1-1-2014

Present Futures: Possibilities For Selfhood At A Community Mental Health Center In Detroit, Michigan

Talia Gordon
Wayne State University,

Recommended Citation

PRESENT FUTURES: POSSIBILITIES FOR SELFHOOD AT A COMMUNITY MENTAL HEALTH CENTRE IN DETROIT, MICHIGAN

by

TALIA GORDON

THESIS

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

MASTER OF ARTS

2014

MAJOR: ANTHROPOLOGY (MEDICAL)

Approved By:

_____

Advisor   Date

TABLE OF CONTENTS

> This person, this self, this me, finally, was made somewhere else. Everything had come from somewhere else, and it would all go somewhere else. I was nothing but a pathway for the person known as me.
>
> —Haruki Murakami, *The Wind-Up Bird Chronicle*[1]

INTRODUCTION

It is nearly 10 a.m. and members of the Clubhouse – a psychosocial rehabilitation program for people diagnosed with severe and persistent mental illness – are filtering into the common room to find a seat before the start of the weekly meeting. A handful of people are already sitting around the large round tables, reading the newspaper, chatting to each other, or waiting quietly for the meeting to begin. Some are still wearing their winter coats and hats and many have bags or purses with them, though staff usually encourage members to store these items in the front room of the Clubhouse when they arrive each day.

The meetings take place every Wednesday morning and are member-run; each week two individuals volunteer to act as facilitator and secretary. Today, Caleb[2] is leading the meeting and Rosemary will take minutes. Neri, the Clubhouse director, hands out the meeting agenda, which follows the same structure each week and includes a reading of last meeting's minutes, a review of Clubhouse policies, Work Unit reports, general announcements, Issues and Concerns, new member approval, and at the end, time for Compliments and Encouragements. Meeting attendance varies, but during the winter months when Clubhouse attendance is higher, there are usually between 20 and 30 people

---

[1] Haruki Murakami. *The Wind-Up Bird Chronicle*, trans. Jay Rubin (New York: Knopf, 1997) 262.
[2] In keeping with privacy regulations, all names have been changed to pseudonyms.

in the room. Most are "active" members who attend the Clubhouse at least four hours per week (and many of whom attend the program daily), while others make a special effort to come on Wednesdays in order to learn about upcoming activities or changes to the program's structure, policies, or rules.

As usual, the tone of today's meeting is businesslike and Caleb moves enthusiastically through the agenda at a brisk pace. Early on, Neri interjects to correct him – he has skipped over the part of the agenda where last week's meeting summary is read. Caleb is momentarily flustered by the interruption and says loudly, looking out at the room, "I'm doing the best I can." He begins to read, and Neri interrupts again to tell him that Rosemary is supposed to read the summary. Caleb apologizes and repeats himself, sounding at once defensive and assured, "I'm just doing the best I can." Rosemary reads the summary, and the meeting continues.

One of the items for discussion on today's agenda is whether or not the Work-Ordered Day (WOD) should be restructured to more closely match that of the Clubhouse Model set out in the International Standards for Clubhouse Programs. As the backbone of the daily schedule, the WOD entails tasks related to the organization and operation of the Clubhouse. Neri explains that members are supposed to be "busy" during the whole time they are at the Clubhouse and points out that even though the doors open at 7:30 a.m., the WOD doesn't begin until 10 a.m. She proposes lengthening the WOD both ways, so that members start their tasks earlier and the Clubhouse can remain open later.

Austin, a member who oversees many of the tasks in the Business Unit, raises his hand to speak and stands, smoothing down the creases on his khaki pants. He's wearing a worn blue t-shirt that says, "The Consumer Empowerment Day: Peer Support and

Empowerment, 1997" in faded yellow writing. Austin directs his comment to Neri, rather than the group. "I *do* manage my skills during the day and I manage my conditions. But if I stay late, it might affect my day the next day, know what I mean?" he says, sounding concerned. Another member named Lorraine raises her hand and echoes his tone, "And I'm at the front desk, just trying to do my best," she says. Neri gently cuts her short: "This isn't about you working more. It isn't about you. It's about changing the structure of the day."

