x”; and then at some other point in our lives, we stop thinking of this very same self as an “x”!

How do we make the social psychological transition from *being* a particular someone to *not* being that particular someone? And, importantly, how do we decide *when* to make that transition? This pair of questions underlies my inquiry into the *temporal management* of personal identity. I pursue this inquiry through examining the autobiographical narratives of people who formerly identified with emotional disorder labels (i.e., “anorexic,” “agoraphobic,” “bipolar,” etc.) and no longer use these labels as a source of identity. In other words, these people have *disidentified*¹ from their emotional disorder labels. I refer to these individuals as *de-labelers*. This case offers a

¹ ¹ My use of the concept of “disidentification” is distinct from the traditional role theory approach to processes of “role change” (see Turner 1990 for a review of role change literature) in that disidentification places emphasis on the subjective sense of identity over the social attributions that define a “role incumbent.” This is not to say that processes of acquiring and discarding personal identities are free from structural constraint; rather, it is an analytic emphasis that highlights the individual’s self-definition, whether or not it corresponds to social definitions.

particularly rich site for an analysis of the temporal management of identity because the exit from emotional disorder labels is a culturally unrecognized identity passage and thus does not have a “socially expected duration” (Merton 1982). That is, there is no standard point at which the disorder identity is presumed to be “over.” Unlike the “adolescent” or “fiancé” identities, for instance, that are expected to “expire” on one’s eighteenth birthday or on the announced wedding date, respectively, the disorder identity is a *temporally ambiguous* identity that does not have a “publicly articulated” (Glaser and Strauss 1971) end point. The fact that there is not a cultural template for exiting this identity requires individuals to make subjective determinations about the duration of their disorder identities. Consequently, de-labelers’ narratives prompt questions about how, for instance, individuals decide when to discard their disorder identities when there is no “institutionally scheduled” (Ebaugh 1988) termination point; what social psychological factors encourage and/or discourage this decision; how individuals’ expectations about the duration of the identity career change over time; and what narrative strategies are used to accommodate changing self-understandings over time.

This concern with the temporal management of subjective identity also, inherently, implies a concern with the degree to which individuals may or may not determine their own identities. In other words, inquiring into the social psychological factors that influence individuals’ temporal management of their disorder identities is also an inquiry in the to roles of agency and structure throughout the course of the identity. According to Emirbayer and Mische (1998), this is a natural pairing, as they theorize that temporality and human agency are intrinsically linked. Agency, they

argue, can only be fully understood when it is “situated within the flow of time” (963). They suggest that the human capacity for deliberation and reflective choice results from a “continual reconstruction of [one’s] orientation toward the past and future in response to emergent events” (970). That is, our decisions and actions simultaneously reflect our past experience, imagined futures, and evaluations of the present. It is precisely through this ongoing temporal negotiation that we gain the capacity to distance ourselves, at least partially, from the “schemas, habits, and traditions that constrain our social identities and institutions” (984). Thus, from this perspective, exploring how de-labelers temporally manage their disorder identities inevitably highlights the ways in which individual agency is both enabled and constrained throughout identification and disidentification processes.

I draw inspiration for this analysis from theories of narrative construction of identity (Bruner 1990; Polkinghorne 1988; Somers 1994) as they tend to be particularly sensitive to both structure and agency in processes of identification. This perspective views identity as the product of the autobiographical stories individuals tell about themselves (McAdams 1993; Sarbin 1986; Schafer 1981). It views identity as a “narrative accomplishment” (Irvine 1999) that takes place through the process of organizing autobiographical experience within culturally meaningful storylines that guide “expectations, projections, and memories” (Somers 1994:614). On the one hand, this perspective places emphasis on subjective self-understanding and recognizes that self-meaning can change as contexts, intentions, and interpretations evolve over time (Frank 1995; Maines 1993). On the other hand, it stresses the importance of cultural discourse and institutional practices in the process of creating

and recreating autobiographical narratives (Somers 1994; Gubruim and Holstein 2001; Irvine 1999). That is, individuals' understandings of their experiences are filtered through broad, cultural meanings and are often shaped by the interpretive conventions and narrative expectations of particular institutions (Loseke 2001; Rosenwald and Ochberg 1992; Zussman 1996). Narrative construction of identity theories thus offer a useful perspective for this analysis in suggesting that any analysis of individual identity must consider both subjective interpretations and the social and cultural contexts within which autobiographical narratives are constructed.

Such an approach to the study of identity also highlights a conceptualization of identity that prioritizes its durational nature rather than treating it as a static entity. While it is common in much sociological research to treat identity as a fixed status or variable, my effort to explore the temporal management of identity requires that identity be understood as a dynamic process over time. This approach to identity is facilitated by the notion of an identity "career." Drawing an analogy with an occupational career that indicates the duration of employment, the notion of an identity career is used as a sensitizing concept to draw analytic attention to the implicit element of temporality in identification. It was first introduced as an analytic concept by Everett Hughes (1958), and was brought into common use in the clinical context through Evring Goffman's (1961a) "The Moral Career of the Mental Patient" and Julius Roth's (1963) study of hospital treatment, *Timetables*. More recently, the life course

perspective has drawn on the career concept of identity in its commitment to temporalize our understanding of social phenomena (Elder 1994; George 1999).²

My use of the career concept of identity largely follows David Karp's (1996) usage in his analysis of the "depression career" because he emphasizes subjective identification as opposed to an objective symptom course or length of treatment. My analysis of disorder careers also parallels Karp's in its emphasis on the dynamic aspect of these personal meanings of disorder and recovery throughout the career. I depart, however, from his exclusive interest in individuals who currently identify with their disorder labels. This aspect of Karp's work reflects a general bias in sociological inquiry to focus on identity acquisition and negotiation (Ebaugh 1988; Killian and Johnson 2006; McCall 2001) while overlooking the exit. Thus, one of the additional values of examining de-labelers' narratives is that it serves as a corrective to this bias.

This tendency to underemphasize the exit from identity careers is particularly notable in studies of labeling and identity in the sociology of mental health. Over 25 years ago, Walter Gove (1980:22) acknowledged this oversight in the labeling literature, stating that "[w]e simply do not know much about . . . the shift in labels from deviant to normal." Despite his recommendation for further investigation, there remains a relative dearth of research on disidentification from emotional disorder labels.

² While the life course perspective's emphasis on such temporally-oriented concepts as "careers," "trajectories," and "transitions" make it a useful sensitizing perspective, I have found the body of life course literature, for the most part, to be of limited use for my analysis because its focus on time tends to emphasize age-graded and cohort analyses (Mortimer and Shanahan 2006).

An important exception to this tendency is John Lofland (1969) who devotes part of his work, *Deviance and Identity*, to the process of assuming a “normal identity” after having been labeled “deviant.” While he introduces some important sensitizing issues to this area of inquiry (most notably the role of others in encouraging deviant or normal identities) he does not research this phenomenon empirically. One of the few who does empirically study disorder disidentification is David Brown (1991). However, his exclusive interest in former alcoholics who exit their disorder identities by way of the “professional ex-” phenomenon (i.e., becoming a professional in the addiction recovery field) limits his contribution to our understanding of disorder disidentification processes more generally.

One factor that may contribute to the relative lack of research on disorder identity exits has to do with the influence of the labeling perspective (Scheff 1966, 1974) on studies of labeling and identity in the mental health context. The primary focus of the labeling perspective emphasizes stigmatizing reactions to deviant labels.³ This interest directs attention to populations who suffer from stigmatizing reactions, and thus its analytic focus tends to exclude the exit from the identification. In addition, the labeling perspective’s dominant interest in stigma also directs analytic focus by placing emphasis on the perspectives and definitions of others toward the labeled individual.⁴ This may also discourage inquiry into the exiting process because

³ Even Bruce Link’s (1989) “modified labeling theory” maintains a focus on external perceptions by emphasizing the affects of anticipated stigmatizing reactions.

⁴ An important exception is Peggy Thoits’ (1985) “self-labeling” theory which recognizes the role that individual interpretation can play in the process of acquiring emotional disorder labels. Her work does not, however, consider the exit from the disorder identity.

disidentification is likely to be the result of subjective reinterpretation of one's experience rather than an official de-labeling process.

Sue Estroff (1981:256) concludes her ethnography of psychiatric patients by offering an additional clue as to the source of this analytic bias. She notes that while we socially acknowledge entry into disorderhood (i.e., through the formalities of diagnosis, hospitalization, etc.) the exit is culturally unacknowledged. Estroff elaborates:

[T]hough there are many rituals and symbols of *entry* into psychiatric patienthood and the treatment system, there are few powerful correlates surrounding *exit* . . . other than discharge from hospital . . . there is not the experience of 'status passage to health'.

Put in other terms, those who have discarded these identities are a "socially unmarked" (Brekhus 1998) population. Wayne Brekhus' (1998) work on "social markedness" draws on the concept of markedness that was first introduced in linguistics as a way to describe how one item in a phoneme pair is always highlighted with a mark while the other is defined through its absence of the mark (Trubetzkoy 1975). Brekhus extrapolates this concept to analyze social contrasts, pointing out that there is a disproportionate amount of sociological attention paid to culturally labeled, or socially marked, social phenomena. Consequently, "the least visible features of social reality" receive less analytic attention, which tend to reinforce common cultural images and categories. This practice is a likely cause for the minimal attention paid to the unmarked population of de-labelers (evidenced, in part, by the fact that there is not even a culturally recognized name for this group; I have had to invent "de-labelers" for the purposes of this analysis). This has consequences not only for sociological

research but also for popular discourse. Over half of the participants in this study express having felt frustrated that the self-help and recovery literature offers an abundance of guidance for acquiring and maintaining the disorder identity but little to help them negotiate their way out of it. Thus, this study may, ideally, be of interest not only to identity theorists but also to the lay reader who may share some of the experiences de-labelers describe. It is also my hope that this study may prompt other scholars to pursue research that will increase our understanding about this populations' experiences and the social psychological contexts in which they take place.

De-labelers

De-labelers, as I define them here, constitute a population of individuals who share a particular way of relating to emotional difficulties: they adopt psychological interpretations of their troubles, identify with the corresponding disorder label, and subsequently discard it. This population can be distinguished from two other ideal-typical categories, *non-labelers* and *labelers*. Non-labelers would be individuals who feel emotionally troubled in some way but do not utilize conventional disorder labels to interpret their experiences. They may instead, for example, consider their struggles to be variants of the “normal” range of human emotion and may seek social support from family, friends, and/or religious figures thus bypassing therapeutic interpretations and terminology entirely. Labelers, on the other hand, would make use of diagnostic labels to comprehend their emotional problems. These individuals understand their emotional behavior in terms of socially recognized “symptoms” which tend to guide

their efforts to understand the conditions' causes and to direct their treatment endeavors.

Labelers serve as the subjects for most mental health research, whereas non-labelers and de-labelers tend to receive much less attention. This is most likely the case because labelers are a socially marked population while the other two groups are socially unmarked. This research bias is understandable as it is natural to study subjects that are socially visible; however, it can be sociologically valuable to focus analysis on populations that are yet unnamed and thus analytically less visible. The narratives of this unmarked population of de-labelers is the focus of this analysis. The only criterion for being considered a de-labeler is to have formerly identified oneself with an emotional disorder label and, subsequently, to have discarded it. I do not distinguish between those who were professionally labeled or "self-labeled" (Thoits 1985), nor do I consider the presence or absence of "symptoms" in my inclusion criterion. This means that being a de-labeler is not necessarily synonymous with being "cured" (although in some cases it may be); it simply implies that one has chosen to no longer use the disorder label as a source of identity, for any reason. The scope of this work is limited to issues of self-identification; it does not address objective clinical outcomes.

One of the distinctive features of this analysis is that the sample is comprised of individuals who formerly identified with a wide range of disorder labels. I analytically lump together labels as diverse as "codependent," "bulimic," "bipolar," and "schizophrenic," and I intentionally "disattend" (Zerubavel 1997) the often significant symptomatic differences between these different labels. Looking at these disparate

identities with a focus on their analytic similarities is helpful in my effort to formally highlight generic temporal patterns in the narratives. Certainly, the emotional disorder experience is influenced by the type and severity of symptoms, but I intentionally overlook this diversity in my efforts to explore the impact of personal identity in the experience of “being disordered.”

This methodological decision is inspired by Zerubavel's (2007) “social pattern analysis” which is informed by the Simmelian tradition of formal sociology. This methodology aims to discover abstract, structural patterns that underlie social phenomena. It is therefore “theme-driven” and attends to similarities between subgroups rather than reporting on the idiosyncrasies of individuals’ unique experiences (Zerubavel 2003, 2007). What is sacrificed in thick description by this approach is gained in analytically rich insight into the narrative patterns of de-labelers’ descriptions of the disorder identity career.

This is not to say that the following analysis is so abstract that it overlooks the lives and experiences of de-labelers in favor of a strictly formal temporal analysis. In fact, focused excerpts from de-labelers’ narratives form the bulk of most chapters. It is not an ethnography of de-labelers lives, to be certain, but within the parameters of my thematic interests, it very thoroughly introduces the phenomenology of this underresearched population and sheds light on some of its defining characteristics.

The unmarked nature of this population makes recruitment difficult because individuals who have disidentified from their labels generally cannot be found attending support group meetings or treatment centers. Therefore, to locate the forty de-labelers I interviewed, I depended on snowball sampling and advertising with

flyers, including voluntary postings by two informants to online networks of therapists and social workers of which they are members. As a result, my informants came from ten different states, and most were interviewed in tape-recorded phone sessions (only four local respondents were interviewed in-person).

I interviewed thirty-one women and nine men, ranging in age from twenty to sixty-nine. More than a third are over 50, and half are in social service, mental health, or other health-related professions. The gender skew may be attributed to the increasing feminization of psychotherapy and other care-giving professions (Philipson 1995) as well as to the socialized gender differences in the level of comfort with speaking about emotional problems (Rosenfield 1999). The occupational concentration may be due in part to the recruitment from the two online postings that target professionals in these fields, as well as to the “professional-ex phenomenon” (Brown 1991), which acknowledges that former sufferers are often attracted to helping professions. One consequence of this is that I may have inadvertently selected especially mature and self-reflective informants, both because these qualities can be expected to increase with age and because social service and mental health professions encourage sophistication in psychological matters.

There is a wide range of disorder labels represented in this group of de-labelers, ranging from “codependent”⁵ to “schizophrenic.” The distribution, however, leans heavily toward the conditions that would be classified in the *DSM-IV* (1994) as

⁵ While “codependent” is not listed in the *DSM* as a clinically diagnosable condition, I include it in the sample because those who identify with the label tend to consider themselves to suffer from an “addiction” to “dysfunctional” behavior and relationships (Irvine 1999), thus qualifying the “codependent” identity as a recovery identity.

anxiety, eating, substance, and mood disorders.⁶ There are only eight cases of identification with psychotic or dissociative disorders. Nearly one quarter identified/disidentified with more than one label. A majority identified with their labels for less than ten years, while eleven de-labelers report having identified with the labels for more than ten years.

There is considerable variation in the amount of time it takes for de-labelers to complete the disidentification process. The estimates range anywhere from immediately to several years. For instance, there are three individuals whose descriptions of their disidentification process resemble something closer to a dramatic “turning point” (Pillemer 1998; Ebaugh 1988) that was actualized almost immediately; the majority, however, describe disidentifying from the labels as a gradual process. For over three-quarters of this group, disidentification took place within the last decade (with nearly half of those occurring within the last five years). For five individuals, however, this process was much more distant, having occurred well over ten years ago.

Interviews and Analysis

I approached the one-and-a-half- to-two-hour interviews with de-labelers with a directed openness. I did not go into the interviews with a particular theory to confirm or disconfirm; rather, I began each interview with a broad, orienting question that implicitly set the parameters of my interest: “How has your relationship with the

⁶ In addition, there are six individuals who formerly identified as “codependent,” two as “overeaters,” and one as a “sex and love addict.”

disorder label changed over time?” This approach allows the narratives to reflect the experiences that are most salient to the individual narrators while keeping the content of their stories relevant to my thematic interests. Following Susan Chase’s (1995b) recommendation, my contributions to the interviews were primarily limited to questions for clarification or requests for elaboration.

I analyzed the resulting, transcribed narratives in the spirit of “grounded theory” (Glaser and Strauss 1967) by initially highlighting recurring themes around which to organize further analysis. One of the dominant themes that emerged involves three discrepant portrayals of the disorder identity: it is described at different times as “useful,” “limiting,” and “irrelevant.” By systematically pursuing these incongruent characterizations, I discovered that most de-labelers’ accounts include three distinct narrative forms, each reflecting a different orientation toward autobiographical time, and consequently, a different attitude toward the disorder identity. For over 80 percent of de-labelers, these three, ideal-typical sub-narratives depict a chronology of the way in which the subjective meaning of the disorder identity changed over the course of the identity career. For instance, the early part of the disorder identity is characterized by what I call the *recovery narrative*. This narrative form communicates a hopeful expectation that the disorder identity is a temporary identity that is understood to be a means to an end (recovery). In contrast, the later part of the disorder identity career is characterized by the *disability narrative*, which expresses a resignation to the status quo, as it treats the disorder label as a permanent, essentialized aspect of one’s identity. The *disidentification narrative* describes the termination of the disorder identity career, typically presenting the disorder label as irrelevant to one’s current

sense of identity. It is typically constructed in reaction to the sense of personal limitation de-labelers describe in the disability narrative.

My analysis is structured around the ways in which the changes in the subjective meaning of the disorder identity are narratively constructed over the course of the career. Because over 80 percent of de-labelers' narratives follow this three-part pattern, I have organized the chapters of this analysis around the themes associated with these three sub-narratives. In the final chapter, however, I do consider the eight individuals whose narratives deviate from this pattern.

The remaining eight narratives are divided amongst four alternative temporal variations, with just a few individuals representing each pattern. For instance, there are two de-labelers who initially assume their labels to be permanent and maintain an accepting orientation throughout the course of the disorder identity career, until they eventually choose to discard the disorder identity. Contrary to the dominant pattern, this subset of de-labelers never comes to view the disorder identity career from an expecting orientation. There are also three de-labelers who deviate from the common pattern by employing an expecting orientation initially and maintaining that orientation until choosing to exit the identity altogether. Two other de-labelers describe taking on an accepting orientation in the short-term and developing a subsequent expecting orientation in the long-term before eventually exiting the identity career. Finally, one individual's narrative describes alternating between expecting and accepting orientations many times before exiting.

In the final chapter, I speculate about some possible reasons why these four alternative patterns are so rare relative to the majority. For the moment, I simply wish

to bring attention to the fact that the following analysis is based on the majority of de-labelers' narratives, noting that there are some exceptions. I have chosen to focus this analysis on the dominant temporal pattern for two reasons. On a practical level, this pattern offers significantly more material to work with than with any of the other four temporal patterns, simply because it is reflected in so many of the narratives.

Additionally, from the standpoint of my theoretical interest, this dominant pattern tells a more elaborate temporal story that highlights a dynamic that has not been the topic of sociological analysis up to now. In a couple of instances in the following chapters, I draw on excerpts from a couple of narratives that deviate from the majority in my illustrations of the various aspects of the expecting and accepting orientations. Even though these few narratives do not share the entire temporal pattern with the majority, they do represent the formal features of the expecting and/or accepting orientation particularly well. The few times I use excerpts from these few individuals, I indicate it in a footnote.⁷

Chapter Overview

The following chapters are arranged as a chronology of the disorder identity career, from entry to exit. This chronology is organized around three ideal-typical sub-narratives that reflect themes common to the majority⁸ of de-labelers' accounts about

⁷ Excerpts from the narratives of two of these individuals also appear in Howard 2006. This article is based on an initial analysis of 29 de-labelers and does not recognize narrative deviants. Further analysis, within the context of the full sample, prompted me to reclassify these two narratives as deviant from the majority of the sample. While the temporal pattern in both of these narratives is not clear-cut, it seems that they are better classified as atypical.

⁸ Eight (out of the forty) that do not fully map onto the pattern reflected in the other narratives will be addressed specifically in Chapter Six.

the changing meanings of their disorder identities over time. These sub-narratives include the *recovery narrative* (discussed in Chapter Two), the *disability narrative* (in Chapter Three), and the *disidentification narrative* (the focus of both Chapters Four and Five). Each of these sub-narratives highlight de-labelers' attitudes toward the disorder identity, their corresponding expectations for the future, and the social psychological factors that influence their strategies for temporally managing the disorder identity career.

Chapter Two, "Expecting Recovery: The Delimiting Benefits of Short-Term Disorder Identification," highlights the early part of disorder identity career, which is characterized by the perceived benefits of identifying with disorder labels. These benefits can be understood as the result of the disorder label's capacity to cognitively and temporally organize individuals' emotional troubles. The disorder label helps them to "make sense" of their distressing emotional experiences by delimiting the universe of possible interpretations. This cognitive structuring consequently enables them to situate their experiences within their autobiographical pasts as well as provide direction for their therapeutic efforts. The result of this autobiographical coherence is a greater sense of personal control and a feeling of hope for a future of change. Thus, de-labelers' *recovery narratives* are characterized by an *expecting orientation* that treats the disorder identity as a temporary crutch to aid in coping with a distressing time.