Welcome to the Clubhouse

From December 2013 to March 2014 I conducted an ethnographic study of members of a Clubhouse program located in Detroit, Michigan. Following the Clubhouse Model of Psychosocial Rehabilitation, the program was voluntary and non-clinical, meaning that members attended out of choice and staff did not provide psychiatric treatment or care. All members had a diagnosis of severe and persistent mental illness, and as part of eligibility for membership, were receiving mental health care services elsewhere. Many were clients of Detroit Mental Health Services (DMHS)[3], an outpatient psychiatric and social service organization that acted as the auspice agency under which the Clubhouse operated. Though technically separate entities, the Clubhouse shared a building with DMHS, located at the corner of a main thoroughfare and bustling side street in Detroit's Midtown neighborhood. Although Midtown has been (and continues to be) the focus of widespread commercial and residential development, the corridor that was home to the Clubhouse remained surrounded by abandoned buildings, empty storefronts, vacant lots, and rundown high-rises. A network of local neighborhood organizations, including

---

[3] In keeping with privacy regulations, the name of the agency has been replaced with a pseudonym.

DMHS and the Clubhouse, provided various services to the large homeless population and low-income residents in the area.

According to the 2013 DMHS Annual Report, the Clubhouse had 80 "active" members and 40 "part-time" members, a distinction based on program attendance in hours per week.[4] The Clubhouse was open Monday through Friday from 7:30 a.m. until 3:30 p.m., a schedule inversely matched to that of the homeless shelter next door, where a number of members were residents. Others stayed in Adult Foster Care (AFC) homes, halfway houses or supportive housing. Some people, though few, lived with family or independently. Though many members lived in the Midtown neighbourhood or areas nearby and could walk to the Clubhouse, some members travelled by bus, or relied on transportation provided by their AFC homes or DMHS. For long-time members, especially those with stable housing arrangements, attendance was usually regular and frequent. For others whose lives were wrought with unpredictability, membership entailed sporadic attendance often marked by periods of absence that sometimes stretched into disappearance altogether.

Prior to starting my fieldwork, I had been involved with the Clubhouse as a volunteer for over a year. I attended the Clubhouse weekly, participating in daily activities, helping out in the literacy class, teaching members to use the computers, assisting with job applications, and attending Clubhouse community meetings. In the afternoons, I ran an open-discussion group for female members. During my time as a

---

[4] Members logged hours spent at the Clubhouse by signing in and out on a sheet of paper at the front desk each time they arrived and left. The attendance sheet was used for billing procedures – as part of the fee-for-service funding structure, the Clubhouse received money for every 15 minutes a member spent within its walls – and as a way for staff to monitor attendance (i.e., absences) for outreach purposes, a key element of the Clubhouse system of support.

volunteer, I began to observe the different ways that members enacted forms of selfhood within the Clubhouse space, through everyday activities, and exchanges with staff, other members, and myself. As I continued to return to the Clubhouse each week, I found myself wondering how the act of regular (and irregular) return to this space shaped for members a sense of self in time. In particular, I became interested in how ways of thinking about the self and the future were shaped by the paradigm of recovery central to the philosophy and structure of the Clubhouse program.

Throughout my fieldwork, I attended the Clubhouse three days a week and continued to participate as a volunteer in the sense that I remained available to assist members with various activities and continued to run a weekly women's group. However, from December 2013 until the end of my fieldwork, I made clear to members that I was conducting a research project and so my role at the Clubhouse changed, both in how I self-identified (as a volunteer, student, researcher) and how others, including members and staff, identified or recognized me.[5] Besides working with members as a volunteer, I sometimes helped staff with administrative tasks and a few times, accompanied group outings in the role of chaperone. Other than these occasions, my fieldwork was contained within the physical space of the Clubhouse. I did not follow individuals elsewhere into their neighbourhoods, homes, jobs, or other institutional settings as others have done (See Meyers 2013), a choice that limited my ethnographic frame to what I observed in the daily