Chapter Three, "Accepting Disability: The Limiting Consequences of Long-Term Disorder Identification," highlights a process by which the meaning of the disorder label changes from being considered a temporary recovery tool to being viewed as a

permanent feature of oneself. Whereas in the short-term the recovery narrative expresses the benefits of the label's capacity to delimit complexity by cognitively and temporally organizing one's troubling emotional experience, in the long-term the *disability narrative* revolves around the limiting consequences of identifying with the very same label. Unlike labeling research, which focuses on the social consequences of psychiatric labeling (due to stigma), de-labelers' narratives emphasize the internal, self-limiting consequences of long-term identification with the disorder label. I draw on excerpts of the narratives to illustrate this sentiment as well as to demonstrate the shift in temporal orientation from an expecting orientation to and *accepting orientation*.

Ultimately, this awareness that their self-perceptions are being limited by continued identification with disorder labels motivates the decision to discard the identity altogether in an effort to gain a more expansive perception of themselves. This decision to discard the disorder identity, however, is only the beginning of a typically arduous process that is detailed in an analysis of de-labelers' *disidentification narratives* in Chapters Four and Five. Chapter Four, "Obstacles to Disidentification: Existential, Interactional, and Cultural Sources of Ambivalence," highlights the tension between individuals' decision to discard their labeled identities and their simultaneous reluctance to relinquish these identities. I describe this tension as the consequence of existential, interactional, and cultural sources of ambivalence that characterize de-labelers' narratives, including both a fear of the consequences of dissociating with the label and a simultaneous attachment to the identity, the community, and the cultural support associated with the disorder label. I outline the most common strategies de-labelers describe using to overcome these

existential, interactional, and cultural sources of ambivalence in Chapter 5, “The 13th Step: Developing Exit Strategies.”

I conclude in Chapter Six, “Managing Temporally Ambiguous Identities: Reflections, Speculations, and Implications,” by discussing some of the ways that the themes that run through de-labelers’ narratives may guide future research. I begin by discussing the handful of de-labelers whose narrative patterns differ from the majority; speculating about why there are so few of them in this group may motivate further research into this understudied population. I then consider how the temporal themes in de-labelers’ narratives may be useful for expanding the discussion of mental health labeling in sociological analyses. Following that, I speculate about some ways in which the insights from de-labelers’ experiences may be useful within clinical contexts of therapeutically managing individual disorder identities. Finally, I end the discussion by moving beyond the specific case of de-labelers into a discussion of individual identity more generally by suggesting some ways in which a greater sensitivity to the themes that this study highlights may add temporal nuance to our social psychological analyses of identity careers.

Chapter 2

Expecting Recovery: The Delimiting Benefits of Short-Term Disorder Identification

De-labelers' narratives draw attention to the changing subjective meaning of disorder identities over time. While all de-labelers, by definition, eventually chose to discard their disorder identities, there was a time when the disorder label served as a source of identity for each of them. Despite the fact that this identity was ultimately rejected, most de-labelers' narratives describe their disorder identities in positive terms when referring to the early part of their disorder identity careers. Typically, they describe having initially embraced the disorder label as a means of overcoming their problematic conditions. These narratives about their short-term identification tend to treat the disorder identity as a crutch that is considered to have been temporarily useful in their efforts toward recovery.

This attitude reflects an *expecting orientation* toward the future, as it anticipates change. The formal features of the expecting orientation can be represented graphically as a trajectory that is depicted as both *ascending* and *finite* (see figure 1). Its ascending, diagonal shape indicates the belief that there will be improvement over time and that experiences in the future will break mold with those of the past and the present. This orientation equates the passage of time with continual improvement. In addition, its finite character, as symbolized by the end point, indicates the expectation that the identity will be temporary. The line terminates at a point in the projected future when the problem has been transcended (i.e., recovered).

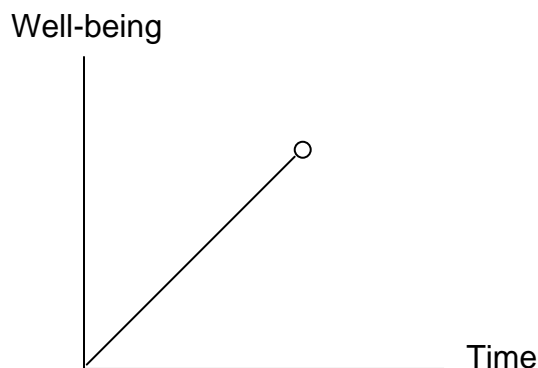


Figure 1. "Expecting" Trajectory

This notion of an expecting trajectory is an ideal-typical construction that is based on the most prevalent patterns in this set of narratives. The purpose of using ideal-types is to intentionally minimize ambiguity for the sake of analytical clarity. Thus, abstracting the formal features of temporal orientations and narrative patterns allows the analysis to emphasize general temporal patterns without getting encumbered by the array of idiosyncratic details in each individual's narrative.

The expecting orientation is expressed in an ideal-typical narrative form that I refer to as the *recovery narrative*. The distinguishing characteristic of this narrative pattern is that it treats the disorder identity as a means to an end. That is, it reflects the expecting orientation's assumption that the disorder identity is a temporary identification by treating it as a "useful tool" for coping with the current difficulty. In the recovery narrative the disorder identity is always positioned as a provisional identity; it is given an "external-unstable-controllable attribution" (Weiner 1985) in that one's emotional difficulties are presumed to be a changeable state and not a permanent trait. The disorder identity is given a remedial role in this narrative as it is described as a way of helping one to understand the troubling experience and thus provides a

means of contending with the uncertainty and confusion that typically accompanies a time of emotional difficulty. Consequently, the recovery narrative is characterized with a tone of hope and forward-looking optimism. The prominence of this orientation in de-labelers' recovery narratives is consistent with one of the major tenets of Albert's (1977:499) Temporal Comparison Theory which states that in the construction of autobiographical narratives "evidence of maturation, progress or growth will be favored over those that present evidence of decay or decline." The sense of hope that the recovery trajectory encourages was particularly helpful for de-labelers in coping with the uncertainty that characterized the onset of emotional difficulty.

These recovery narratives typically express de-labelers' appreciation for the ways their disorder identification helped them cope with their most distressing times at the onset of emotional disturbance. Most de-labelers describe having gone through an immobilizing sense of disorientation before they had a label for their troubling experiences. Without a name for their condition, they felt they did not have a way to "make sense" of their disturbing experience. They did not have a way to classify the disturbing experience or to position it within their autobiographies; consequently, they lacked a sense of direction in their actions toward treating the problem.

De-labelers' recovery narratives highlight the ways in which the disorder identity served as a kind of a compass to help them to navigate through the sense of cognitive, biographical, and directional disorientation that they commonly experienced at the onset of their emotional troubles. That is, having a cognitive framework with which to comprehend one's present circumstance provides an interpretive lens through which to reinterpret one's past and to anticipate the future. Since the future

can only be imagined on the basis of one's interpretation of the present and the past (Emirbayer and Mische 1999; Schutz 1967; Markus and Nurius 1986), the disorder label also provides the cognitive structure necessary to "give direction" to de-labelers' therapeutic actions. Thus, being able to associate the condition with a label provided a valuable sense of understanding, coherence, and optimism early in the disorder identity career.

This optimism can be attributed in part to the increased sense of personal control derived from having a label for their problems. Since personal control is understood to be the expectation that one's choices and actions are likely to influence the outcome of a situation (Mirowsky and Ross 1986), it follows that having a label to direct therapeutic effort would increase the sense that one's actions can positively influence one's situation. Consequently, the majority of de-labelers praise their former disorder labels for helping them in their short-term coping with the emotional difficulty.

Cognitive Orientation: Naming the Present

Given that by definition this group of de-labelers no longer identifies with their former disorder labels, it was initially surprising to hear accounts of the positive role the disorder identity had played for most de-labelers. Many refer to their former labels with affection, gratitude, and even a sense of nostalgia for the way that the labels had helped them through their short-term coping with their problems. This sentiment highlights the initial uncertainty and distress that de-labelers experienced at the onset of their emotional troubles and the value of having a name for the problem while they were coping with this confusing time.

The short-term value of labeling the condition is that it serves as an interpretive framework through which to comprehend one's experience. This cognitive structure can be understood in Hazel Markus' (1977:64) terms as a "self-schema," which she defines as a "cognitive generalization about the self, derived from past experience, that organizes and guides the processing of self-related information contained in the individual's social experiences." We all require such schemata in order to organize our perceptions of experience into meaningful interpretations of ourselves, but this cognitive need can be felt even more acutely when faced with a troubling situation that disrupts expectations about ourselves or our environment (Marris 1974). Being able to associate the problem with a recognized diagnostic label provides a set of cultural meanings with which to make sense of the experience. This association with a framework of meanings can be extremely helpful during an otherwise undefined and difficult time (Charmaz 1991; Frank 1995, Irvine 1999). One of the reasons a name can be helpful is that it *delimits* the range of possible interpretations of the experience.

Theorists of social cognition emphasize the fact that any given perception is only a selection of the sensory information that exists in any moment (Fleck 1979; Schutz and Luckmann 1973; Zerubavel 1991, 1997). To perceive anything requires mentally foregrounding some information and disattending the rest. What information makes it into the field of our attention and what remains in the background can be understood in terms of "socio-mental filtering" (DeGloma and Friedman 2005). This refers to the process of retaining schematically appropriate information and "filtering out" what is deemed irrelevant. As DeGloma and Friedman (2005) explain:

Filters purify and concentrate meaning around a small portion of the

technically available sensory information, simplifying and stabilizing meaning. 'Irrelevant' alternate information – any information that would destabilize the coherence of the available categories and meanings – is filtered out of our perceptions and rendered invisible.

Diagnostic labels can serve as such delimiting meaning systems because they define the mental, emotional, and physical experiences that comprise “symptoms” as well as the combinations of symptoms that are recognized as various illnesses and disorders (Kleinman 1988; Brown 1995; Kirk and Kutchins 1997). As Horwitz (2002:116) notes, “Culture provides publicly available and shared meanings that facilitate certain kinds of symptom interpretations while discouraging others . . . [and] shape which sensations are attended to or ignored, remembered or forgotten, responded to or neglected.”

One of the consequences of naming is that it can reduce the complexity of the situation in question. Rather than leaving open all possible explanations, a schematic rendering of emotionally problematic behavior helps to delimit the universe of possible interpretations to a clearly demarcated set of diagnostic meanings (Zipporyn 1992:23). Zerubavel (1991:119) helps to explain the cognitive and psychological importance of having a way to delimit our interpretive possibilities. He notes, “It is our basic need for order and deep fear of chaos that makes us draw lines. A world with no lines is a chaotic world . . . By providing closure, boundaries make us feel more secure.” This need to delimit cognitive possibilities by assigning labels to one's (and others') experiences is a psychological necessity (Heider 1958). The alternative to this interpretive process would be a complete lack of intrapsychic order and essentially an intolerable psychological environment (Howard and Levinson 1985). Given this impulse for naming even under typical circumstances, it is understandable that there

would be an even greater sense of urgency for categorization in situations of intensified uncertainty and disturbance, such as the experiences described in de-labelers' narratives.

Rose's⁹ experience illustrates the benefit of having a label with which to give order to her narrative of disorder. She explains that she had become completely housebound and was forced to quit her successful, corporate job because she would be overcome with fear every time she left her house. She suffered a great deal of psychological distress from not having a way to understand or explain this paralyzing terror to herself or others. She eventually learned about a recovery program for problems like hers, and there she was introduced to the label "agoraphobic" with which she immediately identified. Emphatically, she explains that she found it to be "a huge relief, after over a year without a name for it!"

Rose's statement suggests that the degree of relief she experienced from having a name for her problem was enhanced by the length of time she suffered without a label for it. This sentiment is highlighted in Karp's (1996) analysis of the "depression career;" he notes that the quality of the psychic pain associated with depression is exacerbated if one does not have a label that can give meaning to the experience. Karp claims that before possessing such a "conceptual apparatus" (i.e., the diagnostic label) his informants "live[d] in a state of frustrating bewilderment and consternation" (39-40). A young woman quoted in his study articulates the experience with striking poignancy: "What was so bad about it [was that] I had no words for it. I

⁹ Rose's narrative is one of the few who largely maintained an expecting orientation throughout the disorder identity career before exiting. While the temporal pattern of her narrative is atypical compared with the majority, I quote her here because she succinctly expresses the value of having a disorder label to name one's condition.

didn't understand what it was . . . and the pain is really kind of raw because you have no vocabulary for it" (40). This experience of suffering from such unnamed, "inchoate feelings" is so common among Karp's interviewees that he distinguished it as the first stage of a four-stage process of developing a "depression identity."

De-labeler Daphne's narrative expresses a similar sense of "diagnostic relief" (Charmaz 1991) when she was given the label "schizophrenic." She maintains that this disorder label was initially very helpful to her because she had known since high school that "something was wrong." She did not have a label for her problems, however, until several years later when she was diagnosed by a psychiatrist during a temporary hospitalization. As she explains, "I was having a lot of trouble functioning and didn't know why. So, it made me feel good when I first got a label from someone else because it put a name to the problem I was having – so that it wasn't just some vague, weird thing – it had a *name*." Juxtaposing "vague, weird thing" with "a name," suggests that having a name helped Daphne to both define the problem as well as to make it more comprehensible. The greater the sense of understanding, the more the problem can be experienced as manageable (Blaxter 1978; Brown 1998). This is reminiscent of the phenomenon experienced by many discontented housewives in the early 1960's when Betty Friedan identified "the problem with no name" in *The Feminine Mystique*. Identifying their common feeling of discontent not only gave these women a context in which to understand their difficulties but also a sense of comfort in the recognition that they were not alone in their feelings. Referring to the value of Friedan's book, Zerubavel (2006:67) notes that it was a significant instance of "naming the conventionally unnamable thereby making it more discussable. . ."

It is interesting to note that the cognitive and psychological value of naming the problem may have little to do with how accurately the label reflects “what is wrong.” Regardless of how well the label reflects the objective circumstances, the act of naming the condition may provide an independent sense of comfort and meaning to the individual who uses it to explain his or her troubles. Haley’s recovery narrative illustrates this point when she recalls that during a time of great emotional difficulty, the lines of demarcation provided by her diagnostic label were more important to her than the accuracy of the diagnosis itself. As she explains, she identified with two different disorder labels through the course of her disorder identity career: she was first diagnosed as “bipolar,” and then several years later she was shown her medical records which indicated a diagnosis of “chronic undifferentiated schizophrenia.” In retrospect, she believes that the “schizophrenic” label was a much more accurate description of her experience, but during her time of great emotional trouble early in the disorder career, the accuracy of the label did not seem to be as important to her as simply having a label at all. As she explains, “I always knew in the back of my mind tha I wasn’t an actual ‘bipolar’, but I had to be someplace, so I accepted it. [Having a label] was very helpful because it was like a container . . . a collection point. It gave me a home. “

Haley’s comments attest to the benefit of cognitive boundaries. Even though she had always doubted that she was “bipolar,” she feels that even an inaccurate label was useful to her during her time of crisis. Her narrative expresses appreciation for the delimiting function of the label because it gave her a “home” and a “collection point” to delimit her interpretation of her situation during a crucial time.

Similar imagery in Mary's narrative parallels Haley's suggestion that the disorder label served a "containing" function during her worst period of emotional turmoil. Mary explains that she was very welcoming of her diagnostic label "agoraphobia" when she was so immobilized by anxiety that she could not leave her house without suffering from extreme panic. The label served as a sort of psychological enclosure she felt she needed in order to heal. As she explains, "If your leg hurts and you go to the doctor who says there's a break in it and it can be put in a cast, that's hope. So for me it was like, "Ok, I'll go into a cast for a little while; then I'll be better." Mary's analogy of a cast evokes imagery of a cocoon: it is a dynamic container that both holds and protects so that its contents can transform. As Mary, Haley, and other de-labelers suggest, the delimiting function of having a name for their emotional troubles is that it can "contain" the experience and thus cognitively buffer one from the complexity of a myriad of potential interpretations.

Autobiographical Coherence: Aligning the Past and the Present

Making sense of personal experience is not only an issue of classification; it is also a biographical matter. In order for a label to serve as a source of personal meaning it must be situated within one's autobiography. It is therefore not enough to simply have a diagnostic interpretation of the experience; one must also be able to integrate that interpretation within one's personal sense of self. An important way of achieving this sense of autobiographical integration is to construct one's self-narrative to demonstrate a sense of consistency between the past and the present. Such autobiographical coherence is, in fact, a requirement for experiencing a sense of

selfhood as a continuous individual over time (Polkinghorne 1988). Memory of the past and the ability to relate it to the present is, to a large extent, what enables the perception of oneself as a continuous individual “me,” despite daily changes in one’s physiology, behavior, and surroundings. Thus, the greater the coherence between the “scattered data of one’s biography” (Berger 1963:63) the more profoundly one can experience him- or herself as a reliably unified entity.

While this narratological process of connecting autobiographical dots is an ongoing chore that we all engage in regularly to integrate disparate experiences into coherent self-stories, the process is more deliberate during time of tremendous change or uncertainty (Albert 1977:490). Anything that is experienced as a disruption in one’s expectations of oneself can create a disjuncture that requires explicit effort to narratively realign the past and the present.

According to Arthur Frank (2000:135) this process of “narrative repair” can be crucial when illness has disrupted one’s life and the self-narrative that underlies it. The unpredictability and confusion brought on by illness or disorder can only be expressed by what he calls a “chaos narrative;” this is, in essence, a “non-self” narrative, since one’s sense of selfhood depends on some degree of narrative order. Having a diagnostic name for the disruptive condition, then, provides the scaffolding for constructing a new self-narrative that aligns the current malady with experiences in the past.

This narrative realignment can occur in two reciprocal ways: it can both facilitate the use of past experiences to make sense of the present circumstances as well as the use of one’s interpretation of the present to make sense of the past. In other

words, identifying with a disorder label both allows one to place the present crisis within a biographical context of the past as well as providing a way to make sense of mysterious or confusing aspects of the past by viewing them in light of the present. In both cases, the integration of the past and the present create a sense of autobiographical coherence that contributes to de-labelers' feeling that their troubling experiences "make sense."

While these two processes are not mutually exclusive, some cases highlight one aspect more than the other. De-labeler Vicky's narrative about her former "alcoholic" identity illustrates the process of narratively locating her interpretation of a current problem within the context of past experiences. She explains that although she had not drunk heavily in over five years, she decided to attend some Alcoholics Anonymous (AA) meetings because she had a history of heavy adolescent drinking and had been feeling that "something wrong was going on in [her] life." There, she learned to call herself an "alcoholic" and to reinterpret her teenage rebelliousness as a sign of her alcoholic "disease." She was encouraged to consider herself a "dry drunk" because one of the tenets of the AA philosophy is that "once an alcoholic, always an alcoholic." Initially Vicky appreciated having a single explanation for her current problems that she could view as a manifestation of a long-standing disease:

I went to AA for 5 1/2 years. . . because I knew I had some big emotional problems, and it was easy to blame them all on drugs and alcohol...I had plenty of old stories to share [in AA] because I partied my butt off when I was a teenager and in college, and my mom smoked pot with me when I was younger. But, then I started realizing that I

was having to exaggerate about when I was younger. I had to exaggerate and stretch to make them fit that whole thing of 'once you're an addict you're always an addict'.

Vicky eventually discovered that making sense of one's current situation through one's interpretation of the past requires having to figuratively "mine" (Budgeon 2003: 49) the past for events and experiences that can be reinterpreted as "causal precursors" (Pillemer 1998:85) to the current disorder. This imagery of mining the past suggests that only selected or "mnemonically filtered" (DeGloma and Friedman 2005) experiences have narrative value, as pre-determined by the interpretive purpose of any given mnemonic excavation. For Vicky, this meant that in order to understand her current problems as symptoms of her long-standing "alcoholism," she had to review her past and select out those memories that could serve as "evidence" of a budding dependency on alcohol. Therefore, she felt obliged to emphasize (even "exaggerate") her adolescent "partying" so that her personal story would justify her current "alcoholic" identification.

Whereas Vicky's narrative emphasizes the mnemonic strategy involved in understanding one's present within the context of the past, Thor's recovery narrative offers an example of the reciprocal process of "mak[ing] sense of the past from the perspective of the present" (Garro 2000). He explains that he had lived with a "really deep pain" for a long time, the source of which he had never been able to pinpoint. After reading a book about "codependency" he felt that he could finally make sense of his personal history in a way he had not been able to before. Thor remembers:

I knew things weren't right in my life. I hated my parents, I wasn't functioning well in my life . . . relationships were difficult . . . I knew it was parentally instigated in some way, but I didn't know how . . . When I read this book it all became crystal

clear to me. It was like, 'Wow, this book explains what I've been going through!' . . . I thought, 'Well at least I finally found out what I am!' It was very reassuring.

The reassurance Thor describes can be understood as an existential response to a narrative problem. That is, creating “retrospective coherence” (Albert 1977:488) by aligning his narrative of the present and the past provided him with a stronger sense of self, as reflected in his assertion that “I finally found out what I am!” This suggests that having unexplained experiences in one’s autobiographical past can create a certain amount of incoherence in one’s self-narrative; this translates, to some degree, into an incoherent sense of self. Thor’s disorder label helped to fill in the narrative gaps in his autobiography by allowing him to “retroject into the past various elements that were subjectively unavailable at the time”(Berger and Luckman 1966:163). In other words he was able to align the past and the present into a coordinated narrative by retrospectively classifying mysterious problems in his past as undiagnosed “symptoms” of his “developing” condition; he could thereby interpret his present condition as the logical culmination of the his past.