---

[5] In his chapter, "Institutional Encounters: Identification and Anonymity in Russian Addiction Treatment (and Ethnography)" Eugene Raikhel (2009) describes how, as an ethnographer working in clinical and institutional settings, possibilities for self-identification are facilitated – "opened up or foreclosed" – by identities ascribed by others (p. 203). Raikhel observes how first introductions and the identifications that follow, that is, what "role" is assumed by or ascribed to the ethnographer, shape the ethnographic encounter (p. 208).

unfolding of the Clubhouse social world.[6] In addition to attending and participating in Clubhouse activities, I conducted semi-structured interviews with 10 members over a three-month period.

Selfhood, Structure, Space

Questions of how selfhood takes form and how possibilities for subjectivity are shaped by and within institutional environments have long been taken up by medical anthropologists and other scholars (Foucault 1965; Desjarlais 1997; Estroff 1985; Goffman 1961). More recently, interrogations into selfhood-making have attended to the ways in which developments in biomedicine and the emergence of novel technologies of care shape modes of self-management and forge new norms and forms of life (Weiner 2011; Schüll 2006; Rose 1996, 2007, 2009). Looking at modes of self-management in the psychiatric sciences, scholars have observed a "discontinuous and uncertain" form of selfhood modeled by bipolar self-managers (Weiner 2011), a dependent, "modulating self" engaged in various and apparently contradictory techniques of self-care (Schüll 2006) and the making of biological citizens through the use of pharmaceutical technologies (Rose 2007, p. 223).

Writing through the distinction made by Georges Canguilhem between the normal and the pathological, Nikolas Rose has described a turn in contemporary biomedicine towards envisioning (and managing) the self at the genomic or molecular level. Rose suggests that by thinking of the body and mind on the molecular scale, the distinction

---

[6] Robert Desjarlais (1997) argues it necessary "to try to account for the constitution of subjects within a specific cultural setting" by way of attending methodologically to conditions that lead to "specific ways of being" (p. 26). Contrary to approaches that place selfhood-making within broader historical or political contexts, Desjarlais argues that such analyses neglect the everyday and in doing so, miss possibilities for understanding how it mutually shapes experience. By examining the daily unfolding of life within a particular setting, Desjarlais argues, it becomes possible to get a sense of "how the stuff of personhood is built of the events and doing of everyday life" (p. 28).

between the normal and pathological is increasingly blurred and "pathology without normality" in fact becomes the new norm (Rose 2009, p. 74). By moving away from the normality/abnormality binary, Rose argues, new modes of self-governance emerge, as do new possibilities for selfhood:

> [I]n the new world of molecular neuroscience and psychopharmaceuticals, a perception has taken shape of the burden of mental disorder, as brain disorder, which makes abnormality into a new kind of norm and requires continual work of the self on the self in order to manage that immanent possibility by the will, by lifestyle, by drugs, in order to achieve an ideal form of life – which is the life of the autonomous self (Rose 2009, p. 80).

Drawing on daily observations, conversations with staff and members, and narratives of the people I interviewed, this paper explores how the possibilities for autonomous selfhood were conditioned through the regular return to the Clubhouse program, and how members came to envision themselves in (and through) time both within and beyond the program setting. At the Clubhouse, the paradigm of recovery and its discourse of self-determination, empowerment, and self-improvement required members to continuously manage and work upon the present self, while imagining and working *towards* a future self. Yet, for many members, the daily realities of living with chronic mental illness were often at odds with expectations for recovery set out by the Clubhouse Model. While the logic of recovery envisioned the self as responsible, agentive, and transformable, participation in the Clubhouse program conditioned ways of thinking and acting that called into question the very possibilities for self-determination upon which this logic relied. By following members through their daily engagements with the program's structural and philosophical parameters, I began to observe the often precarious and contingent forms of selfhood that took shape.

For instance, Caleb's exchange with Neri and Austin's expression of concern illustrate how ways of thinking about and presenting the self occurred alongside and against expectations for daily participation in the program. By volunteering to facilitate the Wednesday meeting, Caleb modeled an empowered and responsible form of selfhood encouraged by the Clubhouse paradigm of recovery. Yet his response to Neri's corrections – "I'm just doing the best I can" – conveyed a sense of personal limitation that contradicted Clubhouse expectations for envisioning the self as workable and transformable. Similarly, Austin's concern that changes to the Clubhouse daily schedule would disrupt his ability to self-manage revealed the precariousness and contingency underlying possibilities for enacting the self as independent and responsible. Austin's comment also spoke to the tensions bound up in negotiating the everydayness of his illness against a discourse of self-improvement that encouraged him to envision and work towards a future way of being distinct from the present.

I argue that for Caleb, Austin, and other Clubhouse members, the nexus of their everyday experiences living with mental illness and their engagements with the program's expectations for enacting, managing, and working upon the self produced a contingent, precarious, and often contradictory form of selfhood. I suggest that through the regular return to the Clubhouse space, members became engaged in a reiterative temporal process in which the present and future often shaded into one another, rendering possible certain ways of being, while deferring or altogether foreclosing others. By tracing out the ways in which the self took shape within the Clubhouse space, my aim is to show how novel and complex subjectivities can begin to emerge through encounters with contemporary institutions and technologies of care.

Possibilities

Anthropologist Sue Estroff (1985) has suggested that in studying chronic mental illness, "we are perhaps observing the formation, reformation, and struggling of individuals to form acceptable identities – acceptable to them and others" (Estroff 1985, p. 36). While contemporary biomedical models enforce a logic that separates pathology from personhood, for those diagnosed, mental illness is indivisible from the possibilities for selfhood – pathology, symptomatology, and treatment modalities become folded into and shape the very processes of identity-formation from which subjectivities emerge and are enacted. Estroff describes the "Catch-22 dynamics" of psychiatric patienthood to point out the contradictory possibilities for distinguishing the self:

> Control, command, choices, self-determination – these are aspects of competent selfhood in our society when applied to life situations and life actions. Our cultural emphasis on independence and individuality is curiously matched with an underlying emphasis on conformity. One [diagnosed with mental illness] pays for those behaviors and experiences that exceed codified and consensually understood limits with losses in such valued possession as freedom, self-determination and control of one's life (ibid, p. 175).

Estroff's seminal ethnographic work in an outpatient community treatment program (PACT) illustrates the paradoxical experiences of illness and selfhood for chronically mentally ill individuals who become "enmeshed in a complicated system" of care that simultaneously encourages, and denies 'normal' ways of participating in the world (ibid, p. 38). For instance, PACT clients are told they must take medication in order to maintain a certain level of functioning; at the same time, opportunities for employment and independent living (and a future free from medication) are limited through these very same technologies and practices of care. As Estroff observes, chronicity is twinned with

various forms of dependency – upon therapeutics, welfare assistance, housing arrangements, relationships with staff and other clients, and on the PACT program itself.

While Estroff explores the ways in which identities are shaped for PACT clients through processes of social construction and intersubjective engagements, I examine how possibilities for the self are conditioned through the everydayness of chronic mental illness and the trajectories of progress and recovery set out by the philosophy and structure of the Clubhouse program. Robert Desjarlais (1997) argues that experience is a "result of specific cultural articulations of selfhood (namely, a sense of self as possessing depth, interiority, unity, stability, and the capacity for transcendence) as well as certain social and technological conditions that foster and legitimate that sense of self" (Desjarlais 1997, p. 13). Following Desjarlais, I ask what possibilities for experiences are conditioned for members through their participation in the social world of the Clubhouse and how experience mutually shapes and enters into forms of selfhood that emerge. As well, I consider what possibilities exist for envisioning the self through time, as past, present, possible, and future, and what it means when these temporal and ontological distinctions become blurred.