Narrative scholars remind us that in these late modern times we all increasingly bear the burden of having to construct and reconstruct self-narratives (Giddens 1991; McAdams 1995). It is possible, however, that people suffering from emotional difficulties may experience the requirement of self-construction as even more problematic than it is for others. Peter Berger (1963) explains that one of the consequences of knowing that our autobiographies are but one self-selected configuration of a nearly infinite number of possible narrative arrangements is that it can lead to a feeling of “metaphysical agoraphobia before the endlessly overlapping

horizon of one's possible being" (63). While he suggests that this awareness can be a source of existential anxiety for anyone, it seems likely that it would be even more unsettling for individuals who are already in a state of emotional crisis. Donald Polkinghorne's (1988:119) observation that there can be great "therapeutic power [in] a coherent narrative" is especially meaningful in this context. Having a readily-available, culturally sanctioned disorder label around which to coordinate one's present difficulty with one's personal past can help to increase the sense of coherence in one's autobiographical narrative, and consequently, in one's sense of a consistent self. This helps to explain why a majority of de-labelers describe initially welcoming their identification with a disorder label during their most desperate times.

Therapeutic Direction: Anticipating the Future

In addition to delimiting the understanding of one's emotional trouble and helping to align that understanding with one's memory of the past, the interpretive boundaries imposed by naming one's emotional distress with a disorder label can also help to direct one's action toward remedying the problem. A number of de-labelers agree that the most difficult aspect of initially lacking a name for their suffering is that they felt immobilized to take action toward improving it. Without a framework with which to cognitively structure one's experience or to integrate it into one's autobiography, it is impossible to anticipate the future, and thus, to know how to act.

Markus and Nurius (1986) articulate this interconnection between the autobiographical past, present, and future in their work on the "possible self." They suggest that possible selves are the cognitive counterparts to our hopes and fears

about the person we could become in the future, providing evaluative, interpretive, and motivational contexts for the “now self.” The authors theorize that:

[Anticipatory selves] derive from representations of the self in the past and they include representations of the self in the future. They are different and separable from the current or now selves, yet are intimately connected to them.

This view suggests a reciprocal relationship between the future and its precursors: on the one hand, a conception of a possible self depends on an interpretation of past and present selves from which a future self may be extrapolated; on the other hand, such a conception of a future self provides a context of meaning for current self-understanding. In other words, comprehension of the current circumstance, as well as its background provides a cognitive platform from which to extrapolate an expectation of the future. The disorder label, then, provides the cognitive and temporal orientation necessary for adopting a direction for therapeutic action. Understandably, many de-labelers initially embraced their disorder labels with great enthusiasm.

Anticipating the future is always a hypothetical endeavor, but it is nevertheless a requirement for intentional action. Such action is necessarily “emplotted” (White 1978) action that is temporally positioned within a narrative that causally connects isolated “events” by transforming them into “episodes” of an autobiography in progress (Polkinghorne 1988). Action is both a response to the narrative’s portrayal of the past as well as a means of achieving some projected future end. Action is not prompted simply by the classification of events and experiences; action is motivated by its placement in the context of an unfolding plot (Mattingly 1998; Somers 1994).

Harold Garfinkel's (1967) famous analysis of Agnes, a 17 year-old male-to-female transsexual, emphasizes the centrality of emplotment in establishing her new identity as a woman. After her operation she is faced with the problem of a "17-year gap" in her autobiography. That is, "she lacked a proper biography to serve as a historico-prospective context" for managing her current identity. With this notion of a "historico-prospective context," Garfinkel draws explicit attention to the inherent connection between perceptions of the past and anticipations of the future. The viability of Agnes' future identity as a female depends on having a past that supports it because projection into the future relies on a certain degree of extrapolation from one's understanding of the past.

Emirbayer and Mische (1998) make a similar point by emphasizing that any intentional action has an intrinsically "retrospective-prospective" character. That is, one's action in the present is guided both by one's anticipation of the future and rendering of the past. In fact, their theory of agency contends that agentic action must be understood as a "temporally embedded process of social engagement" that is based on an "internal conversation between the past, present and future" (963). It follows then that, without a narrative rendering of the present and the past, one's imagination of the future becomes stilted and action is paralyzed.

Most de-labelers' narratives suggest that having a disorder label to define their troubling conditions afforded them a hopeful and optimistic attitude toward their futures because it helped to direct their therapeutic endeavors in ways they expected would be helpful in overcoming their difficulty. This attitude can be partially understood as a consequence of the belief that there was now some measure they could take to

improve their condition. In other words, having a name for their problem and a therapeutic direction provided them with a greater sense of personal control. It is established in the social psychology literature that a sense of personal control is associated with greater psychological well being (Rosenfield 1989); increased effort, motivation and persistence in problem solving (Mirowsky and Ross 1986); a more vigorous management style toward illness (Seeman and Seeman 1983); and can serve as buffer against stress (Thoits 1991). All of these consequences are likely to facilitate an optimistic attitude.

Similarly, Drewery et al. (2000:254) affirm that because disorder labels tend to “lead to treatment . . . they may offer hope where previously where was only incomprehension.”¹⁰ This sense of hope can also be understood as a result of subscribing to a therapeutic mindset. Any therapeutic paradigm rests on the assumption of improvement over time and, therefore, implicitly encourages the adoption of an expecting orientation. For instance, psychotherapeutic models tout various means of “recovery” as the expected outcome of engaging in a given approach; similarly, pharmaceutical advertising typically uses a before-and-after format with imagery to suggest darkness and hopelessness in the pre-medication segment and sunshine and hope in the post-medication section (Karp 2006). Having a course of treatment associated with the disorder label thus supports a sense of confidence that the future will be one of change. This further helps to explain why de-

¹⁰ This is one of the consequences of mental illness labeling that critics of labeling theory (most notably Walter Gove [1975; Gove and Fain 1973]) have tended to emphasize in making a case for the benefits of labeling. See Rosenfield (1997) and Link and Phelan (1999) for reviews of additional literature in this long-standing debate.

labelers consistently associate a sense of hope with their short-term disorder identification.

De-labeler Harold's recovery narrative demonstrates how the label can inspire hope by leading to a therapeutic direction. For most of his adult life, Harold had suffered from such extreme anxiety in so many situations that his mobility was virtually restricted to the route between his home and his workplace. His first exposure to the term "phobic" was on a TV news story about a local phobia treatment program. He recognized the description of "severe claustrophobia" as his own, and the very next day he called to enroll in the program. There, he learned to interpret his fears as symptoms of an anxiety disorder, and he was given cognitive-behavioral therapeutic strategies to help to change his fear reactions. He explains that although it actually took about two years for his "phobic" symptoms to completely fade, within four weeks he "had all the tools [he] needed to systematically cure every phobia." As he puts it, "After those first four weeks I was a phobic with a path!"

Harold's narrative illustrates the way in which having a "path" for his treatment enabled him to anticipate a hopeful future with regards to his condition. This notion of a path is a spatial image for a temporal concern: it serves as a conceptual bridge between the known present and the unknown future. A path, by definition, implies an established direction and can thus facilitate a sense of confidence that the future may be extrapolated from one's present course of action. In fact, for Harold, having a path to direct his therapeutic actions gave him such a sense of optimism that he told me twice that he "got [his] cure after four weeks" in the recovery program. Even though he made it very clear that it actually took much longer than a month to be free of "phobic"

symptoms, just being *on* his “path” allowed him to have an expecting orientation; the resultant sense of hope was profound enough for him to consider it to be his “cure.”

Like Harold, early in the disorder identity career a majority of de-labelers assume an expecting orientation, which implies that defining their problems with discrete labels and identifying as a corresponding type of “disordered” person will aid them in ultimately achieving a future that is free of the labeled condition. They see the disorder identity as a point of departure in that it serves as a base from which to launch their recoveries. Several de-labelers refer to imagery in their recovery narratives that reflects this perspective.

Gretchen and Claire use imagery that emphasizes their view of the disorder label as a transitional crutch from which to pivot into a state of improved emotional health. For example, Gretchen’s story treats the short-term use of her former label “addict” as a touchstone during a time of crisis; she insists that identifying as an “addict” actually “saved [her] life.” As she explains, “[the disorder identity] gave me something to hold onto . . . it helped me get through the terrible despair I was in. It was something to get me over a hump.” Gretchen’s description of “holding onto” the disorder identity as she made her way through her “despair” suggests the labels’ supportive potential during a tumultuous time.

Using somewhat different terminology, Claire’s recovery narrative suggests similar insight about the disorder identity’s potential to bridge the temporal expanse between the labeled present and a future possible self. In her story about identifying as someone with an “anxiety disorder,” she describes having had “bizarre sensations that [she] couldn’t render as normal...whenever [she] was in a classroom, driving, in

an elevator or standing in line in the grocery store.” After hearing about the term “anxiety disorder” in the media, she was inspired to seek professional help; soon after her first appointment with a specialist in anxiety disorders, she started applying the diagnostic label to her understanding of her condition. As Claire explains:

It was a relief that there was some way to talk about and identify this thing. I really embraced the label, and it became something that was central to my existence . . . The language surrounding the diagnosis of anxiety disorder really helped me get a handle on it. But, once I got a handle on it, I didn't need that to be the center of me anymore.

Drawing an analogy between her label and a handle emphasizes a utilitarian perspective toward the disorder identity. Similar to Gretchen and others, Claire attributes her ability to eventually discard the label to her identification with the label itself. This idea evokes imagery of a child crossing the monkey bars one rung at a time. Accomplishing the goal of getting to the next rung is possible only if the child is able to get a firm hand hold on the preceding rung; a loose grip will prohibit the forward momentum needed to reach the next rung without falling. Thus, it is with anticipation of recovery that Claire, Gretchen and other de-labelers describe temporarily choosing to hang on tight to the disorder label.

* * *

These examples of de-labelers' narratives demonstrate the orienting value of short-term identification with emotional disorder labels. The labels serve to delimit the complexity of the troubling condition as well as to and help in creating a sense of biographical coherence by offering an interpretive framework through which to align the present and the past, and thus provide direction for future therapeutic action. From an expecting orientation, the sense of understanding, integration, and hope that de-

labelers derive from disorder identification in the short term, is experienced as beneficial for the process of personal change. “Yet,” as Zerubavel (1991:120) reminds us, “these same lines [of demarcation] that provide us with a sense of order and security . . . [also] promote tunnel vision and narrow-mindedness by forcing reality into ossified pigeonholes . . .” Such limitations reflect the consequences of an *accepting orientation* toward disorder identification; this orientation is expressed in de-labelers’ *disability narratives*, the focus of Chapter Three.

Chapter 3

Accepting Disability: The Limiting Consequences of Long-Term Disorder Identification

Commonly, the very same individuals who describe their disorder identities in positive, hopeful terms when referring to the early part of the identity career express negative sentiments about the role of the same disorder labels later in the career. Coming from an expecting orientation in the beginning of the career, de-labelers' recovery narratives suggest that the disorder identity functions as a useful coping strategy in the short term; over time, however, the identification with the disorder label tends to take on a life of its own, and the expecting orientation becomes an *accepting orientation*. This orientation is articulated in the *disability narratives* that characterize de-labelers' accounts of their long-term disorder identification. Whereas the recovery narrative expresses an expectation of change, the disability narrative emphasizes the status quo. In contrast to the optimistic tone of the early recovery narrative, the subsequent disability narrative resounds of resignation.

Graphically, the accepting orientation can be depicted by an infinite, horizontal vector (see figure 2). The arrow at the end of the vector represents the assumption of permanence, suggesting an acceptance that the current identification will continue into the future *indefinitely*. It is based on the belief that the disorder identity indicates an essential quality of the person that will never be removed; one will *always* identify as "disordered." Additionally, its horizontal shape stands for an assumption that the severity of the condition will not change. There is no anticipation that one's symptoms

will improve or worsen over time. It equates the passage of time with a continuance of what has gone before.

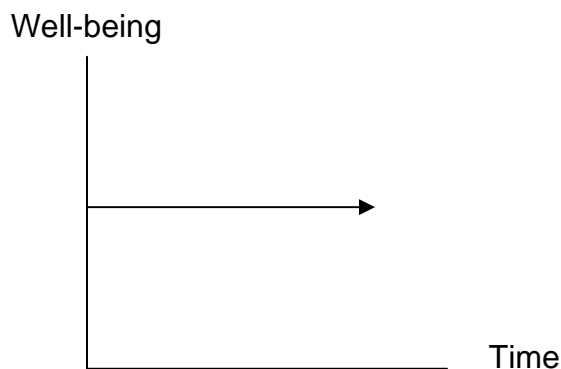


Figure 2. "Accepting" Trajectory

Whereas the recovery narrative revolves around themes that can be characterized as *delimiting*, the primary themes in the disability narrative emphasize the *limiting* consequences of disorder identification. The concepts of delimiting and limiting both imply boundedness, but there is a subtle difference. To delimit implies a process of demarcating or defining boundaries for the purpose of clarity. To limit, on the other hand, suggests more prohibitive overtones that evoke notions of restricting or confining. Both terms have association with an element of control but with different connotations. In the first instance, the concept of control implies mastery over something. Therefore, the delimiting consequences of a label that allows one to comprehend, classify, or clarify implies a degree of interpretive mastery over cognitive chaos and consequently, a greater sense that one's actions can have a positive influence on the future. The limiting consequences of a label, on the other hand, imply being controlled and thus losing a sense of influence on one's situation. This suggests

the restrictive and reductive consequences of allowing a single label to dominate one's self-understanding. Highlighting the two ways in which control is implied in the notions of delimiting and limiting draws attention to their very different implications for de-labelers' narratives: whereas delimiting the universe of possible meanings of one's emotional condition may be crucial for helping to structure a confusing experience within an interpretive framework and corresponding course of action, the resulting cognitive stability can become ossified and consequently constrain the possibility for change.

As noted in Chapter Two, common imagery in the recovery narrative tends to revolve around a positive sense of being contained by the boundaries of the label (i.e., a "cast" or a "home") or being mobilized by using the label as leverage to move forward (i.e., a "handle"). In the disability narrative, such imagery is replaced by constraining and immobilizing imagery (i.e. being "stuck" or "boxed in"). Whereas the recovery narrative highlights the label's capacity to "hold" one in comfort or to be "held" for support, the disability narrative focuses on the disorder label's tendency to "hold" one captive. Concomitantly, whereas the short-term consequences of the disorder identity can offer a greater sense of personal control, long-term identification may make one feel controlled by the definitional limits of the label itself. De-labelers' narratives thus suggest that one danger of long-term disorder identification is that it has the potential to undermine the very possibility for change that inspired de-labelers to embrace the disorder labels in the first place.

The process by which this shift in temporal orientation (and consequent narrative style) occurs is highlighted through the notion of the *identity whirlpool*.

Exploring this concept suggests several factors that contribute to the tendency for identification to breed further identification in a self-reinforcing manner.

The Identity Whirlpool: From Expecting to Accepting

From an expecting orientation, adopting a disorder label is useful precisely because it is understood to be a tool, and there is an expectation that when it has outlived its utility, it will be discarded. De-labelers' experiences indicate, however, that it can be difficult to maintain such a perspective over time; the identity can become self-validating and an accepting orientation can easily develop. Despite the original intention of using the disorder identity as a temporary recovery tool, continual identification can, over time, reinforce the assumption that one *is* a "disordered" person; this perspective can thereby keep the disorder identity at the top of the identity "salience hierarchy" (Stryker 1980) indefinitely. Ironically, it is the label's cognitively delimiting function, which initially facilitates an expecting orientation, that ultimately propels the disorder identity into this indefinite spiral of acceptance. I refer to this self-perpetuating tendency as the *identity whirlpool*, suggesting by the name that identification can create a momentum that takes on a life of its own.

The metaphor of the whirlpool is helpful for illustrating two aspects of this transformation from the recovery to the disability perspective. The first, *identity entrapment*, refers to the whirlpool's circular motion, which represents the self-perpetuating consequences of repeatedly asserting one's disorder identity. The second aspect, *identity funneling*, draws on the inverted conical shape of whirlpools: the whirlpool not only spins in a circular path, but the diameter of its orbit also

decreases with every rotation. This imagery refers to the tendency for a narrowing of self-perception with long-term disorder identification.

While the entrapping and narrowing aspects of the identity whirlpool are interrelated, I distinguish them as discrete processes for clarity. Brekhus' (2003) "identity grammar" framework helps to distill the essence of this distinction. He theorizes three distinct ways of relating to one's identity by drawing a parallel with the grammatical functions of nouns, verbs, and adjectives. For instance, treating an identity as a noun implies subscribing to an essentialist identity strategy, as it indicates a totalizing identity both in terms of its presumed permanence and singularity. To use an identity as a verb, on the other hand, emphasizes its impermanence as it is seen as a temporary identification; it is only relevant when the identity is actively being performed. Alternately, when an identity functions as an adjective it represents one self-modifier among many.

Conceiving of the identity whirlpool in this context distills the consequences of the identity whirlpool to a "grammatical" conflict. That is, the consequences of identity entrapment (i.e., inhibiting change) highlight the subtle distinction between treating the identity as a verb versus a noun, or a temporary act of identifying (i.e., doing identity) versus a permanent state of identification (i.e., being the identity). In other words, it addresses the tension between relating to the disorder identity from a utilitarian versus an ontological perspective. The notion of identity funneling, on the other hand, draws attention to the difference between regarding the identity as an adjective (i.e., identity multiplicity) versus a noun (i.e. identity singularity). It distinguishes between using an identity as a descriptor of an aspect of oneself versus treating identity as a claim to an

essential self. In grammatical terms, then, the pull of the identity whirlpool is in the direction of nounhood.

Identity Entrapment

One of the defining features of a whirlpool is its trap-like character. Whatever gets caught within the orbit of the whirlpool can no longer move forward with the river's current; it becomes locked in a repetitive loop, indefinitely stuck traveling the same circular path. This imagery represents a possible consequence of long-term disorder identification, as described in de-labelers' narratives: identification, over time, spawns more identification. Even when the disorder identity is initially assumed to be a temporary aid in recovery, the act of repeatedly identifying oneself as disordered can, with time, encourage an accepting orientation. As Sue Estroff (1981:248) observes in her ethnography of psychiatric patients, "Nearly all of the clients have succeeded in constructing a monstrous trap, from which there is no easy exit." The dangers of this tendency are reiterated by Drewery, et al. (2000:254) in their discussion of the dominant cultural discourse of emotional disorder:

[T]he liberation initially felt in having a set of private experiences named may be replaced by a different kind of entrapment if the recipients allow themselves to become fully inscribed by the pathology of dysfunction implied by the naming of the symptom cluster.

One way to understand how individuals may unwittingly encourage their own identity entrapment has to do with the reflexive way in which we acquire knowledge about ourselves. One of social psychology's insights is that we know who we are largely by inferring from our observations of our own behavior. Self-perception theory

(Bem 1967) suggests that we learn about ourselves by watching ourselves react to situations, play out our preferences, perform our identities, and so on. In the case of long-term disorder identification, this process can create a self-validating feedback loop: if I observe myself repeatedly asserting that “I am a [disorder label]” then I must conclude that “I am a [disorder label].”

A narrative construction of identity perspective comes to similar conclusions about how we derive our self-knowledge. This approach suggests that we learn who we are as we organize our experiences into meaningful narrative (Hewitt 2003). Our identification with our stories is further enhanced as we tell them to ourselves and to others. Robert Wuthnow’s (1994) observation of participants in small groups highlights this point:

People in groups do not simply tell stories – they become their stories. That is, as far as the rest of the group is concerned, the identity of any particular member of the group becomes almost synonymous with the personal stories that member tells. And, that process in itself can have impact on the way in which individuals think about themselves.

Thus, a feedback loop is established between telling stories about who we are and coming to know who we are through the telling of our own stories. This dynamic is illustrated in Leslie Irvine’s (2000:25) analysis of the narratives of Codependents Anonymous participants. She suggests that most people do not come to the group because they are looking for a new lifestyle; they come for help with a particular experience of emotional distress. She notes, however, “By the time the crisis period ends, many people feel little need to move on.” Through the personal narratives they co-construct within the group context, “[t]hey have ‘become’ codependent.”

Thor's narrative of his codependency identity career offers an insightful illustration of how this self-referential dynamic has the potential to contribute to a self-perpetuating disorder identification. After two years of identifying as a "codependent," he began to feel that his identification with the label was in itself becoming the source of further identification:

[The label] was starting to become an affirmation . . . like having to say before meetings, "I am a co-dependent." . . . You're required to define yourself as a codependent; you can't say, 'I'm moving though codependency' or 'I'm finished being a codependent'. You're constantly defining yourself. I felt it was about maintaining myself not to be a codependent within the context of their definition! . . . Over time, I decided that if I stay in that context and keep telling myself I'm a codependent, then I'm always going to think of myself like that. If you really look at that it's kind of an oxymoron because you're always going to be redefined as a codependent. It's like a never-ending circle.

As Thor's narrative suggests, the very phrase "I am an 'x'" can reinforce the identification over time. This is partly due to the fact that regardless of how long the individual has been identifying with the label, the present conjugation of the verb "to be" (e.g., "am") is always used in this phrase, implying an eternal present. In addition, the lack of modifying terms in this phrase to qualify the label (i.e., "I am a newly identified bulimic" or "I am a rapidly improving phobic") makes it impossible to communicate degrees of change over time. This reinforces the "never-ending circle" of the identity whirlpool.

In addition to reinforcing the assumption that the claimed identity is both permanent and static, asserting "I am" can also increase the momentum of the identity whirlpool simply through the process of repetition. As Estroff (1981:244) points out, it is the "duration of difficulty that lays the groundwork for the meshing of self and symptoms." In other words, the "fusion of illness with identity" is the outcome of

repeatedly assuming that one *is* disordered over time. Repetition increases familiarity (as advertisers and political candidates know well), which can contribute to the identity whirlpool in two related ways: it can encourage habituation as well as attachment. These two consequences highlight different degrees of intentionality in the identity whirlpool process.

The notion of habit refers to action that is more or less absent of conscious motivation. As social psychologist Jane Piliavin (1991) suggests, habit is driven by “inertia.” Drawing on its meaning in physics, she refers to inertia as the “tendency just to keep doing what we have been doing (261).” By the same token, familiarity can also generate efforts to perpetuate action, but it often involves more intentionality than habit. Attraction to familiarity tends to stem from a desire for a sense of security, and because familiarity is typically presumed to be more predictable than the unfamiliar, it is generally perceived as safer and can thus be seductively comforting.

The sense of stability that results from engagement with the familiar can be especially helpful in the short term during times of uncertainty, as suggested in Chapter Two. However, by allowing unconscious inertia to dominate or by yielding to the conscious attraction of the familiar, a resignation to the status quo can develop in the long term. The power of repetition may intensify the pull of the identity whirlpool and thus encourage one’s expecting orientation to become an accepting orientation. De-labeler Anne summarizes this entrapping aspect of the identity whirlpool in the beginning of her narrative:

Let me start at the end, with my ever-growing conviction about how powerful words are . . . It’s an interesting dance – to not deny our experience or to be afraid of the label. But, on the other hand, to go with the “*I am*,” those are strong words! And,

when we say it over and over again, ‘I am this; I am that,’ we start to redefine ourselves in a way that’s hard to break because we really believe that’s who we are, as opposed to being more than that!

Identity Funneling

In addition to the entrapping quality of long-term disorder identification, the identity whirlpool also represents its narrowing tendency. Just as the diameter of the whirlpool decreases the deeper it goes, identification with disorder identities can have a simplifying influence on the complexity of one’s self-concept over time. One of the factors that fuels this narrowing process involves a decrease in what Patricia Linville (1985; 1987) calls “self-complexity,” or the capacity to view oneself multidimensionally. She argues that the greater the number of dimensions included in one’s self-concept, the less salience (Stryker 1980) any single dimension will have. Identity funneling thus illustrates a process by which self-complexity decreases over time.

In Brekhus’ (2003) “grammatical” terms, the identity whirlpool tends to funnel the diversity of identity adjectives down to an increasingly uniform identity, based around a single, celebrated identity noun. This narrowing process tends to produce “lifestylers” who treat the disorder label as a dominant and immutable feature of themselves. Several de-labelers allude to what Brekhus calls an “identity monopoly” – where one’s identity is dominated by a single attribute. Anne, who formerly identified with “multiple personality disorder” (MPD) makes this point with spatial imagery. As she explains:

I found that I needed to actually step outside of the label altogether, or I would be bound by it. The label was taking up more and more of my life so other things got *smaller* and *smaller*. . . because there’s only so much space!

Using a similar spatial analogy, Reina (who previously identified as an “agoraphobic”) comments, “This whole issue of being ‘phobic’ took up so much of my screen; it absorbed a whole lot of my time and energy and creativity.” In these de-labelers’ terms, the funneling aspect of the identity whirlpool reduces the limited amount of self-space available for identity attributes that are unrelated to the disorder identity.

An additionally important factor that can contribute to this funneling process involves narratively locating the origins of the current problem in one’s autobiographical past. As discussed in Chapter Two, de-labelers consider such alignment of the present and the past to have been initially helpful in their efforts to create autobiographical coherence during a time of emotional difficulty. In the long-term, however, continuing to use retrospective evidence of the disorder’s origins in the past can serve to justify one’s interpretation of the present, indefinitely. Thus, this “retrospective causality” (Pillemer 1998) helps to validate the present as a natural outcome of the past. Constructing disorder narratives that establish the origin of the present condition deep into one’s past can reinforce an essentialized notion of the disorder. Rather than viewing one’s condition as a response to potentially changing psychosocial circumstances, being able to trace the origin of the problem in the past gives weight to essentialist claims. The stronger the narrative link between the present and the past, the more the present claim is legitimated (Carr 1999).

De-labeler Raquel tells a chilling narrative that illustrates this relationship between identifying past origins and justifying an essentialist present. Her story revolves around what she now understands to be her misdiagnoses in the 1980’s of

“multiple personality disorder” (MPD). She was placed in an MPD unit in a private psychiatric hospital where, she explains “I was told that the only way to recover was to accept that I was MPD and to undergo this terrible treatment.” This treatment involved systematically reinterpreting her autobiographical past in the context of daily intensive group therapy. Raquel recalls, “If ever my mood changed in any way, the immediate response from the staff would be, ‘Who are we talking to now?’ And, it was implied that I would come up with a name and come up with a history for that ‘alter personality’.” If she refused, the staff would lecture her about having “split off what you can’t bear to remember.” She claims that through the course of the treatment, she actually learned MPD behavior and temporarily “lost [her] own story of the past.” The new autobiographical history that was co-constructed between the staff and herself reinforced her acceptance of the MPD label.

What makes this story of autobiographical reinterpretation even more intriguing is that since Raquel’s experience, the MPD diagnosis has been removed from the *DSM*. This means that even the hospital staff, who had been instrumental in reshaping her personal history, no longer have the cultural authority of the *DSM* to legitimize their interpretations. Reading Raquel’s narrative within the context of MPD’s cultural history (Horwitz 2002) highlights an important way in which cultural meanings can have profoundly personal consequences. While this example may represent an extreme case of such mnemonic manipulation, it illustrates a common strategy of using the past to justify one’s interpretation of the present.

Reinterpreting one’s past in terms of the label may encourage an essentialized view of the disorder in an additional way by promoting autobiographical simplification.

That is, when autobiographical memories are structured around a causal explanation of the current label, it narrows the *mnemonic field* from which to draw one's recollections. A mnemonic field can be likened to the field of vision as viewed through a camera's lens. Technically, it consists of anything that takes place within the bounds of the view finder. However, the photographer has a considerable amount of perceptual play (with such elements as depth, contrast, focus, etc.) with which to compose the image. Similarly, a meaningful autobiography requires managing the nearly infinite range of potential mnemonic material by selecting out the "relevant" memories of the past according to the parameters set by the thematic interests of the present narration (Zerubavel 2003; Zussman 1996).

The consequence of a narrowed field of autobiographic content is that it necessarily simplifies one's account of the past. For de-labelers this means that by systematically foregrounding past experiences that can justify the present disordered condition, one's account of the past can be drastically simplified. The range of memorable experiences contracts, thus minimizing the diversity and complexity of the past for the sake of consistency. In the early stages of coping with emotional crisis, such simplification is considered beneficial, but in the long run it can be a contributing factor to the persistence of the identity whirlpool. That is, there becomes increasingly less incentive to explore the complexity of the past with depth because this ever-available retrospective interpretation via the disorder label provides an immediate and consistent account of the present condition. The consequence is that the less nuanced the lens through which one views the past, the less chance there will be to consider alternative interpretations of one's biography that could potentially challenge the

retrospective inevitability of the current interpretation. The lack of alternative interpretations can contribute significantly to the narrowing tendency of the disorder identity and thus to the development of an accepting orientation.

The Internal Limits of An Accepting Orientation

At some point in the disorder identity career, when most de-labelers become aware that their orientation toward the future has shifted, their attitude about the disorder labels change as well. They become critical of the labels they once embraced. Their narratives express two common complaints about the limiting consequences of long-term disorder identification: one is that it hinders personal change; the other is that they feel the label does not accurately reflect who they are. Both of these limitations can be understood as the restrictive and reductive consequences of the identity whirlpool. The former can be viewed as a result of the repetitive, self-reinforcing quality of the identity entrapment process; the latter as an outcome of the narrowing, simplifying character of identity funneling.

It is significant to note that de-labelers attribute the disadvantages of disorder labels primarily to internal limitations; only one de-labeler even mentions external limitations (i.e., stigma and limited social opportunities), as a contributing factor in the decision to discard the labels. Previous research that considers the consequences of labeling overwhelmingly emphasizes the social limitations that result from being labeled.¹¹ As mentioned in Chapter One, this is most likely due to the fact that the labeling perspective has been so influential in mental health research. Since the

¹¹ See Sarah Rosenfield (1997) for a review of this literature.

labeling perspective is primarily concerned with social reactions to deviant identities, it has a bias toward emphasizing the social consequences of such labeling processes due to the individual's stigmatized status (or perceived stigmatized status [Link et al., 1987, 1989]). De-labelers, in contrast, emphasize the labels' limiting influence on their self-perceptions. This is not to say that de-labelers have never experienced stigma. Rather it means that stigma is not mentioned as a reason for the eventual decision to disidentify from the disorder label.

"The perfect excuse not to grow"

Many de-labelers criticize the long-term identification with disorder labels for limiting their growth. An orientation toward change and growth is central to nearly every de-labeler's initial recovery narrative, so it is not surprising that these individuals would feel frustrated to find themselves stuck in the identity whirlpool, inadvertently spinning disability narratives. One of the common variations of this criticism is that identifying with the disorder label encouraged them to avoid doing the therapeutic work necessary to continue changing their problematic behaviors. For instance, Kasey, who previously identified as an "alcoholic," expresses resentment that the "culture of AA" encouraged her to continue identifying as an "alcoholic" even after she had been sober for five years. She explains that although she was "accepting of the label when [she] first decided to get sober," she feels that it ended up serving as an "excuse" for any of her shortcomings. She recalls that she initially appreciated having the label "to be able to say this is the reason my life is so screwed up!" She eventually became critical, however, of this very attitude:

A lot of people will go on with that thinking, 'Because of my alcoholic thinking, because of my alcoholic thinking . . .' And they attribute every damn thing they do to being an alcoholic! I think, you might have been that way if you'd never even touched a drop of alcohol! I get annoyed with that kind of thinking.

This notion that identifying with a disorder label has the potential to become a "cop out," as one de-labeler put it, is addressed in Stanton Peele's (1989) *The Diseaseing of America*. He warns that a danger of "addicted identit(ies)" is that individuals can use them to "explain all their previous problems without actually doing anything concrete to improve [them]" (198). Robert Granfield and William Cloud's (1999) study of people who recovered from problematic drinking without treatment claims that these individuals actively resisted involving themselves in AA or other treatment venues so as to avoid the "possible deleterious effects of treatment and self-help on [their] self-concept" (127). They point out that such effects can include a weakened feeling of self-efficacy, a decreased sense of responsibility for one's behavior, and a negative self-image as a consequence of taking on a potentially lifelong identity as an "addict" (167-170). By refusing to identify at all with disorder labels, these "self-remitters" attempt to avoid the "excuse not to grow" that many de-labelers' describe struggling with in their long-term disorder identification.

Anthony's feelings about his identification as "clinically depressed" illustrates a similar awareness of the label's potentially limiting effect on personal change. He remembers having to make a conscious effort not to let himself "hide behind the label" or make use of the "massive secondary gains" it offered. He believes that claiming identification with his label was the "perfect excuse not to grow," and he says that he

had to work hard to resist that temptation. His feelings are summarized in an extended analogy:

Let's say you broke your leg. They set it in a cast, the bone begins to heal, and they take the cast off. If you identify yourself as 'someone with a broken leg' and you always have to take care of that leg, it's never going to heal to what it was. You have to push yourself and endure a little bit of discomfort each day to build up the strength in that leg because a broken leg is a transitory thing. I believe you have to think about mental illness that way, too.

Anthony's insistence on viewing the disorder as "transitory" is reminiscent of Talcott Parsons' (1951) "sick role" theory which conceptualizes illness as a social role that carries behavioral expectations and temporarily absolves the "sick" person from many responsibilities as long as he or she demonstrates good-faith attempts to heal. While this theory specifically refers to acute, physical illnesses and not the typically chronic, identity-forming emotional disorders that concern this discussion, it could be extrapolated that in these chronic cases the same privileges could be claimed indefinitely, as long as one identifies with the sick role. The danger, according to Anthony, is that the license allowed by the sick role can discourage one from taking responsibility for one's improvement. Drewery and associates (2000:256) offer a similar caution by suggesting that while emotional disorder labels "may sometimes be helpful to experts in the field, [they are] very often productive of passivity and thus incapacity in the person of whom they speak."

Jillian's narrative suggests a variation of the notion of the sick role. Instead of using the label as an excuse to withdraw from the social responsibilities and behavioral expectations that Parsons' theory emphasizes, she implies that the disorder identity can be used as a kind of an existential retreat. While she only

identified as “bipolar” for a few months before deciding that it was an inaccurate diagnosis, she admits that during those months she appreciated having something that could serve as a ready answer for many difficult questions and life issues. She acknowledges:

The useful thing for me about believing I was bipolar for a period of time is that I could put everything onto that label. ‘I’m uncomfortable and tired – of course, I’m bipolar!’ It allowed me to say, ‘What’s happening today is because I’m bipolar’, and not, ‘What’s happening today is Jillian and her soul’ . . .

The requirements of constructing, maintaining, and accounting for one’s individual sense of self are immense in these late-modern times. Within the current cultural context that is increasingly “saturated” (Gergen 1991) with competing sources of authority about how we should understand ourselves, treat ourselves, present ourselves, etc., “being a self” is a full-time endeavor that asks a great deal of self monitoring, evaluating, and planning (Giddens 1991). Understandably, using a single disorder label to comprehend various aspects of one’s existence can feel like a welcome reprieve from the demanding work of identity-construction and maintenance. De-labeler Anthony acknowledges that having a disorder label to explain oneself can provide some useful “breathing space” in the thick of an emotional crisis. Jillian concurs that “put[ting] everything onto the label” can serve as an escape from taking responsibility for one’s life. She also recognizes, however, that doing so can undermine change because it “stops thought processes and closes off possible meanings.” Thus, if the sick role is utilized for long-term exemption from existential responsibilities, identification with the disorder label can become “enfeebling” (Karp 1996) by standing as a barrier to one’s growth.

“It’s not all of me”

In addition to de-labelers’ criticism that long-term disorder identification inhibits personal change, they also commonly complain about the failure of disorder identities to accurately represent who they feel they are. As these individuals begin to realize that their disorder identities are gaining salience (i.e., “taking up all of my screen”) they describe feeling increasingly troubled by the fact that many aspects of themselves are not reflected by the disorder labels. One of the common ways that several de-labelers express this frustration is by insisting that the label “isn’t all of me.” This sentiment is always communicated in the context of explaining why they had discarded their labels, and it is consistently accompanied by an underlying tone of irritation or resentment.

In terms of Brekhus’ identity grammar, this frustration expresses the tension between treating the disorder identity as a noun versus an adjective. As the funneling effect of the identity whirlpool increases the “density” of the disorder identity, it is increasingly treated as an identity noun. That is, it comes to stand as a representation of who one believes one is, essentially. This way of relating to the disorder label stands in contrast to treating the disorder label as an adjective, where the “volume” of any one identity is low and one’s multiple identifications are emphasized. As an adjective, an identity is a descriptor of one aspect of a complex, multifaceted sense of self.

The crux of the difference between identity adjectives and identity nouns has to do with one’s cognitive style of seeing identity in parts versus as a whole. This distinction is at the heart of de-labelers’ rejection of the disorder label for failing to

reflect “all of me.” As one’s sense of self is progressively resigned to a single identity through the process of identity funneling, that particular identity falls under an increasing amount of pressure to fulfill the impossible task of providing a totalizing self-definition. For de-labelers, the label’s failure to fulfill these mounting demands prompts them to reject it altogether; they blame the label for falling short of an unattainable expectation. On the other hand, if an identity were treated as one adjective among many, it would never be expected to represent anything more than a small aspect of one’s experience of self and may thus be subject to less scrutiny.

De-labeler Lettie¹² passionately opposes treating the disorder label as a noun. She strongly identified as “bipolar” after she was diagnosed over a decade ago, but she discarded that label after coming to recognize the internal limitations of defining herself so completely as “disordered.” She explains that, as an employee for a mental health agency, she is now part of a growing movement to help mental health services consumers avoid treating their disorder identities as the essence of who they are. In one story about a talk she gave at a recent conference, she explains an exercise she created to bring attention to this issue:

As usual, the participants all went around the circle saying their name and identifying with their diagnoses (like, “I’m Sally and I’m a schizophrenic, etcetera”). My stomach just sinks when I hear this. So, I spontaneously changed my plan for the talk I had prepared and had them go around again and introduce themselves by name and a physical condition they have. Like, “I’m Jack and I’m foot fungus.” As you can

¹² Lettie’s is one of the atypical narratives in the sense that, for the most part, she held an accepting orientation until deciding to discard the disorder identity.

imagine, it's a ridiculous exercise, and they were all laughing. Half of them couldn't even do it or would stumble over the words because they are so used to saying "I have..." when it's a physical illness. Then, I told them to go back for round three, and this time introduce themselves as the multifaceted people that they are, including their diagnosis as just one part of themselves. Many of them couldn't do it, but for those who could, it was incredible: 'Hi my name is Nancy, and I write and I cook and I have bipolar illness, and it's just one part of me.' My god, what a difference!

Lettie clearly recognizes that the language used to communicate one's identities can have subjective consequences for the way one's sense of self is experienced. She is also sociologically sensitive to the fact that the cultural authorities in the mental health treatment field can have a tremendous influence on the language consumers chose to use with regard to their conditions. She explains that she has been trying to educate treatment professionals to use language that encourages a descriptive versus an essentialized relationship with the diagnostic label. In the courses she teaches, she explains that she often poses a challenge to the class to break the habit of referring to people with mental illnesses as "schizophrenics" or "bipolars," etc. Instead, she encourages them to "add two little words to the diagnostic name: 'people with' – as in 'people with schizophrenia' instead of 'schizophrenics'." Because it can be a hard habit to break, she puts a "kitty" in the middle of the classroom to collect the quarter that each student pays every time he or she forgets. She is committed to this effort because, as she puts it, "We professionals are the ones teaching and preaching recovery and I still hear non-recovery language; as far as I'm concerned that's the crux of the matter! That's where it all begins." In effect, Lettie is

teaching identity grammar to both consumers and mental health professionals because she knows from her own experience with her former disorder identification how subjectively limiting it can be to treat one's disorder label as an identity noun.

While Lettie's narrative illustrates a protest against using a single identity to represent the *depth* of an individual's sense of self, Mae's narrative highlights the failure of the disorder label to portray the *range* of an individual's personal qualities. Mae's narrative expresses frustration over the fact that because her identification with her disorder label encourages her to focus on aspects of herself that support her "overeater" identity, she is inclined to overlook her most positive qualities. She explains, "When I feel that the label is defining who I am completely, it makes me feel like I am a problem . . . I feel like I'm feeding the negative parts of myself . . . [without the label] I'm able to honor all the parts of myself that are healthy and strong, too." Drawing again on DeGloma and Friedman's (2005) cognitive filtering imagery, Mae's statement draws attention to the "perceptual residue" that remains outside the bounds of awareness. She helps to illustrate how the qualities that support a perception of herself as "disordered" pass freely through the filter, but the "healthy and strong" parts are systematically prevented from receiving attention.

This recognition that treating the disorder identity as a noun precludes "honoring" many other identity adjectives highlights the potential consequences of what Turner (1978) refers to as a "role-person merger." This involves a failure to compartmentalize "role-specific behaviors and attitudes, thus allowing a particular role to become a master status. When such a merger occurs, one identity is foregrounded while the salience (Stryker 1980) of all other identities is reduced. De-labeler Gretchen

describes this phenomenon as the consequence of a way of thinking that Zerubavel (1991) calls the “rigid mind.” This cognitive style is governed by an “either/or” logic that resists acknowledging multiplicity, intermediacy or ambiguity in its classificatory thinking. Gretchen’s reasoning for eventually choosing to disidentify from the her “addict” identity demonstrates this mentality: “There’s a rigidity to identification; if I’m identifying with something then I’m not identifying with something else.” Her lifestyle reflects this mental approach: she selected out environments consistent with the “addict” identity, such as regularly attending AA and NA meetings, living in the “recovery dorm” for college students who are recovering from substance abuse, and developing friendships only with people who are “in recovery.” In exasperation, she explains that she eventually felt the need to discard her disorder identity altogether because, as she puts it, “My entire life was recovery!”