Recovery

Hanging on one of the walls in the front hallway of the Clubhouse is a sign, printed on sheets of computer paper and held together with tape, that reads, "A Bridge to Self-Discovery: Recovering Together." On the front of the Clubhouse brochure and member handbook, the same words are set to a background photograph of a silhouetted figure, arms raised with clenched fists, standing against an ocean sunset. It's hard to tell from the picture whether the figure is looking out onto the water, or facing forward. Inside the Clubhouse common room, above one of the doors, is a large poster affixed to the wall, titled "Recovery Enhancing Environment: Integrating Health, Home, Purpose, and Community." In the center of the poster are concentric circles showing "Best Practices" of recovery, starting with the individual. Under the title is the most recent working definition of recovery according to the Substance Abuse and Mental Health Services Administration (SAMHSA):

> 'Recovery' is a strength-based process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA, December 2011).

The concept of recovery as a model and goal of community mental health care emerged in the United States in the early 1990s. Part of an ideological and pragmatic shift throughout the latter half of the twentieth century away from long-term hospitalization towards psychiatric rehabilitation, the recovery model reflected changes in the ways that life was envisioned for people diagnosed with mental illness. Historically, the status of the mentally ill in Western society placed those seen as mad alongside beasts and criminals, devoid of rationality and moral reason; viewed as incurable, the mad were imprisoned

through the seventeenth and eighteenth centuries (Porter 2002; Scull 1989; Foucault 1965). By the nineteenth century, beastly imagery had begun to be edged out by the idea that rationality could be returned to the insane through disciplining practices that emphasized work and the restoration of self-control. At the helm of reforms to psychiatric treatment that took shape in late eighteenth- and early nineteenth-century Europe were Dr. Philippe Pinel and William Tuke, whose approaches steeped in Enlightenment humanism and beliefs about rationality defined a therapeutic modality collected under the heading "moral treatment." In *A Treatise on Insanity* (1806), Pinel posits the curative potential of work for the institutionalized mad:

> [I]n all public asylums as well as in prisons and hospitals, the surest, and perhaps, the only method of securing health, good order, and good manners, is to carry into decided and habitual execution the natural law of bodily labour, so contributive and essential to human happiness (Pinel 1806, p. 216).

Traditionally portrayed in histories of psychiatry as "a kind of oasis, an island of humane and gentle care, existing between eras of negligence, ignorance, and even maliciousness" (Lillehet 2002, p. 169), Pinel's and Tuke's moral treatment has elsewhere been critiqued as a "gigantic moral imprisonment" (Foucault 1965, p. 278) in which the mentally ill, although freed from chains, were preserved as subjects of control under the authority of the psychiatrist. Writing beyond valorization or critique, Philippe Huneman (2014) suggests that to examine Pinel's *Treatise* as a compendium of case histories clarifies the project of moral treatment as one by which psychiatry was inaugurated into the realm of medicine as "an autonomous discipline with its own object, its own modes of intervention, and its own territory" (Huneman 2014, p. 7). Figured as sole practitioner of practices entailed under moral treatment, the psychiatrist governed this discipline and its territory, the hospital, within which madness could be potentially cured. Huneman argues

that Pinel's writing of the psychiatric case in the *Treatise* configures a particular and constitutive relationship between illness, patient, physician, and institution, and in doing so, "makes the process of entry into madness and recovery understandable even though there is no explanatory theory for this process; it establishes that, when there is no recovery, asylum and moral treatment were lacking" (ibid, p. 26). From the Pinelian project of moral treatment thus emerged a new mentally ill subject, no longer unreasonable, and essentially recuperable within the contained space of the institution.