It is precisely this all-consuming disorder identification that the “self remitters” in Granfield and Cloud’s (1999) study attempted to avoid with their refusal to engage in formal treatment programs for substance abuse. The authors explain their informants’ resistance to treatment as a way to “salvage the self.” They claim that these individuals “adamantly refused to be placed in the rigid category of addiction and dependency, preferring instead to see themselves in less definitive, more fluid ways” (111) than they felt a formal recovery context would allow. This fluidity can be compared to Zerubavel’s (1991) ideal-typical notion of the “flexible mind.”¹³ This mental approach avoids assigning fixed categories and closure, but instead “promotes

¹³ To clarify, Zerubavel uses the term “fluid” to refer to a “fuzzy-minded” orientation in which categories of meaning are avoided altogether. Granfield and Cloud use the term “fluid” here to describe an orientation toward identity that resembles Zerubavel’s “flexible-mindedness.”

a rather plastic notion of meaning” (121). Zerubavel recommends developing a quality of flexible-mindedness as a remedy to the narrow compartmentalization of the rigid mind. While de-labelers clearly acknowledge the benefit they received from the sense of order and predictability they derived from the disorder labels in the short-term, the funneling consequences of the identity whirlpool tend to encourage an increasingly rigid identification. Edward de Bono (1969) offers an ideal that is sensitive to both the short-term and long-term concerns that characterize de-labelers narratives: he recommends, “Enough rigidity to give context, meaning and security. Enough flexibility to give change, improvement, adventure and hope.”

* * *

The irony of identification is that the very same delimiting aspect of the disorder identity that was celebrated as helpful from a recovery orientation – and even lifesaving in some cases – is exactly the quality responsible for encouraging a disability orientation over time. The cognitive orientation, autobiographical coherence, and direction for treatment that are enabled by naming one’s emotional condition with the disorder label, eventually end up circumscribing the possibilities for the future within the definition of the labeled present. Instead of providing a hopeful direction to go toward the future as the label can in short-term identification, de-labelers warn against the danger of being sucked into a vortex of disabling identification in the long term. Eventually, de-labelers recognize that long-term identification with disorder identities is limiting to their growth and self-perceptions; this motivates them to disidentify themselves from the disorder identity altogether. Despite the decision to discard the labels, disidentification is not a straightforward process for most de-

labelers. Chapter Four discusses the obstacles that tend to stop them at the border of disidentification.

Chapter 4

Obstacles to Disidentification: Existential, Interactional, and Cultural Sources of Ambivalence

All de-labelers, by definition, ultimately decide to discard their disorder labels. However, the recognition that the label has “out-served its purpose” is often just the beginning of an emotionally arduous process of *recovering from recovery*. I use this phrase to refer to the process of disorder disidentification so as to highlight de-labelers’ sentiment that the long-term identification with the disorder label can itself become a problem that must eventually be overcome. In other words, the process of identifying oneself as “in recovery” from an emotional condition can create an additional set of “symptoms” from which one must “recover.” De-labelers’ experiences of recovering from recovery are expressed in what I refer to as the ideal-typical *disidentification narrative*. Whereas the recovery narrative reflects the short-term expecting orientation and the disability narrative communicates the long-term accepting orientation, the disidentification narrative is characterized by *ambivalence* toward discarding the labels, which is eventually resolved through a variety of *disidentification strategies* de-labelers develop to contend with such ambivalence. While the recovery and disability narratives emphasize divergent interpretations of the disorder identity (i.e., helpful/hindering; delimiting/limiting; containing/ constraining, etc.), the disidentification narrative tends to muddle these polar perceptions, as it highlights “mixed feelings” (Weigert 1991) toward the disorder identity. The disidentification narratives suggest that as de-labelers consider the possibility of discarding their disorder identities, they experience renewed attachment to the

positive aspects of the identity and concurrently reject the negative aspects. This chapter outlines the common sources of de-labelers' ambivalence on the existential, interactional, and cultural levels. Chapter Five completes the analysis of the disidentification narrative by addressing the corresponding strategies de-labelers' commonly employ to resolve their ambivalence. Together, these two chapters describe a process of recovering from recovery.

Ambivalence

The concept of ambivalence has two dimensions (Luescher and Pillemer 1998; Weigert 1991). One dimension highlights contradictions at the level of subjective cognition, emotion, and motivation. Weigert (1991) refers to this dimension as "psychological ambivalence." The other dimension, "sociological ambivalence" (Merton and Barber 1963), emphasizes contradictions at the level of social structure, expressed in conflicting normative expectations for behavior. Whereas psychological ambivalence is conceptualized in terms of "contradictory emotions toward the same object" (Weigert 1991), sociological ambivalence refers to the "opposing normative tendencies in the social definition of a role" (Merton and Barber 1963). In other words, the subjective focus zeroes in on individuals' feelings and expressions of ambivalence while the sociological focus highlights the social structural arrangements that may cause ambivalent feelings.

This analysis of de-labelers' ambivalence toward disidentifying from their disorder identities considers the role of ambivalence from both of these perspectives. For instance, my discussion of the existential sources of de-labelers' ambivalence

addresses purely the subjective experience of “simultaneous attraction and repulsion” (Weigert 1991) toward the disorder identity. Simultaneously, I treat the interactional sources of ambivalence as the result of a social dynamic of “entrapment” that can arise in the context of groups who are emotionally and/or ideologically dependent on one another (Smelser 1998). On yet another level of analysis, my consideration of the cultural sources of ambivalence suggests that there is a double message in the recovery discourse that places contradictory demands on those identifying as being “in recovery.” While these three sources of ambivalence are experientially interrelated, I distinguish them here for analytic clarity.

Existential Sources of Ambivalence

Exiting a disorder identity can be an existentially uncomfortable experience. Several de-labelers describe having gone through a period of questioning, “Who am I *now*?” after deciding to disidentify with their labels, and some talk about having anticipated the identity transition with a great deal of anxiety about a potential lack of self-meaning. These de-labelers describe the existential uncertainty that can accompany the decision to discard the disorder label as a profound source of ambivalence about disidentification. While de-labelers make it clear that continuing to identify with the disorder label in the long-term is experienced as limiting, the prospect of discarding the label prompts an appreciation for the sense of self-meaning they have derived from it.

As de-labelers’ narratives of the short-term identity career suggest, the disorder label offers an important source of self-meaning by providing both a cognitive framework for

understanding one's troubling experiences, as well as a template for interpreting one's past experiences and anticipating the future. The disorder identity thus becomes deeply implicated in one's autobiographical narrative and reinforced through the identity whirlpool. In a sense, then, to discard the disorder identity requires extracting oneself from a source of identity has become existentially foundational.

What makes discarding disorder identities, in particular, so existentially unsettling is that it involves a transition from a culturally marked category to an unmarked one. While many identity transitions involve a shift from one identity status to a subsequent "ex-role" (i.e., employee to retiree; spouse to divorcee; native to immigrant) (Ebaugh 1988) disidentifying from emotional disorder labels does not involve adopting a new, labeled status. Rather, the transition moves the exiting individual from a socially marked, culturally recognized status (with associated support groups, national organizations, media attention, and self-help literature directed toward that status) to a completely unmarked, unrecognized *non-identity*. Instead of replacing one identity with another one (as when a transsexual trades one gender identity for a new one) this identity transition requires individuals to simply forfeit a source of identity.

This notion of a non-identity that results from discarding disorder identities is significantly different than the "ex-role" that Ebaugh (1988) elaborates. Her concept highlights the way in which the new "ex-" identity incorporates the "role residual" from the former status. She is predominantly concerned with the ways in which individuals are able to account for their "current role occupancy . . . on the basis of who they used to be"(5). The centrality of the "role residual" in Ebaugh's analysis of "becoming an

ex-" is not characteristic of the identity exit that de-labelers describe. Instead, they emphasize an *absence* of identity, as a result of relinquishing a culturally marked identity without having an identity with which to replace it. This emphasis is better captured by the notion of a non-identity.

In addition to letting go of a marked identity in a cultural context that does not provide a marked ex-identity, de-labelers face an additional existential challenge in their exiting processes. Almost unanimously, they choose to discard the label because they become aware of the internally limiting consequences of disorder identification. Many de-labelers explain that this recognition initiates a questioning of the nature and consequences of identity, more generally. For this reason, many conclude that simply replacing their attachment to the disorder identity with another categorical entity would not help them to avoid the limitations that prompted them to discard the disorder identity in the first place. This creates an existential predicament for a number of de-labelers after they decide to discard their disorder identities: they are faced with an *identity void*.

I adapt this term from Ebaugh's concept of the "vacuum" which she uses to describe the transitional stage between two social statuses. She focuses on the anxiety individuals experience after deciding to exit former social roles but before fully establishing themselves in their subsequent roles. My concept of the identity void differs in that it draws attention to the experience de-labelers describe of choosing to exit their disorder identities without intending to create a replacement identity. The anxiety they report is not so much about a "limbo" between two roles as Ebaugh's concept emphasizes, but rather it is about the prospect of letting go of a former

identity with an awareness of the potentially self-limiting consequences of recreating a replacement identity. For these de-labelers, discarding the disorder labels is better characterized as walking into an identity void than as straddling two distinct identities.

For this reason many de-labelers describe feeling a tremendous reluctance to turn in their illness identities. Anne's narrative offers some insight into the experience of the identity void. In her story about her exit from her identification as a "multiple" she explains why it can feel desirable to hold onto a label even after determining it has "out- served its usefulness." After having considered herself a "multiple" for many years she became aware that she "needed to be very cautious" about using the words "I am" in reference to her label. She ultimately came to believe, "By saying it over and over ('I am this; I am that') we start to define ourselves in a way that's hard to break because we really believe that's who we are, as opposed to being more than that." Despite this insight, however, the prospect of disidentifying with a label that had provided a way for her to understand her experience for so many years was unsettling. Articulating her reasoning for wanting to maintain her disorder identity, she poignantly explains, "It can be so comforting to know who you are, even if it's a false self."

Like many de-labelers Anne describes having experienced a sense of ambivalence about her disorder identity; on the one hand, she recognized that her disorder identification was a partial, limiting stand-in for a more complex and accurate sense of self, while at the same time, she felt attracted to its self-defining simplicity. The dynamics of such ambivalence are elaborated in Marris' (1974) analysis of the social psychology of loss and change. He suggests that in instances of uncertainty,

our conservative tendencies come into conflict with the demands for change. We can have both an attachment to the security of the past as well as a simultaneous attraction to the potential changes in the future. This tug of war between the past and the future, the known and the unknown, the static and the dynamic, is common in the narratives of de-labelers, and it contributes to an existentially challenging experience of self during the process of recovery from recovery.

Naomi's narrative offers a striking example of an extended experience of such ambivalence. She was diagnosed with "MPD" and was hospitalized in an intensive MPD unit where she was assumed to be a "textbook" case of the disorder. The staff's assessment, she recalls, was that "if I wasn't MPD, nobody was." There was, however, much more conflict in her own understanding of her condition. She describes a dual relationship with her disorder identity: on the one hand, she claims that she always doubted whether the diagnosis was accurate, and at the same time, she was deeply attached to the label. She describes feeling great anxiety at the very thought of not having that label with which to identify. Describing these contradictory feelings she explains:

I knew this diagnosis was wrong on a level that was not allowed to be discussed...But at the same time I had become terrified that if anyone contradicted the idea that I was a "multiple," then what in the hell had my life been about? . . . If I wasn't 'multiple' then what the hell was going on? I was very invested in, 'You better believe me! Don't you dare tell me I'm not 'multiple'. And, on another level I knew I wasn't.

Naomi struggled with this dual understanding of her identification for several years. So much of her self-understanding depended on her disorder label, and yet she was also eager to let it go because she was simultaneously convinced that "this was not [her]

story.” She had, however, “invested” so much of her sense of self into this label that the prospect of discarding it was “terrifying.” Albert (1977:488) recognizes this tendency to want to maintain self-consistency. He articulates this desire as one of the defining principles of his Temporal Comparison Theory: “[I]ndividuals are motivated to maintain and protect a sense of enduring self-identity despite the possibility of growing evidence that they are undergoing change.” While he does not elaborate on the consequences of disrupting this sense of self-consistency, Naomi and other de-labelers suggest that it can involve an existentially challenging sense of identity void.

This identity void is also what Thor claims was the most challenging aspect in his identity transition. He had strongly identified as a “codependent” for about two years and had even participated in an intensive, residential codependency clinic. When he began thinking that the label had “outlived its purpose,” he said it was still a “long process” to get to the point where he could fully discard it. He concedes that giving it up was “not something that could happen in a day,” explaining that he had “a lot invested” in his identification with the label because “it had served an important role for me . . . if I gave it up I was afraid I’d be back to the nebulousness, just free floating . . .” Most de-labelers suggest that the primary value of identifying with disorder labels is that it minimizes the discomfort of feeling that “nebulousness” and sense of “free floating” that Thor describes. Thus, as Thor points out, to give it up evokes the fear of cognitive chaos, of not “knowing what I am.” Recognizing the labels’ role in quelling existential fears offers further insight into the attachment de-labelers describe toward their disorder labels.

The reluctance to relinquish their disorder identities that Anne, Naomi, and Thor describe is reinforced in Lettie's narrative about disidentifying from her "bipolar" label. She had been diagnosed by a psychiatrist in college and over time came to believe that "this is who I *am*." Her transition out of the identity was inspired by a friend's suggestion that she, in essence, is not "bipolar" but rather a complex person who happens to experience some particular emotional challenges. The friend suggested that she view it as similar to having an illness such as diabetes, and she challenged Lettie to question, "Why it is it that we consider someone to 'have' a physical illness but to 'be' a mental illness?" That suggestion was a revelation for Lettie, and soon thereafter she adamantly declared, "I am not bipolar!" She goes on to explain, "Then, I wrote two and a half pages of all the things I am not: I am not all this stuff that had been my labels, identities, boxes, things that I had put on myself and others had put on me." Although making that statement and writing those pages was a profoundly transformative moment for her, it was followed by what she describes as a disturbing "morning-after experience" in which she found herself "terrified" to realize that "although I now knew who I was *not*, I had no idea who I *was*!" The existential anxiety created by this identity void made her question whether her decision to disidentify from her label "was a good thing or not."

The anxiety of this existential uncertainty can present a serious obstacle to the disorder identity exiting process. Identity transitions of any kind can be difficult, but when they involve giving up an identity without the cultural support of a recognized ex-identity, there can be a disconcerting sense of existential loss. This is compounded when the exiting process is actually prompted by a questioning of the nature and

consequences of personal identity itself. Consequently, the identity void posed a difficult obstacle in de-labelers' process of recovery from recovery.

Interactional Sources of Ambivalence

In addition to the existential anxieties about displaced identity, de-labelers also describe interactional influences that make exiting disorder identities especially stressful. Despite their expressed desire to disidentify from the disorder labels, de-labelers' narratives commonly describe an experience of ambivalence about discarding the collective identification. This is especially common among the individuals who participated in support groups or associated with other people who shared their disorder labels. This response to the desire to leave such a group is recognized in Neil Smelser's (1998) analysis of the ambivalence that tends to accompany social solidarity: "When we bond with people deeply, or even superficially we become to some degree less emotionally free as a result . . . [F]reedom to leave – choice – is restricted because it is costly politically, ideologically or emotionally." He suggests that groups that exist on the basis of shared ideology or emotional support can breed a form of mutual dependence that fuels a sense of "entrapment," and thus ambivalence.

This ambivalence is expressed in de-labelers' narratives as both a sense of guilt and a sense of fear about disassociating with the collective identification. The guilt is a consequence of individuals' feelings of indebtedness *toward* the group; I call this the *deserter complex*. The fear stems from an anticipation of being ostracized *by* the group for choosing to disidentify with the label; I refer to this dynamic as *reverse*

stigmatization. Both are expressions of ambivalence that add complexity and distress to the disidentification process.

Deserter Complex

The deserter complex is characterized by a feeling of obligation to remain involved with the recovery group and the resulting sense of guilt for choosing not to fulfill this obligation indefinitely. This sense of obligation to the group even after they no longer consider the disorder identity to be beneficial can be understood by considering the type of solidarity that is often generated in these small groups. This phenomenon is addressed in Kevin Hetherington's (1998) theory of modern, small-group identification. His argument is based on the assumption that "identity . . . is fundamentally about issues of belonging, expression, performance, identification and communication with others" (62). Reflecting this assumption, he characterizes the process of identification, particularly within self-help groups, as "neo-tribalism" (4). For Hetherington, what characterizes these modern "neo-tribes" is an "affectual solidarity" that is based on emotional ties with fellow group members as opposed to relations that are produced by tradition and custom, as described by Durkheim's (1893) notion of "mechanical solidarity." The significance of a solidarity rooted in friendship and support is that the group identification is an "elective" identity that is held together by individuals choosing to affiliate. For this reason, the often-intense social bonding that takes place is not very robust because it can be threatened by the prospect of individuals electing to terminate their participation.

Therefore, a considerable amount of effort is required to maintain strong group cohesion by constructing a shared sense of identity through routine “performances of one’s commitment to the group’s goals, and through identification with its ethics of aesthetics and tribal symbols” (Hetherington 1998:98). Consequently, the stakes of continued involvement in the group become quite high for both the prospective defector as well as for the fellow group members. It is in this context that many de-labelers describe feeling compelled to continue identifying with the label even after they no longer considered it to be useful.

De-labeler Reina describes having experienced feelings of solidarity guilt when she decided to minimize her involvement in the regional, telephone support network she had established for people suffering from anxiety and panic attacks. As the founder, Reina had developed a reputation within the network as being an especially supportive, sympathetic listener for “phobics” who called her in need. Similar to the Twelve-Step philosophy, her network was founded on the principle that identifying with fellow sufferers and sharing similar experiences is mutually beneficial for both participants’ recovery processes. As her own “recovery” progressed, however, she found herself less interested in talking about anxiety and decided to remove herself from the network she had built. She experienced a great deal of guilt when someone would call, and she would have to tell them that she does not have the time to talk that she used to have. This guilt created a troubling sense of ambivalence for Reina about dissociating herself from her recovery community. In her guilt she would question herself, “Am I still a good person?”

In another example of the deserter complex, former “co-dependent” Judy felt that after several years of participation in Codependents Anonymous, she had “outgrown” the group and the disorder label associated with it. Despite this recognition, deciding to exit was not straightforward, as she suffered from guilt for deserting the group that had, at one time, been so helpful to her. Judy explains that even though she was “ready to move on,” she remembers:

I felt like I was abandoning them . . . I thought I was supposed to stay. But, then I realized I can't rescue anyone. I had to do this for me. It's not that I didn't want to pay back what the group had done for me . . . [but] I came to realize that I had been giving all along by participating in the group, even in my need. The hard part, though, is letting go.

This sense of ambivalence and guilt about abandoning one's fellow sufferers parallels a theme that is common in many class mobility narratives. As an example, in Carolyn Leste Law's (1995) introduction to her co-edited volume on working class academics, she laments the feeling of alienation from her family that her career in academia has created. She admits:

The pride I feel in my academic and professional achievements, generously applauded by the institutions of higher education that . . . believe that I am their success story, is always tempered by the guilt I feel in having chosen a life path that has made me virtually unrecognizable to my kin. This book is about the ambivalence inherent in trajectories such as mine. (1-2)

Law explains that this ambivalence is often experienced by the family of origin as well as by the socially mobile son or daughter. She contends that many working- class families send their children off to college “hoping for them the realization of the American Dream;” but they often do so with mixed messages: “[D]o well but don't get too smart; succeed but don't make us look stupid; pursue your lofty goals with enthusiasm but don't become one of ‘them’ (5).”

This ambivalence is symptomatic of the tendency for relationship maintenance to encourage the status quo, while mobility trajectories depend on change, by definition. This same formal dynamic characterizes relationships formed within a recovery setting; while these relationships are formed in the context of a presumed mobility trajectory, attachment to the association may actually discourage change. Psychiatrists Ben Burnsten and Rose D'esopo (1967) allude to this phenomenon in their recognition of subtle pressures on the mentally ill from significant others that can create an unspoken "obligation to remain sick." They point out that this dynamic can be difficult to see, and thus to counter, because those who care for the ill person are unlikely to express expectations that contradict their overt helping efforts. The authors conclude that, in some cases, failure to recover from mental illness may actually be the result of the ill person's "compliance with the demands of others" (218). This observation supports de-labelers' narratives in suggesting that the deserter complex can be a powerful inhibitor to discarding one's disorder identity even after identification is no longer considered advantageous. This interactional source of ambivalence highlights the irony that solidarity with other "sufferers," who can initially be so supportive of personal change, can eventually become an obstacle to that desired change.

Reverse Stigmatization

De-labelers' narratives reflect concern about negative reactions to their decision to disidentify from disorder identities in an additional way: despite their desire to leave the recovery community, they fear being ostracized for their decisions. This

fear of criticism creates an additional form of ambivalence toward disidentification. The prospect of losing close friends or being considered “in denial” is a difficult prospect for some individuals to face. This ostracism from the group (actual or anticipated) can be understood as a form of “stigma” for behaving as a “deviant,” from the perspective of the group of labeled individuals. I refer to this as *reverse stigmatization* because traditional conceptions of stigma assume the culturally dominant “normals” (Goffman 1963) to be the “reference group” (Shibutani 1955) according to which the stigmatized “deviants” are defined. In this case, the reference groups are reversed. De-labelers’ narratives suggest that this reverse stigma (or even the perceived potential for it) can be quite distressing and can discourage disidentification.

Gretchen’s narrative illustrates this when she discusses her fear of stigmatization by her recovery community for choosing to discard her “addict” identity. As a college student, she had lived in a special dorm for recovering students, regularly attended AA and NA meetings, and interacted only with friends who were “in recovery.” As she puts it, “My whole life was recovery!” When the semester ended she moved out of the recovery dorm and chose to stop going to meetings. Despite her conviction that she had made the right decision for herself, she finds herself “deathly afraid of the judgments” of her “recovery friends.” Anticipating their reactions she admits, “I know I’ll look like a failure to them. Even though I don’t see it like that, to them I am. I dread that.” Although this fear did not ultimately prevent her from exiting the disorder identity, she admits that even now (several months later) she has remained fearful of encountering friends from recovery and facing the anticipated criticism.

Gretchen's sentiments parallel the experiences of Ebaugh's (1988) informants in her study of the process of "becoming an ex-". She explains that in the most extreme cases, the negative reactions from family and friends actually halted the exiting process for five or more years. Although Gretchen's fear of being ostracized by her friends does not ultimately prohibit her from exiting the disorder identity, her anticipation of carrying the stigma of a "failure" did put her through a good deal of distress. Her experience parallels Bruce Link's (1989) "modified labeling theory," which highlights the negative consequences of adjusting one's behavior out of the fear of anticipated stigmatizing social reactions. While his theory treats "normals" as the reference group from which stigmatized reactions are anticipated, Gretchen's narrative suggests that a similar dynamic can play out even when the "in-group" and "out-group" (Sumner 1979 [1906]:12) are reversed.

In an analogous case, Arlene Stein's (1997) analysis of "ex-lesbians" offers a poignant illustration of the tremendous fear that can be involved in anticipating reverse stigmatization. Quoting one of her informants, Stein presents a theme that comes up in the narratives of several of her informants. She explains that ex-lesbian Laura admits to being "'terrified' of running into people, either alone or with her male partner." While her closest friend seems to respect her decision, she suffers from feeling that to her "second-tier friends and acquaintances, [she] was a traitor" (171). Similar to many de-labelers, Stein comments that many former lesbians experienced disapproval from their friends, a loss of community, and a sense of being "divided between their loyalty to other lesbians and their own yearnings" (172).

The fear that underlies this divided loyalty may play a significant role in shaping behavior, even if one is not aware of it at the time. De-labeler Alexandria's narrative draws attention to the subtlety of this dynamic. She explains that she did not consciously experience the fear of reverse stigma, but she realizes in retrospect that a fear of rejection from her "AA friends" had nevertheless been influential in her attachment to her "alcoholic" identity. She explains that, even after 14 years of sobriety, it had never crossed her mind to question whether or not her "alcoholic" identity was still useful to her; it was only after she moved to another state, and thus had much less at stake socially, that the thought even occurred to her that perhaps she did not need to continue to identify as an "alcoholic." As she recalls, "Before I moved, I just wouldn't have done it [disidentified with the label] because I have too many friends in A.A. who wouldn't agree. When I got here [to her new community] and hadn't started going to meetings yet and found that I was fine, I thought, 'Maybe I just don't need to go anymore'. Alexandria's experience suggests the significance of reverse stigmatization more profoundly perhaps than any of the other narratives. Her story highlights the way in which one's attachment to the group and desire for their approval can create such a strong fear of ostracism that it can prevent one from even experiencing ambivalence about disidentification because it discourages even considering an exit!

Cultural Sources of Ambivalence

These interactional sources of ambivalence are not only a consequence of individuals' idiosyncratic attachments and fears; neither are they strictly the product of

interpersonal dynamics between specific de-labelers and the members of particular recovery groups. The ambivalent emotions that underlie de-labelers' ambivalence about leaving the recovery community can also be understood as the outcome of an unspoken contradiction within the larger cultural discourse of recovery. That is, the notion of recovery implies an orientation toward change, but the discourse tends not to include reference to the possibility of an exit from the disorder identity. The discourse's tendency to neglect consideration of an eventual disidentification creates a cultural expectation that disorder identification is (or should be) permanent. Thus, when individuals opt to discard their disorder identities, they inevitably become cultural deviants because the discourse does not recognize them.

From this perspective, individuals who identify themselves as being "in recovery" from an emotional disorder can be viewed as occupying a social role with contradictory normative expectations: they are simultaneously expected to work toward "recovering" from their troubling conditions and to remain identified as disordered indefinitely. This built-in contradiction in the "recovery" status can thus be understood as an instance of sociological ambivalence, which consequently, makes disidentification from disorder labels especially challenging.

As an example, Stacey's description of her experiences with the Supplemental Security Income (SSI) system illustrates the contradictory expectations she felt as someone who identified as a sufferer of Post Traumatic Stress Disorder (PTSD). Stacey explains that, until recently, her anxiety symptoms made holding a job impossible, and so she depended on disability benefits for survival. She is now employed in her first part-time job since the diagnosis but does not feel quite ready for

a full-time position. In the meantime, she continues to claim eligibility for half of her original SSI benefits because her salary as a part-time employee is only about \$600 each month. She explains that although she no longer identifies with her diagnosis, using the disorder label to claim benefits makes complete disidentification from the label difficult:

One of the difficulties for me now is that on the one hand, I don't want to be limited by a label or think I'm limited because of what I've gone through. But, at the same time, in terms of losing my benefits, sometimes I find myself having to argue for the limitations, and that's really frustrating for me. I don't want to be arguing it so convincingly that I start to convince myself!

While this source of disability assistance is intended to assist individuals only for the duration of their incapacitation, Stacey finds that the system itself encourages her to remain more identified with herself as “disordered” than she would if she were not dependent on the benefits. Estroff (1981:242) echoes Stacey’s observation in her analysis of the “undermining” consequences of SSI and other income-maintenance programs. She suggests that it is “paradoxical” that employment tends to be recognized to as having therapeutic benefits, but the SSI system “simultaneously invit[es] [clients] not to need to work if only they demonstrate how disabled they are by not working.” Despite the fact that SSI eligibility operates according to symptom-based criteria, there is a tacit expectation that qualifying as emotionally disordered reflects a permanent trait as opposed to a transitory state of emotional difficulty. Thus, Stacey is faced with contradictory expectations: she is only supposed to claim disorderhood as long as necessary, but she is also expected to remain disordered indefinitely. This contradiction spawns an experience of sociological ambivalence.

While individuals like Stacey describe sociological ambivalence within the specific context of qualifying for disability assistance, the contradictory expectations of the recovery identity are based within broader cultural trends. One such trend involves the increasingly prevalent assumption that disorder labels are needed in order to understand and cope with difficult life experiences. This assumption can be seen as symptomatic of the ubiquity of what Philip Rieff (1966) named the “therapeutic culture” in the 1960’s. The four decades since then have seen an expansion of this cultural trend, encouraged by an ever more widely accepted worldview that John Steadman Rice (1996) calls “liberation psychotherapy.” This worldview understands psychological sickness to be the result of the “repressiveness” caused by “*any* imposition of collective will” on the individual (32). Such a broad interpretive orientation allows even the most common experiences of emotional difficulty in life and relationships to be open for psychotherapeutic interpretation.

Keith and Vicky’s narratives illustrates how this cultural orientation makes a psychologistic interpretation of life’s challenges readily available. For example, when Keith tells of how he came to see himself as “codependent,” he explains that because he was unhappy and having problems in his marriage he felt he “had to go somewhere,” implying that he should participate in some kind of therapeutic setting. He says that he went to an Al-Anon¹⁴ meeting “because it was available” and he was “familiar with the name.” When Keith eventually concluded that he had “gotten all that [he] could” from Al-Anon, he continued to believe that he “had to go somewhere.” His mother had recently begun to identify as a “codependent” and suggest that he fit the

¹⁴ Al-Anon is a Twelve-Step group for adults and friends of alcoholics.

profile. With this suggestion, Keith began attending CoDA meetings and identified as a “codependent” for the next decade.

Similarly, Vicky explains that after five years of AA membership, she concluded that she was not an “alcoholic” but found herself assuming, “I should be in *something . . .*” She explains:

I went around and around and could never figure out which group to go to: Should I go to AA again? No, that doesn't fit anymore. Should I go to an Adult Child meeting? Al-Anon? Nothing really ever fit right so I ended up never going back, but many times I thought maybe I *should*.

Keith and Vicky's narratives about feeling compelled to have a label to understand their emotional problems reflect the cultural encouragement offered by an increasing number of institutions that provide resources for constructing and maintaining self-stories around what Gubrium and Holstein (2001) refer to as the “troubled self.” This model of self includes identities that are structured around notions of having “‘too much’ or ‘too little’ of every conceivable combination of thought, feeling or action” (9). This template of the troubled self has spawned self-help and recovery groups for “troubled” behaviors as diverse as “sexual adventuring, love and romance, spending, shopping, religious faith and observance, child and spouse abuse, incest, [and] relationships” (Rice 1996: 8). Rice (1996:139) argues that these groups fill a cultural gap in the wake of the “ethical shift” he refers to as “liberation psychotherapy,” which has helped to weaken individuals' connections to traditional relationships and institutions such as “families, neighborhoods, communities, and the like” in the pursuit of individual autonomy and “self-actualization.”

This increased psychologization of everyday life and the interplay between the expert domain of psychological professionals and popular self-help culture and media representations further reinforces a cultural preoccupation with therapeutics (Becker 2005). As Dana Becker (2005:6) points out, “[T]he ideas that emanate from both the popular and professional cultures . . . are often combined, transformed, recycled, and used for purposes other than the therapeutic.” The result is a culture that increasingly views normal human emotion in pathological terms (Horwitz 2002; Kirk and Kutchins 1997; Sommers 2005). Frank Fruedi (2004:7) observes this cultural trend, commenting that the discourse of emotional difficulties “turns an expanding variety of experiences into sites where emotional survival becomes an issue. This is a perspective that persuades people to regard themselves as ill.” While public perception holds that emotional problems are increasing, he argues that this perception is largely due to the change in our “cultural imagination” (5). By this he is referring, for instance, to the way in which therapeutic vocabulary (i.e., “stress, anxiety, addiction, compulsion, trauma, negative emotion, syndrome, mid-life crisis [and] counseling” [1]) has become part of the way we understand and speak about normal challenges in everyday life. This therapeutic imagination has made its way far beyond the therapists’ office to become a common way of interpreting experience, as it is now evident in arenas as diverse as the judicial system, popular culture, politics, welfare services, and education (Fruedi 2004:10; Kirk and Kutchins 1992).

An integral aspect of this cultural development, as Horwitz (2002) explains it, stems from the transformation in mental illness construction that resulted from the publication of the third edition of the *Diagnostic Statistical Manual (DSM-III)* in 1980.

With it, a categorical system of diagnosing “disturbed behavior” replaced the “continuous, dynamic system” of understanding psychopathology that had been predominant in the psychological community since Freud. Horwitz notes that the array of human behaviors that have become diagnostically classified in the *DSM* has become so extensive that by the early 1990’s major community studies of mental illness were claiming that half of the U.S. population suffered from at least one mental disorder at some point in their lives. Suggesting the largely cultural origins of this phenomenon, Karp (2006:212) points out that “A 480% increase in the number of psychological disorders over 50 years cannot be the result solely from dispassionate scientific discovery.”

This transformation in our understanding of emotional disorder is not only a matter of increasing diagnostic categorization; the very nature of emotional disturbance has also come to be seen more and more in biomedical terms (Conrad and Schneider 1980; Horwitz and Wakefield 2007). Karp (2006:209) cautions, “With the increasing acceptance of the biomedical model, we begin to believe that more and more of our feelings are illegitimate and abnormal and require biological intervention to correct.” He asserts that the consequence of this belief, which is “unrelentingly pushed by pharmaceutical companies and some doctors,” poses a threat to “personal autonomy and responsibility” (208).

This unfortunate potential is suggested in several de-labelers’ narratives which reveal that an internalization of the disease concept of their emotional behavior was a source of great ambivalence about disidentifying from their disorder labels. Eva, for

example, was diagnosed as "clinically depressed" when she was in her early 20's.

She explains:

I was always told I had a 'chemical imbalance' and that taking this pill everyday would make everything wonderful. I was given various pills over a period of twenty years . . . The idea that 'depression' is an illness is so pervasive on TV, and I used to read articles in magazines and books, and these people like [William] Styron come out with these books and say they suffered all their lives, and they had a chemical imbalance and now they take this one pill everyday and everything is wonderful. I would read them, and I did kind of believe it was true – I really wanted to believe because I was unhappy, and I wanted to believe that all we had to do was find the right pill and everything would be wonderful. . . And, I was like most people, wanting to put my trust and faith in somebody else, especially the medical profession and have them tell me what to do.

Eva's eventual inclination to disidentify with the disorder label posed a challenge for her because of her desire to trust the medical system, as well as the cultural encouragement to feel that she should trust it. In retrospect, she realizes that in the hands of the psychiatrists, she had become "very passive and dependent; dependent on somebody else to figure things out." She eventually began to internally question the psychiatric authorities, but she kept it a private struggle because she had "never heard of something that was not a biochemical analysis [of depression]." Deciding to discard the disorder label was, therefore, so difficult because it required her to take a stand against a cultural authority when she believed that she was alone in her views. She emphasizes, "I always thought it [doubting 'the system'] was just me."

In the intervening two decades since Eva first adopted a biomedical explanation of her depression, that interpretive model has become even more culturally influential. To illustrate this trend, Horwitz and Wakefield (2007) draw attention to a national movement toward screening adults and children for undiagnosed cases of depression through such means as public announcements, educational campaigns, direct-to-

consumer advertising, and brief pre-screening questionnaires administered by physicians. It is reasonable to assume that the escalating ubiquity and cultural authority of this paradigm may make Eva's experience of not having "heard of any other analysis of depression" increasingly common.

De-labeler Ethan also expressed that the cultural pressure to view his emotional state within biomedical terms was a source of ambivalent feelings about eventually discarding his disorder label. He explains that he sought psychological treatment after the review board of the ministry evaluated him as "unfit for the ministry" during his ministerial internship. They encouraged him to get psychological treatment and to come back for re-evaluation. He enrolled in an intensive codependency treatment program because someone in his congregation had recently completed it and seemed to have been "transformed" by it. Shortly into the program, the director diagnosed Ethan with bipolar disorder and insisted that if he wanted to continue with the treatment he would have to take medication. The combination of the ministerial board's authority and the authority of the psychiatrist had a profound influence on his decision to take the medication. Although he admits that, at the time, he found the treatment to be "fabulous" and that he "learned a lot" from it, he subsequently struggled for many years with his desire to disidentify from the label after the treatment was over and he stopped taking the medication.

Whenever I'd have my tough or vulnerable times or feel depressed, that's when I'd believe that I am bipolar. . . when I'd be having a really hard time, then I'd think, 'They're right, there's something mechanically wrong with me; I'm this deficient thing; I'm this bipolar person; I am this defective brain person' . . . During the toughest periods of my life, I would be resigned to, "I guess 'I am'." It was a battle for years.

Despite the fact that Ethan no longer wanted to associate his emotional issues with the “bipolar” label after the treatment ended, he found himself unable to shake his belief that the “authorities” may be correct about his biochemical makeup. Even though he says he has always been highly aware of the way labels tend to “oversimplify” and “segregate” reality, Ethan’s experience concurs with other de-labelers in that he found the cultural prescription for viewing his emotional life in terms of (biochemical) disorder difficult to disregard. The strategies de-labelers use to resolve this cultural source of ambivalence (as well as the ambivalence posed by existential and interactional factors) are outlined in Chapter Five.

Chapter 5

The “13th Step”: Developing Exit Strategies

By definition, de-labelers have all resolved the existential, interactional, and cultural sources of ambivalence that posed obstacles to exiting disorder identities. Although the process of recovering from recovery is in many ways unique for each individual, their narratives suggest some common strategies for contending with these obstacles to disidentification. Collectively, I refer to these strategies as the *13th Step*. This term makes reference to the Twelve-Step model of recovery to emphasize that these strategies represent efforts by de-labelers to resist permanent identification with disorder labels, which the Twelve-Step paradigm epitomizes.¹⁵

These exit strategies draw attention to the asymmetry in the identification and disidentification processes. The process of identification with the disorder label, as highlighted by the notion of the identity whirlpool, can deepen one’s attachment to the identity with little or no conscious awareness of the process. Disidentification, however, requires conscious effort to extract oneself from the habituated identity. Identification can be imagined as a magnet that has the capacity to exert an attractive force on objects within its field, while disidentification can be likened to the energy required to yank a magnet away from the object it has attracted. Whereas the former occurs without intention, the latter requires directed exertion.

¹⁵ My use of this term does not suggest affiliation with the Twelve-Step model in any other way. I use the notion of the 13th Step to refer to any strategy of overcoming obstacles to exiting disorder identities.

This imagery of the magnet suggests that the processes of identification and disidentification differ in their involvement of individual agency and social structure. De-labelers' narratives suggest much more structural influence on the acquisition and maintenance of the disorder identity (i.e., through social and cultural encouragement to identify as "disordered"), while an element of agency is foregrounded in the process of disidentifying from the label. Clearly, an interaction between structure and agency are involved in both processes; however, examining de-labelers' strategic efforts to defy existential, interactional, and cultural forces that encourage identity inertia offers an opportunity to highlight the important place of agency in this dynamic. Thus, the notion of the 13th Step draws attention to the potential role of individual responsibility in disorder identification.

Expanding the Scope of Identification

A number of de-labelers claim that the process of reflecting on the consequences of their disorder identities initiated an examination of identity more generally. Several describe having experienced feelings of existential anxiety upon realizing that all identification functions in a similar way: it is always an incomplete approximation of a much more complex experience of self. Thus, the problem of the identity void that these de-labelers describe is not only that by discarding the disorder label they are left with a definitional gap in their self-constructions; the difficulty becomes much more profound when this particular process of disidentification prompts de-labelers to realize that replacing the forfeited identity with an alternative one will eventually lead them into the same existential knot. Several de-labelers

describe having consciously resisted the temptation to fill the existential space that is created by the abandoned disorder identity with some kind of a replacement, or *rebound identity*. As de-labeler Eliza reasons, substituting the discarded identity with any other personal identity “would put me back in the same place – another box I’d eventually have to climb out of!”

Stacey, who formerly identified with the diagnostic labels “major depression” and “post traumatic stress disorder” (PTSD), uses the same imagery to make a similar point:

For me, the thing about labels is how much they become a box that you then have to get out of...labels really limit you but to get beyond that you have to get rid of the box you’ve surrounded yourself with. All my labels have come into question through this process – even the positive ones. It’s been interesting that in sending off this [disorder] label, I’ve been going through a backward process of developing a new kind of identity . . . this has been a spiritual journey for me . . . These other labels don’t really work for me anymore with how I understand myself, in essence.

This contemplation of the inherent limitations of any identity resulted for many individuals in a quest for what de-labeler Ethan calls the “largest possible identification.” This identity-expansion effort is described in a variety of ways, depending on the individuals’ worldview. For instance, for a few de-labelers, the interest in a “more inclusive” identity inspired them toward a more conscious identification with “all humanity.” For these individuals, the impulse to identify in a way that would minimize the limitations of narrowly defined categories of self prompted them to more profoundly consider the common human experience as a source of identification.

Gloria’s narrative exemplifies this process. After having identified as “bipolar” for 15 years she became “really disillusioned with labels and diagnoses” because, as

she puts it, “It became clear to me over time that the answers the labels offered were not answers to questions I wanted to ask.” She felt that her deepest questions about “the meaning in life and a reason to pursue it” were not being addressed by fitting herself into a “little clinical box.” While she realized that continuing to identify as “bipolar” and “keeping the option of suicide on the table” was not helping her “get on with anything,” she was faced with a void of “meaning and hope and a reason to stay alive.” She claims that she found a significant level of resolution to this crisis when she began to prioritize her “very basic feeling of connection to humanity.” This strategy of emphasizing her sense of connection with humanity served as the bridge out of her existential chasm. She explains, “I began thinking about myself more holistically . . . and became a human rights advocate out of a desire for the world to stop doing violence to the beings that live in it. I started giving some serious thought to issues that were *much bigger than me*.” Out of this expanded sense of identification with the collective human experience, Stacey describes developing a sense that her life had “become meaningful and worth pursuing.”

Gretchen’s narrative also expresses her decision to view her identity within the expanded context of her membership in the human community. After seven years of developing “an entire personality” and “lifestyle” around being a “recovering addict,” she came to the conclusion that continuing to identify with the label had become “an exercise in futility” and that, over time, the identity had become “its own worst enemy.” Although discarding her disorder identity was uncomfortable because it forced her to face the “vast and complex human experience” and more acutely “grapple with her inner being,” she could not deny her desire to entirely shift the focus of her

identification away from the disorder identity and other identities she found to be limiting. For instance, she had strongly identified as a “vegan” and came to feel that the identification itself had begun to undermine the “original intention of non-violence.” She explains, “It got to the point that being ‘vegan’ was creating more judgment and division – like I’m more conscious or better than you because I don’t kill animals . . . at some point, I just wanted to break from it all.” Elaborating on her rationale, she explains:

I didn’t want to *be* anything anymore; I didn’t want to represent *anything*. I just wanted to be a neutral human being, like a conduit of existence, to put it in an odd way. I now believe that identification is the root of all violence . . . I just wanted to walk out into the desert, so to speak, and not *be anything* anymore. Ever since that time, everything that has to do with labels has left the same sour taste in my mouth. It’s not resignation; it’s just about being here and now . . . just being a human being.