In the 150 or so years that followed, moral treatment and corollary approaches to mental illness continued to evolve across Europe through political and philosophical shifts in attitudes towards institutional care. In France, psychiatric reforms that sought to refocus the role of the institution took full force in the middle of the twentieth century with the institutional psychotherapy movement and French psychiatrist Jean Oury's La Borde, an experimental psychiatric clinic that radically reimagined possibilities for patient subjectivity. Founded by Oury in the early 1950s, La Borde offered an integrative therapeutic community model of decentralized and democratized care wherein patients worked together with staff in daily clinic life. Oury's legacy continued to unfold at La Borde throughout the 1960s and 1970s as a practical and philosophical model of community psychiatry; La Borde itself remains open today and continues to draw together ideas about the role of the social in the treatment of mental illness.[7]

Models of community psychiatry arrived more slowly (and more clumsily) in the United States psychiatric system by way of the dismantling of state-run mental hospitals

---

[7] See Nicolas Philibert's 1997 documentary film, *La Moindre des choses* (*Every Little Thing*), which chronicles moments of daily life for patients and staff at La Borde as they prepare together for the annual summer play.

around the same time Oury opened La Borde. For much of the late nineteenth and early twentieth century, a diagnosis of mental illness in the U.S. had generally forecast long-term hospitalization and isolation from society. By the early part of the twentieth century, scholarly appraisals of institutionalization began to argue that the mental hospital represented a new form of social control (See Goffman 1961), and various social, technological, and ideological developments soon led to an overhaul of the U.S. mental health care system throughout the 1950s and 1960s. By the 1970s, the deinstitutionalization movement had resulted in the countrywide shuttering of state mental hospitals and a sharp reduction in inpatient services, and in the wake of this movement, many people with psychiatric illnesses found themselves essentially unmoored from systems of mental health care. Soon, networks of community-based mental health services sprung up all over the country, however many individuals who experienced displacement from long-term institutional care now faced homelessness, poverty, addiction, relapse, and other forms of insecurity.

Described in stark terms as a "particular American social tragedy" (Scheper-Hughes and Lovell 1986), deinstitutionalization in the United States produced a new population of chronically ill individuals with little access to dependable welfare provision. In their comparison of North American deinstitutionalization and its parallel movement headed by Franco Basaglia in Italy, *Psichiatria Democratica* (democratic psychiatry), Nancy Scheper-Hughes and Anne Lovell illustrate how "new forms of social control" of the mentally ill emerged in the United States through various community programs for ex-patients and the newly diagnosed, including residences, day hospitals, and rehabilitation programs (Scheper-Hughes and Lovell 1986, p. 175). While Basaglia's program of

democratic psychiatry sought to return subjectivity to psychiatric patients through practices of power-sharing between physician and patient, political organization with other community groups, widespread stigma reduction campaigns, and importantly, a recasting of the relationship between law and psychiatry, no such unified project was taken up in the United States. Scheper-Hughes and Lovell call for a Basaglian transformation of ideas and attitudes towards mental illness and an acceptance of new norms for community participation:

> Insofar as a fundamental characteristic of madness is a refusal or an inability to participate according to the 'commonsense' groundrules of everyday living, this new spirit of tolerance would require an acceptance of some disorder, chaos, unreason in the speech, thoughts, actions of the so-called psychotic individual. It would mean a surrender of our reality-centric world view and an acceptance of the subjective experience of alternative realities…In Basaglian terms, this means an empowerment through words, an understanding that even 'delusional' or 'delirious' speech may be a febrile voice of protest, the only possible act of resistance and autonomy available to a silenced and excluded population (Scheper-Hughes and Lovell 1986, p. 176).

In practical terms, the authors suggest the establishment of community spaces in which people with mental illness, particularly the homeless, could seek refuge, find companionship, and receive basic social services. The push for non-therapeutic (as opposed to strictly medical) approaches to care for the chronically mentally ill resonated with reforms to welfare and social service provision and soon became a viable alternative to short-term hospitalization and an answer to the growing problem of homelessness in North American urban centers. In 1993, William Anthony introduced recovery as a new paradigm for the field of mental health, describing it as:

> [A] deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the

development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony 1993, p. 527).