Despite the fact that choosing to exit the disorder identity had caused Gretchen a great deal of “inner friction,” she feels that her decision to expand the scope of her identity beyond the confines of rigid individuality gave her a sense of “strength to face the big mystery.”

For several other de-labelers, this quest for a “more inclusive” sense of identification led them to considerations of spiritual conceptions of identity in order to broaden the context of their self-inquiry. For many, an identification with a transcendent absolute turned out to be an important strategy for contending with the identity void that posed an obstacle to their disorder identity exit. It is not new to suggest that religion and spirituality can benefit psychological health; however, sociological research most commonly emphasizes religion’s cognitive value of serving as an interpretive system for making sense of difficult experiences as well as providing

a source of social support enjoyed by active members of faith communities (Idler 1987, 1995). De-labelers, however, consistently describe their attraction to non-secular notions of identity with a very different explanation: they reason that identification with an absolute (i.e., “God,” “universal energy,” “higher power,” “the Divine,” etc.) is the only identification that would not subject their self-perceptions to the limitations of all other personal identities because it is the only identity that could be considered thoroughly inclusive. After becoming disillusioned by the limitations of personal identities, these de-labelers describe a desire to find a way to satisfy the existential impulse to comprehend “who” they are without falling into the same categorical constraints that they had chosen to exit.

Daphne, for example, claims that her “spiritual path” was instrumental in her ability to let go of her identification as a “schizophrenic” because it gave her a “larger perspective” that helped her to be “less attached” to her difficult experiences. She explains that the teachings of her “Indian spiritual teacher” helped her to “learn some other ways of thinking about [herself] and different ways of looking at things without labels. . . because the body is transient, just a kind of tool to go through the experiences you need to go through. ” Daphne recounts that her teacher’s most fundamental teaching is that “everything is God, the whole material world is a manifestation of God, not something separate from God.” Adopting this perspective facilitated a shift in her understanding of herself and her relationship to the disorder label, and it helped to support her during the difficult transition from identifying as “disordered.” Enthusiastically she explains:

Thinking in terms that I’m a manifestation of God is a much bigger concept than

being a mental patient! [Identifying as ‘schizophrenic’] just seems so limited to me now; it seems laughable to think in those terms. My teacher says that ‘the earth is a hospital and everyone is a patient on a spiritual level because we’ve all forgotten who we really are, which is God!’

Reinforcing her point, Daphne quotes a popular aphorism to summarize the essence of this shift in perspective: “We are not human beings having a spiritual experience but spiritual beings having a human experience.” By interpreting her psychological condition within the context of what she sees as the “human predicament,” she is able to de-emphasize the importance of the psychiatric label in her self-definition and is instead able to highlight her essential identification with all people.

Cara’s story illustrates a similar realization. After spending over three years in intensive in-patient treatment for “schizophrenia,” she became free of “auditory hallucinations” and was discharged from the hospital. Although she spent another several years as an outpatient, she no longer identified with the label “schizophrenic” after her discharge. Remembering the difficulty of that transition, she recalls:

After I was discharged from the hospital and starting to begin my life, letting go of the label was the hardest thing because it had been a part of me for so long. I had to actually grieve for it. I mean, I had had auditory hallucinations day and night for four straight years. . . part of me had to grieve because the schizophrenia was familiar; I knew the terrain very well. Even though it was miserable and I hated it, it was familiar. . . it would have been so easy to let myself slip back . . . out of the fear of the unknown. . . My doctor enabled me to grieve and let go of it. Once that happened, the identity of having schizophrenia was never an issue. If I hadn’t had someone to process those feelings with, it could be easy to just hang onto the label.

In addition to the support she received from her doctor, Cara attributes her ability to face the identity void to a sense of spirituality that was developing as she recovered. During her process of “rebuilding a sense of self,” she explains that she systematically

repeated the affirmation, “You are a child of the universe.” This statement reinforced her growing sense of interconnectedness with all life:

I had always been aware of something inside, like an itty bitty light, even when all the voices were going on. When I started the slow process of getting better, it seemed like that light, that presence, grew – it’s this wonderful sense of God or the Divine that has never left me; it just keeps growing. Being able to meditate and go within and connect with that presence is what makes me feel that life is worth living and helps me to see a greater reason for all this. It has been quite a journey, but it has given me such a profound respect for *all* life and gratitude for people.

While individuals define and pursue the “largest possible identification” differently according to their various worldviews, the underlying motivation for this strategy of expanding one’s identity is summed up best by de-labeler Anne’s decree, “Just go wider!” Explaining what this means to her she states, “[Disidentifying with the label] is not about denying anything; it is a process of stepping outside the label into a larger reality. It’s that larger context that gives everything new meaning. You’re not denying anything, you’re just going wider. Bigger, bigger, wider, more. . .”

Developing Alternate Social Networks

As described in Chapter Four, a significant part of de-labelers’ reluctance to exit the disorder identity is explained as an attempt to avoid the reactions (or anticipated reactions) of the people who shared their identification with the disorder label. A number of de-labelers agonized about the deserter complex and feared the possible reverse stigmatization. Their efforts to contend with these fears can be understood in terms of Goffman’s (1961b) “role distancing” strategies. These are actions that are intended to convey to oneself and to others a disassociation with the role one is performing (in this case, being “in recovery”). The most common distancing strategy

for dealing with these interactional obstacles involves an intentional decision to change one's social environment. At some point in the disidentification process many de-labelers describe beginning to involve themselves in activities that require them to associate with new groups of people in contexts that are not related to recovery. In a number of cases, this is explained as a strategic effort to minimize the pressure from their recovery associates to remain identified as "disordered."

Stanton Peele (1989:198-99) recognizes the value of changing one's social context in the process of "transcend[ing] one's previous [recovering] alcoholic identity." This level of change, he asserts, requires "establish[ing] new life patterns, including relationships and work and leisure activities." This, he argues, can help individuals to "adjust their self-image so that they see themselves as having gone beyond the role of recovering alcoholic . . . having an entirely new range of possibilities and obligations." This strategy of changing one's social network in order to change one's self-perception is consistent with a Symbolic Interactionist view of self, originating with the social psychological insights of early pragmatists such as William James, Charles Horton Cooley, and George Herbert Mead. This approach suggests that "the self-view emerges from the reflexive activity of self-categorization and identification in terms of membership in particular groups or roles" (Stets and Burke 2000:226). It follows, then, that the effort to create a new identity is aided by changing one's social context.

Judy's story illustrates how she used this sociological insight to cope with the issue of the deserter complex. She experienced guilt about feeling that she was abandoning the members of her co-dependency support group after several years of participating. She explains that after she came to the conclusion that she "just had to

leave the group,” she strategically “got busy to make leaving easier.” Judy describes getting “busy” in a variety of new social contexts, such as involving herself more in several of her son’s extracurricular activities, taking up new interests, and joining a Toastmaster’s group. Participating in these new settings eased the transition because they allowed her to foreground aspects of herself that are unrelated to the disorder identity because the “codependent” identity was not the focus of the social interactions in these other contexts. In time, she found that her codependency identity had receded into the background and that her relationships and interests had “just moved onto other things.”

Similarly, Reina describes experiencing a great deal of guilt when she removed herself from the peer support organization that she had founded. Her strategy for coping with this guilt was to find a completely new context in which to help people. She asserts, “At a certain point, anxiety issues just stopped calling to me in the same way . . . so I don’t need to be so engaged in the issue anymore. And, I wanted to free up some time to put my attention on other things.” Reina explains that she began teaching community classes and workshops in other areas that do not revolve around issues of anxiety or emotional disorder because she now finds it “much more fun to teach things that have to do with a larger, more holistic way” of looking at life issues. Although she admits that at times she struggles with bouts of guilt when people call her for support with their anxiety issues, her new involvements have helped her to maintain distance from the anxiety disorder community while still fulfilling her desire to be helpful in her community.

De-labelers who express a fear of being the target of reverse stigmatization from the people with whom they have shared their disorder identification describe using the same social strategy that de-labelers employ to handle the deserter complex; they develop new social networks. Ebaugh (1988) recognizes the value of this strategy in the process of role exiting. She refers to such social involvements as “bridges” to emphasize their value as a transitional aid. She notes that individuals who had pre-arranged involvements in alternate jobs, relationships, and hobbies before exiting had a “far easier adjustment” than individuals who exited without such “bridges.” As a general rule, Ebaugh suggests that “there seems to be a direct relationship between the number and quality of bridges and the degree of role adjustment and happiness after the exit.” Thoits’ (1986) research on the consequences of occupying multiple social roles supports Ebaugh’s observation. She suggests that a greater number of social roles has positive consequences for one’s mental health, as it decreases one’s dependency on any one activity or individual.¹⁶

Kasey’s narrative supports Ebaugh’s observation. Her narrative suggests that having sources of social support outside of the recovery context can mitigate the fear of reverse stigmatization. She mentions that she did not experience any fear of ostracism when she chose to discard her “alcoholic” identity after nine years because, as she puts it:

I never relied on AA for complete social support. I still had a few friends from my drinking days that weren’t drinking. And, I made new friends at work and things . . . So, I never experienced any ostracism or anything. For some people, the only friends they have are in AA.

¹⁶ As Thoits (1986) and Rosenfield (1989) point out, however, the benefit of occupying multiple social roles does not hold if the roles are highly demanding. Multiple high-demand roles tend to increase symptomatology.

Because Kasey never made the recovery community her sole source of support, it was easier for her to replace the group with other relationships because they were already established in her life. Consequently, she was able to place less emotional weight on the judgments of the group members which likely helped to reduce the fear of rejection that many de-labelers experienced. For Kasey, exiting the disorder identity was thus less a matter of reinventing herself through new social involvements, and more a matter of shifting the emphasis from one “reference group” (Shibutani 1955) to another.

Redefining Recovery

De-labelers describe having felt cultural constraints on their identities in a variety of ways, but their strategies for managing these constraints in the process of exiting their disorder identities share the same underlying theme: these individuals make intentional efforts to de-glorify the authority of the psychiatric paradigm and instead claim definitional authority for their own conditions. By giving themselves permission to interpret their own situations, they simultaneously withdraw authority from the cultural institutions that they had previously allowed to define their emotional troubles.

This process of relocating the authority to define oneself from an institutional source to a subjective source highlights the potential for individual agency in identification. This exercise of agency in resisting dominant cultural discourse on illness and disorder does not, however, mean that individuals have control over the way they are perceived by others; it simply means that individuals have some amount

of freedom in their own perceptions of their personal identification. Cheryl Mattingly (1998) reinforces this possibility in her study of narrative identity in the occupational therapy setting, suggesting that “what constitutes healing is often more a matter of how the patient comes to see him/herself than any actual physiological change” (163). Agency in identification is, of course, limited by the fact that self-identification always takes place within a sociocultural context that informs fundamental understandings of individuality and selfhood (Somers 1994). De-labelers’ narratives do, however, suggest that there is a certain amount of subjective maneuverability with regard to personal identity.

This interpretive liberty in emotional disorder identification is enhanced by the fact that, in many cases, the symptoms of emotional disorder are ambiguous and subject to a great deal of definitional flexibility (Brown 1995; Mirowsky and Ross 1989). This is partly due to the fact that the “symptoms” of most emotional disorders include varying degrees of common emotional and physiological discomforts. As Horwitz (2002:220) points out in his critique of diagnostic psychiatry, humans respond to all kinds of stressors and “problems of living” with a variety of anxious, depressive and psychophysiological reactions. In most cases, these emotional responses do not reflect underlying disease entities (as the *DSM* purports), and in fact, the same “symptoms” tend to overlap many *DSM* diagnostic categories. Thus, coming to identify oneself with an emotional disorder label can largely be culturally influenced and may not necessarily be the result of clear-cut symptomatology.

An additional reason that emotional disorders tend to have so much interpretive leeway is that the symptoms tend to be invisible (Goffman 1963). Unlike

many physical conditions that are accompanied by visible indicators, the symptoms of emotional disorder tend to be predominantly internal. Therefore, in many cases, individuals must evaluate their own emotional states to determine whether they fall within the range of “normality” before deciding to seek professional help (Thoits 1985). Even when a professional is involved and responsible for diagnosis, he or she must rely, to a significant extent, on clients’ subjective interpretation and communication of their own emotional experiences. For these reasons, the boundary between “normal” and “emotionally disordered” can be quite malleable.

Despite their initial subscription to *DSM* categories to understand their emotional conditions, de-labelers’ reliance on this model ultimately fades over the course of the disorder identity career. They eventually come to reject the diagnostic paradigm that had previously been the foundation of their disorder identities. In some cases, de-labelers reject the paradigm altogether and even reinterpret their pasts by claiming that the disorder label (and its concomitant diagnostic philosophy) was never an accurate way of viewing their conditions. De-labeler Eva serves as an example of this attitude. She identified with her diagnosis of “clinical depression” for twenty years and took countless medications, “looking for the magic pill.” Although she felt the medications were having “terrible consequences,” she felt reluctant to question the “authorities.” When she eventually joined a therapeutic support group whose participants openly shared their rejection of the psychiatric system, she felt that her “gut feeling” of mistrust in the system was validated. This support for her unorthodox feelings gave her confidence to reject the disorder label, and it bolstered her new

conviction that the neurochemical explanation for her problems (that was encouraged by her psychiatrists and the media) had never been accurate. As she puts it:

There may be things in my life that I don't like, that I feel frustrated by, or whatever . . . but it is not a due to a chemical imbalance. Looking back, I can admit that I didn't always make good decisions, but it was not because there was something wrong with my brain!

Not all de-labelers, however, choose to reinterpret their past understandings of their conditions when they decide to disidentify from the disorder label. Some individuals maintain the belief that the disorder label had been an accurate description of their emotional conditions, but they feel that continuing to identify with it is no longer in their best interest. Lettie is one such individual. When she makes the dramatic declaration that “I am not bipolar!” she is rejecting her former essentialized orientation toward the disorder label and is reclaiming a sense of self that is not confined to the parameters of the diagnosis. In this reclamation, she does not deny the relevance of the diagnosis itself, as she insists, “I’m not taking an antipsychiatry stance.” Rather, she believes that identifying as “disordered” is simply no longer useful to her. She emphasizes the “subtle difference” between using disorder identity and “accepting it as who you are.”

Whereas Eva’s approach can be characterized as a radical rejection of “the system” and Lettie’s as an effort to transform it from within, Daphne’s narrative illustrates a third way in which some de-labelers resist the diagnostic imperative: they adopt an alternative interpretive framework that has a completely different set of meanings for the same emotional experiences. Daphne first began to identify as a “schizophrenic” when a psychiatrist diagnosed her and prescribed medication for her

condition. Because the medication made her feel horrible and seemed to be making her symptoms worse, she eventually began looking into less mainstream modes of treatment. She was intrigued by some things she had read about nutrition and mental health, so she started going to a clinic that treated her with “mega-vitamin therapy” and encouraged a diet of “raw food and juicing.” She recounts, “I started feeling better and better after a few months. Even some physical problems cleared up. My psychiatrist didn’t believe that it could be the mega-vitamin therapy. I didn’t have any support at all for that approach – not from my friends, my mother, or my doctors.” Despite the lack of social support for her unconventional therapeutic approach, she continued on the nutritional protocol until the expense of the vitamins made it impossible for her to continue. She claims her health declined as a result. Observing the degree to which her emotional condition had been effected by the supplements (and lack of them) had a lasting impact on the way Daphne has viewed mental health ever since:

I wondered, if I could get that much better on vitamins and raw food, then was I ever mentally ill to begin with? What is mental illness? . . . I was thinking a whole different way about it, and so I was just getting less interested in labels. . . Even now, I get depressed sometimes, but I just don’t think of it in terms of labels.

Regardless of which version of resistance de-labelers adopt, one of the consequences of de-glorifying the psychiatric authority over the labeling of emotional conditions is that it implies individuals feel a certain sense of internal authority over their own definitions of disorder and recovery. In general, these definitions tend to be dismissive of professional assessment and instead privilege a self-referential interpretation. Additional illustrations of such personal redefinitions of recovery include

Kasey's revised version of "alcoholism," which defies cultural authorities on the subject: "The common wisdom is 'once an alcoholic, always an alcoholic'. But for me, if I'm not drinking then I'm not an alcoholic." Similarly, Jillian offers a reinterpretation of her former identification as "bipolar" by explaining, "What I used to interpret as mania, I now consider to be a human being with feelings." Taking even greater interpretive authority, Lettie asserts that she now understands recovery very differently than she did during the years she identified as "bipolar:" "Recovery means living a good life!" These statements reflect efforts to relocate the definitional authority from cultural institutions to individuals' subjective interpretations.

The common theme in de-labelers' narrative descriptions of this strategy of redefining recovery is that taking responsibility for one's own self-perception requires following some kind of "inner direction" rather than "letting the system define you." De-labelers use different terms to refer to the sense of inner direction, including "gut feeling," "personal truth," "something inside me," "inner conviction," "reliance on myself," "inner resources," etc. Each of these terms are used to communicate essentially the same idea: de-labelers eventually come to rely on understandings and interpretations of their experiences that counter the pathologizing and medicalizing interpretations of mainstream culture on their understanding of emotional disorder. While de-labelers' post-disorder identities are clearly not constructed in a cultural vacuum, their exit narratives do highlight the potential for a degree of agency in identification.

* * *

The strategies presented in this chapter do not comprise an exhaustive list of possible exit strategies, but they give a sense of the creativity with which de-labelers approach the various obstacles they encounter in the process of disidentifying with their disorder labels. Most of the narratives emphasize what a “strain” or a “struggle” it is to negotiate through this identity transition, and they detail the emotional “processing” involved in “coming to terms” with it. For this reason, it seems quite possible that many people who happen not to be as introspective as the individuals in this group may never disidentify from their disorder labels, regardless of the objective conditions of their emotional health.

In fact, a number of de-labelers observe that their motivation to answer the recruitment flyer for this study stems from their hope that their participation in this research will help to minimize the difficulty for others who choose to discard their disorder identities. For example, Anne expresses at the end of the interview, “When I read your flyer. . . I was so looking forward to making contact . . . I’m so happy for any effort that helps people to have their experiences and learn from them and grow and change and move on.” Along the same lines, Anthony concludes by expressing hope that his narrative will be of help to others: “It often helps to let people see that it [the disorder identity] doesn’t have to be permanent. . . And, it’s important for me to help people see that they are part of their own problem.” Similarly, when Daphne comments on how much she enjoyed talking about the topic of disidentification, she acknowledges, “Talking about it made me think a lot. And, I’m glad to participate in this study because I think it’s important for people to think of themselves in broader terms.” I understand the sentiments of these and other de-labelers to be suggesting

that they feel there is value in offering an alternative to long-term disorder identification. Perhaps a greater cultural sensitivity to the temporal management of identity (as suggested by the notion of a 13th Step) would open up the recovery discourse to such alternatives.

Chapter 6

Managing Temporally Ambiguous Identities: Reflections, Speculations, and Implications

De-labelers' narratives offer insights relevant to the temporal management of identity both within a mental health context as well as for broader considerations of identity more generally. In this concluding chapter, I discuss some of the ways that the themes that run through de-labelers' narratives may guide future research. I begin by highlighting eight de-labelers whose narrative patterns deviate from the majority. Exploring these differences and speculating about why there are so few of them in this group of de-labelers may motivate further research into this understudied population. I then consider how the temporal themes in de-labelers' narratives may be useful for expanding the discussion of mental health labeling in sociological analyses. Following that, I speculate about some ways in which the insights from de-labelers' experiences may be useful within clinical contexts of therapeutically managing individual disorder identities. Finally, I end the discussion by moving beyond the specific case of de-labelers into a discussion of individual identity more generally by suggesting some ways in which a greater sensitivity to the themes that this study highlights may add temporal nuance to our social psychological analyses of identity careers.

Alternative Narrative Patterns

While this study deepens our understanding of the underresearched population of de-labelers, it is necessarily exploratory. Our understanding of the relationship between mental health and identity would benefit from further investigation into the

experiences of this population and the social psychological contexts in which their interpretations of these experiences take place. To assist future research on this population, I highlight eight of the forty narratives that do not entirely conform to the temporal pattern of the majority that has served as the basis of my analysis. Exploring these “narrative deviants” raises questions and suggests areas for further investigation that may inspire further research on this population.

My analysis is structured around a narrative pattern that is reflected in the majority of these de-labelers’ stories. Eighty percent of this group describe a similar pattern of relating to their disorder identities over the course of the disorder identity career: they initially adopt an expecting orientation; they subsequently develop an accepting orientation; and a resulting frustration with the limits of the accepting orientation prompts their decision to eventually disidentify from the label altogether. This is not, however, an inevitable pattern. In fact there are eight de-labelers whose narratives do not entirely conform to this pattern. While all de-labelers’ narratives are characterized by expecting and/or accepting orientations, these eight are patterned differently than the majority. Highlighting these alternate temporal patterns and speculating about why they are so minimally represented in this group may be useful in prompting questions and interest for future research.

Two de-labelers’ narratives deviate from the majority in that they describe an accepting orientation toward their disorder identities from the beginning of the identity career; at some point, they come to see the disorder identity as limiting and initiate a process of disidentification. Contrary to the majority, there is no point at which this subset of de-labelers assumes an expecting orientation. The disorder label is initially

internalized as a permanent part of their identities and remains so until they make the decision to exit. The exit process for these individuals is indistinguishable from that of other de-labelers. That is, their reasons for exiting are identical to the other de-labelers, and the duration and character of the exit are just as variable as they are in the rest of the narratives.

A significant point to note about this pair of de-labelers is that while they initiated and executed disidentification processes that are very similar to other de-labelers', they likely did so with an even more entrenched identification with the disorder labels. They never went through a time of expecting that the disorder identity was temporary, and so from the beginning had always treated the disorder as a permanent, essentialized trait. The fact that an exit from the identity was still possible under these circumstances is worth noting, particularly because labeling research tends to emphasize the social forces that encourage individuals to internalize deviant identities. The narratives of these two individuals make an especially strong case for the element of agency that may be involved in orchestrating one's own identity career.

One possible explanation for the scarcity of this temporal pattern among this group of de-labelers' narratives could be that people who accept their disorder identities as permanent from the outset may be less likely to ever even consider discarding them. Given that most de-labelers express experiencing great difficulty in resisting the internal and external influences to maintain the status quo with regard to their disorder identities, it seems likely that disidentification would be even more difficult for individuals whose identity careers are primarily characterized by an

accepting orientation because they are likely to be even more immersed in their disorder identities.

In addition, three of the forty individuals adopted an expecting orientation from the outset and maintained that perspective until making the decision to discard the identity. The fact that this pattern is not more common in this group may have to do with the centrality of the identity whirlpool in other de-labelers' narratives. Most de-labelers credit the pull of the identity whirlpool in influencing the original expecting orientation to become an accepting orientation over time. It may therefore be difficult to maintain an expecting orientation for too long before the identification gets caught in a self-perpetuating dynamic. Thus, a number of the individuals whose disorder identity careers could have potentially been characterized by an expecting orientation until the point of exit, very likely get caught in the identity whirlpool and fall into the pool of de-labelers who make up the majority.

There are two additional de-labelers who describe an identity career that is characterized by an accepting orientation followed by an expecting orientation. As noted above, there are three de-labelers who originally employ an accepting orientation, but none of them subsequently adopt an expecting orientation before exiting. Perhaps it is the case that once one recognizes the limitations of the disorder label, the idea of continuing to identify with it as a temporary aid is not appealing or may not even seem possible. The fact that so few made use of an expecting orientation after an accepting orientation could be interpreted as a sign of a certain degree of identity inflexibility on the part of the majority. For instance, it could be the case that after one has internalized an identity and has assumed it to describe a

permanent essence of oneself, it may require cognitive flexibility to maintain identification with the label on new terms (as a temporary state) than to simply discard the label altogether.

This could suggest that, in some cases at least, exiting the disorder identity may be a reaction to the tight reins the individual may have allowed the disorder label to have over his or her sense of self; in such a case, the decision to disidentify could be understood as a form of rebellion from such a constraint. In some instances, a reactionary rejection of the label could actually be a disservice to one's recovery process, if a more nuanced and qualified identification with the label (i.e., an expecting orientation) could actually still be useful. This possibility reinforces one of the main themes that has emerged from this analysis: identities can be useful tools for particular purposes at particular times; the better we can judge their consequences at any given point in the identity career, the more chance we have of gaining the most benefit from them without suffering from their limitations.

Finally, there is one de-labeler whose narrative represents a temporal pattern that resembles a "zig zag" (Zerubavel 2003). This individual describes having vacillated back and forth numerous times between expecting and accepting orientations throughout the disorder identity career before deciding to discard the label. While it is unclear why this pattern is not more common among these de-labelers, one distinctive aspect of this particular individual's narrative may have encouraged this oscillating temporal orientation. He explains that he was never fully confident with the accuracy of his diagnosis. He used it to help him explain his emotional troubles and to get treatment, but he admits that "on some level, [he] always

questioned it.” Thus, the simultaneous attraction to having a diagnostic label and his simultaneous uncertainty about its relevance (i.e., “it gave me a profile to understand my experience” versus “how can one label explain it all?”) may have predisposed him to a more variable temporal orientation throughout the disorder identification.

Given the small sample size, it is impossible to draw general conclusions from this study about all de-labelers’ experiences; there is, however, a clear consistency among the majority of these cases. There may be a great deal of material for future research in exploring these various patterns more thoroughly and identifying conditions that encourage and discourage each of them. One of the values of such an exploration could be a more nuanced portrait of this population of de-labelers. Because my interest in this research has been to highlight common temporal patterns that characterize the recovery, disability, and disidentification narratives of this population, the diversity within the population is necessarily minimized in this analysis. Further research could attempt to recruit a sample that more evenly represents the various alternate patterns presented here so as to have more data with which to examine them each more fully.

Another theoretically and topically important area for additional investigation could be the post-exit career. It could be instructive to explore to what degree disorder disidentification is lasting. While this study takes disidentification as the career endpoint (as implied in my criteria for recruiting participants) it is possible that there

could be cases in which a period of reidentification follow disidentification, subsequently followed by a period of re-disidentification, etc.¹⁷

A final benefit of further analysis of these various temporal patterns is that it could help to illuminate the conditions that help protect individuals from the tendency to fall into the identity whirlpool. While the majority of these de-labelers describe identity whirlpool experiences, learning more about those who managed to avoid that route may be helpful for elaborating important identity management strategies. In the following section, I consider such implications within a clinical context of therapeutically managing disorder identities.

Possible Clinical Implications

Reflecting on the temporal management of de-labelers' disorder identities may have therapeutic relevance, as well. I am not a clinician, so I cannot evaluate the therapeutic ramifications of the issues raised in de-labelers' narratives; I do, however, think it is worth speculating about possible implications of the fact that de-labelers nearly unanimously claim that their psychological well-being benefited by their decision to discard their disorder labels at a certain point in the disorder identity career.

What seems most relevant about this claim for a therapeutic agenda is that it draws attention to the point that disorder labels are not only diagnostic tools but are also dynamic, subjective identities. Recognizing this requires clinical sensitivity to the

¹⁷ It is worth noting that I typically asked de-labelers if they could imagine any circumstances in the future in which they might re-identify with the disorder label. Two individuals explained that they could imagine using the label for insurance purposes in the future, but none could image identifying with it again.

possibility that the consequences of identifying with disorder labels can change significantly over time. It seems that it could, therefore, be useful for clinicians to monitor the evolution of the disorder identity career and evaluate the consequences and meanings of the disorder label for the client at any given time during treatment. While identifying with the label remains helpful, it could be utilized as a way of assisting the client's sense of stability during a difficult time; if and when the label is deemed to have served its purpose, the professional may consider initiating a disidentification process. This identity exit would not necessarily have to coincide with the end of treatment because it would be a process of disidentification from the disorder label specifically and not necessarily from therapeutic work which may still be valuable. The suggestion is to use diagnostic labels with a consideration for the subjective short-term and long-term consequences of disorder identification and not just an increase or decrease in the intensity of symptoms.

The individual who is receiving treatment may or may not have the capacity to maintain an awareness of the temporal dimension of the disorder identity career. Thus, one of the roles of the professional could be to uphold this perspective and monitor the consequences of the identification along the way. Strategically, the clinician could help the client to adjust his or her relationship with the disorder identity as the client's psychological needs change over time. Such guidance from a professional could help individuals to derive maximum benefit from the use of disorder identities while minimizing the potentially detrimental consequences.

A determination about the consequences of the identification would be made on a purely individual basis and therefore would likely be highly variable. It could very well

be that there are many cases where disidentifying with the disorder label would not facilitate growth at any stage of the career; at the other extreme, there may be cases where the disorder identity can be discarded very soon after the client acquires it. The difference between such diverse cases may have much to do with the amount of “recovery capital” each individual possesses. Granfield and Cloud (1999) have coined this term to refer to the total number of one’s resources that can be used to “promote and sustain a recovery experience” (179). They explain that such resources can include various forms of physical, social, and human capital such as one’s financial status, friendship networks, and vocational skills.

De-labelers’ narratives suggest the importance of some forms of recovery capital in their disidentification narratives. For instance, Claire poignantly highlights the role of support networks outside of the recovery context. She explains:

For many people in my anxiety support group, that was the only support they had. They had a lot invested in staying in that group. I had my very supportive husband and family and friends, so I didn’t have to arm myself with the label. I felt like I had a choice about the label. I think I was privileged to be able to let the label go in a way that they weren’t.

The social source of the “privilege” that Claire recognizes is also noted in Ebaugh’s (1988) study of role exiting. She notes that individuals who have involvements in alternate jobs, relationships, and hobbies have a “far easier adjustment” than individuals who exited without such “bridges.” As a general rule, Ebaugh suggests that “there seems to be a direct relationship between the number and quality of bridges and the degree of role adjustment and happiness after the exit.” This may also speak to the placement of the disorder identity on one’s salience hierarchy. For instance, Claire’s “wife” identity ultimately trumped her disorder identity,

which allowed her to discard the identity with greater ease than those who have few other sources of identity. The costs of disidentification from the disorder label without this social form of recovery capital are likely prohibitive.

One's capacity for self-reflection and tolerance for ambiguity may also be an important component of recovery capital. De-labelers' narratives suggest the relevance of this form of recovery capital in their descriptions of the existential obstacles to disidentification which tend to require a significant degree of abstract reflection on the nature and consequences of identity itself. The extent to which these, or other, forms of recovery capital may be significant in influencing who remains identified with disorder labels and who discards them may be a fruitful avenue for future research.

Particularly interesting for the themes in this analysis of de-labelers, Granfield and Cloud also include as an example of recovery capital the "attitudes and beliefs that one has about the past, the present, and the future" (179). While they do not elaborate on the implications of these temporal attitudes, the idea seems to parallel my contention that one's temporal orientation can have a significant influence on one's relationship to the disorder identity. While Granfield and Cloud define their concept of recovery capital exclusively within the context of substance abuse and treatment, it seems applicable to a broader context of disorder identities more generally. There could be a wealth of future research surrounding these issues. For instance, clinical research could help to develop guidelines for clinicians to use in assessing the relative benefit or detriment of identifying with disorder labels throughout the identity career,

and a consideration of various forms of recovery capital could be an important factor in such an assessment.

It could also be advantageous for a version of such guidelines to be made available for the lay reader as well. In essence, these guidelines could serve the purpose of a “13th Step” as described in Chapter Five. Including a 13th Step in the recovery discourse could provide an analytic tool as well as cultural encouragement to actively assess the consequences of one’s disorder identity throughout the identity career. To critically manage one’s disorder identity over time requires taking greater responsibility in identification (and disidentification) processes, which thus encourages a stronger sense of agency. This process itself could have therapeutic value, as Drewery and associates (2000) argue. They claim that the degree to which one relates to the diagnostic category passively or actively can be an important indicator of one’s health: in their view, health “has much to do with the capacity for agency and less to do with the absence of disease.” Clinical sensitivity to the temporal influences on agency in identification may serve an important role in helping to manage the individual disorder identity career and legitimizing a notion of recovery from recovery as a possible course for some careers.

As a final clarifying note in this speculation about the clinical management of emotional disorder identities, this discussion is not to suggest that everyone who identifies with an emotional disorder label *should* eventually disidentify with it. In fact, as Estroff (1981) points out, for many chronically ill patients, the psychiatric diagnosis may provide a sense of identity and resources that these individuals may be unlikely to receive otherwise. Additionally, in some cases, permanent identification with a

diagnostic label may be necessary for ensuring compliance with needed treatment (Leventhal 2006). This analysis of de-labelers is thus not *recommending* disidentification. It is, however, highlighting the intrapersonal and interpersonal forces that may discourage disidentification, even in cases where it is desirable. It is with this recognition that I suggest, in the following discussion, some ways in which labeling research may be enhanced through a consideration of the themes that characterize de-labelers' narratives.

Expanding the Labeling Discussion

This analysis of de-labelers' disorder identity careers has innovative contributions to make to sociological research on the consequences of labeling emotional disorders. Most research on disorder labeling is attentive to issues that concern the labeling perspective (Scheff 1966, 1974) and its various modifications (Link et al. 1989; Thoits 1985); in particular, the social response to emotional deviance and the social consequences of this response are given analytic priority. One of the distinctive contributions of the present study is that it highlights the subjective consequences of identification with disorder labels as opposed to the social consequences of stigma. Since shifting the focus of inquiry inevitably foregrounds a new set of considerations, it is worth summarizing the most significant of these so as to highlight how research on labeling may be broadened by this study.

As mentioned in Chapter Three, one of the most surprisingly consistent aspects of de-labelers' narratives involves their reasons for choosing to disidentify with the disorder label: not a single de-labeler mentions stigma as a reason for discarding the

label. In total, there are three instances in which de-labelers do mention experiences of stigma in general, but they do not (except for one individual) associate these experiences with their reasons for choosing to discard the label.¹⁸ Almost unanimously, their reasons for exiting the disorder identity have to do with the internal limitations they perceive the label to have on their current self-perceptions and possibilities for future growth. This observation does not dispute the existence of stigma or devalue efforts to highlight its contexts and consequences. Rather, this point brings attention to the fact that stigma is not the only problematic aspect of labeling that deserves concern. By shifting the focus of inquiry from the social consequences of labeling to the subjective experience of identification with labels, a complementary piece of the story emerges that tends to be overlooked because of the analytic interests that have predominated the field.

A related theme that is common to de-labelers' narratives highlights the element of individual agency in the decision to exit the disorder identity. No one in this group describes having been "de-labeled" by a professional; in every case the individual initiated the disidentification process. This element of agency tends to be minimized in sociology (Thoits 1994, 2003). This is especially true in the case of research that draws on the labeling perspective, as its analytic attention is primarily fixed on the social sources and consequences of labeling. It underemphasizes the active process of identifying with and disidentifying from labels.

¹⁸ It is important to consider that since most of these de-labelers are middle- to upper middle class, and all of them are Caucasian, any experience of stigma may be less debilitating than it would be for those with fewer social resources.

Recognizing the role of agency does not, however, reduce the importance of social interaction in labeling. It is unarguable that there are powerful social forces that can be very involved in this process. De-labelers' narratives suggest, however, that there can be a phenomenological difference between social labeling and subjective identification. In other words, one may not be able to control others' perceptions or avoid socially imposed labels, but there can be an element of choice in the extent to which one internalizes the label as a subjective identity. As Killian and Johnson (2006:75) suggest in their study of the identity negotiation process of North African women who refuse the "immigrant" identity despite having immigrated to France, "These women's experience illustrate how the self can affect, or at least stand up to, society. Individuals can refuse an 'objective' social category." Drawing a similar conclusion, Cash's notion of the "phantom fat" phenomenon brings attention to the fact that self-perceived body image often has a "modest-at-best empirical correspondence with socially perceived reality . . . Beauty is not guarantee of a favorable body image, nor is homeliness a decree for a negative body image" (1990:52). In relation to the case of de-labelers, these insights suggest that recognizing that subjective identification and social labeling are two different aspects of disorder identification can enrich our understanding of both the structural and agentic elements involved in identity processes, generally, and in the experience of disorderhood, more specifically.

A final note about this study's contribution to labeling research is that its temporally sensitive perspective can add a harmonizing voice in a longstanding debate about the consequences of labeling. One side of this debate, traditionally referred to as the psychiatric perspective, contends that individuals derive valuable

benefits from labeling; most importantly, the label helps them to get appropriate treatment (Gove and Fain 1973; Linn 1968). This side claims that, on balance, the benefits outweigh any potential consequences of stigma associated with labeling. The labeling perspective, on the other hand, argues the opposite: whatever benefits may come from the label, the suffering caused by social stigma overshadows them. As a conciliatory voice in this debate Rosenfield's (1997) work suggests that there are both costs and benefits of using and identifying with emotional disorder labels. In the same mitigating spirit, my research suggests that a temporal perspective sheds new light on these costs and benefits. That is, by considering the disorder identity as a career that is characterized by changing subjective meanings, this study suggests that the label can have positive and negative consequences at *different times* during the course of the identity career. This analysis of de-labelers' narratives thus does not aim to contradict or refute the labeling perspective; rather its emphasis on changes in the subjective meanings of disorder labels over time sensitizes us to aspects of labeling and de-labeling that can broaden the scope of labeling research.

Implications for Identity Research

Beyond the context of mental health, this study contributes to the study of identity more generally. First, and most broadly, it validates the potential value of studying socially unmarked identities. Because the socially marked categories already tend to attract more cultural attention at large, by emphasizing such social categories, sociologists inadvertently contribute to the "reproduction of common sense images of social reality" (Brekhus 2003:34). My analysis, in contrast, identifies an unmarked

population that highlights themes and considerations that are not apparent when examining populations marked with diagnostic labels. One of the values of focusing on socially “invisible” categories of people is that it can be an under-tapped source of insight about the strategies and consequences of identification (Brekhus 2003; Mullaney 2006).

In that regard, one of the most important insights that has come from exploring the narratives of this unmarked population is the recognition that temporal orientation can be an integral aspect of identification. Acknowledging that the subjective experience of identity can be fundamentally influenced by what I call the expecting and accepting orientations has a couple of implications for our understanding of identity processes and the consequences of identity, generally. First, it highlights that the way we orient toward autobiographical time can be intimately connected with the cognitive complexity or simplicity with which we construct our self-concept. The implication is that if we view our identities from an expecting orientation, we may be more inclined to view any particular identity as one identity among many (as in Brekhus’ notion of identity adjectives that serve as descriptions of one aspect of ourselves). On the other hand, viewing identity from an accepting orientation encourages a more essentialized understanding of the identity (treating it as an identity noun), which tends to simplify the scope of our self-understanding.

Additionally, identifying the social psychological and cultural factors that influence temporal orientation may yield further insight into identification and disidentification processes. In particular, the degree to which an identity career has a “fixed duration” (Zerubavel 1981) has implications for the intensity of the identification.

Clearly, some identities have “highly articulated” (Glaser and Strauss 1971) termination points. Such identities presume an expecting orientation, as they are understood to be temporary. Identifying, for example, as the “president” in a political system with term limits or as an “inmate” with an ordered jail sentence each have predetermined “time tracks” (Lyman and Scott 1970) that set durational parameters on the identity career. On the other hand, there are identities that presume permanence and are characterized by the absence of an articulated termination point. For example, identifying as a “Muslim” or a “woman” each implies an assumption of permanence.¹⁹

These types of identities that have such clear durational expectancies are not analytically very rich for the purpose of considering the role of temporal orientation in identification. There is, however, more temporal intrigue in identities that fall somewhere between the two durational poles, where there is more *temporal ambiguity* in the identity careers. In such cases, there is an expectation that the identity is temporary but the termination point is not rigidly articulated. Temporally ambiguous identities thus indicate a period of transience, but the timeframe of the “passage” (Glaser and Strauss 1971) is not determined. Examples could include identifying as a “foster parent,” a “debtor,” or a “remedial student.” In each case, the identity is often originally assumed to be temporary, but for various personal and/or institutional reasons, they tend to lack clear termination points.

Because of their lack of a fixed end point, these temporally ambiguous identities can be vulnerable to the dynamic that is central to de-labelers’ narratives:

¹⁹ Of course, presumably permanent identities can become temporary and vice versa, but the “durational expectancies” (Merton 1984) do give cultural and institutional support for treating an identity according to its normative duration.

without a scheduled end to the identity career there is potential for the influence of the identity whirlpool. Thereby, an expecting orientation can become an accepting orientation, and a presumably temporary identity can take on a life of its own, indefinitely. This phenomenon is expressed in the title of Stephen Castles' (1985) article "The Guests Who Stayed," about the history and consequences of the guest worker program in West Germany from the 1950's-70's. He explains that, despite the original intentions that guest workers from neighboring countries would remain only temporarily, many of the foreign "guests" who were recruited for temporary labor eventually became "settlers," thus creating an unexpected population of immigrants (517).

In a very different context, this same dynamic may occur in cases of "homeless" identification. Rarely do individuals begin a life on the street with the assumption that it is a permanent status. Despite this original expectation, however, Snow and Anderson (1987) point out that the longer the duration of the street career, the more one may come to embrace the "homeless" identity, thus potentially perpetuating it. This same dynamic may also play out in some cases of academic identities, where the intention of identifying as a scholar of a particular discipline or school of thought may originally be intended as a means to pursue an understanding of some phenomenon in the world; overtime, however, the identification with that discipline's worldview can make the original pursuit of understanding secondary to simply perpetuating one's disciplinary identity.

Stephen Crites (1986:172) poetically summarizes the potential consequences of this dynamic of self-perpetuating identification:

The self becomes its own Frankenstein, a monster of its own making. . . [that] cannot free [itself] from the self-image [it has] created, which becomes more confining the more it succeeds in imposing itself.

This imagery of a self-created “monster” that becomes increasingly more “imposing” and “confining” over the course of time depicts the essence of the identity whirlpool. That is, identity can progressively take up more cognitive space in one’s self-concept as well as limit the scope of past and future selves to the confines of the present identification. While Crites’ observation is astute within the context of the identity whirlpool, it fails to consider the possibility that individuals have the capacity to reflect on their self-identification and its consequences. De-labelers’ narratives suggest that one important way that we can escape the grip of the identity whirlpool is to become aware of our temporal orientation toward a given identity. This reflective capacity may enable us most effectively to temporally manage our identities, thus minimizing the risk of becoming cognitively entrapped by them.

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