Anthony proposed a multi-dimensional concept of recovery that required an expansion and reconfiguration of service outcomes to include, "self-esteem, adjustment to disability, empowerment, and self-determination" (ibid, p. 528) for people with mental illness. The reconceptualization of recovery as more than symptom reduction resonated with ideas about the possibility for community reintegration and a financial impetus for reducing the incidence of hospitalization and patterns of re-hospitalization for chronic patients. In the following years, recovery was taken up as the central goal of mental health policy in the United States, and in 2003 was defined in the President's New Freedom Commission on Mental Health as "the process in which people are able to live, work, and learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms" (DHHS 2003, p. 7). The Commission report described a transformed system that was "consumer-centered" and "recovery-oriented" based on a vision of recovery for all those diagnosed with mental illness.

The Clubhouse Model

As the recovery movement took hold in U.S. during the 1990s and early 2000s, day programs and other custodial forms of care were gradually replaced by models that emphasized community reintegration and participation for individuals diagnosed with mental illness. Among these recovery-oriented and community-based mental health programs was the Clubhouse Model of Psychosocial Rehabilitation. Prior to 2003, the Clubhouse where I conducted my fieldwork had functioned as a day program, which had

operated as part of the social services arm of DMHS since the agency incorporated as a community non-profit in 1971. At the time of my fieldwork, the Clubhouse was moving towards gaining full and formal accreditation from Clubhouse International, the governing organization that oversees the development of clubhouse communities worldwide.[8] Requirements for Clubhouse accreditation are contained in the International Standards for Clubhouse Programs, last revised in 2012, which serve as a guideline for clubhouse programs, a code of ethics for staff, and a bill of rights for members. Originally drafted in 1989 as a "living document" to be reviewed every two years (Propst 1992, p. 26), the Standards continue to define the Clubhouse Model both in ethos and in operation.

The Clubhouse Model itself was developed based on the principles and structure of Fountain House, the first clubhouse, which opened its doors in New York City in 1948. Founded as a non-clinical support system for people discharged from mental hospitals, Fountain House emphasized principles of membership and belonging as key to recovery from mental illness. In 1977, Fountain House received a grant from the National Institute of Mental Health (NIMH) to develop the Clubhouse Model and assist in the national expansion of clubhouse programs. Over the next ten years, clubhouse communities were established across the United States, with 220 programs in place by 1987 (www.iccd.org). Today, Fountain House continues to function as a clubhouse and remains the philosophical and structural model for clubhouse programs worldwide:

> [Fountain House] redefines organizational structures, first shifting the focus of all treatments from the pathologies of patients (who at Fountain House are referred to as "members") to the resilience that they exhibit to engage in everyday activities as the path to their own recovery. Practically, Fountain House establishes itself as an intentional working community in which the need for member participation and

---

[8] Established in 1994 as the International Center for Clubhouse Development (ICCD), the organization changed its name to Clubhouse International in January 2013

choice in all matters empowers its members to take responsibility for their own recuperative progress as well as for that of others (Doyle et al. 2013, pp. 26-27).

While in biomedical discourse, recovery is measured and evaluated based on symptom reduction and effectiveness of pharmacotherapy, in non-clinical literature and practice recovery remains conceptually broad and ill-defined (Leamy et al 2011; Dickerson 2006), and difficult to evaluate from a policy standpoint (Spitzmueller 2014). The body of research on recovery-oriented approaches continues to grow, however the bulk to date has focused largely on program evaluations (Whitley and Siantz 2012;), including appraisals of the Clubhouse model (Hancock et al 2013). Recently, literature on non-biomedical conceptualizations of recovery has taken up the problems of contradiction in its definition as both an outcome and a process (Davidson et al. 2010). As a process, recovery represents a category of experience constitutive of a particular and prescribed way of being in the world – as an outcome, it signals a highly idealized and achievable form of selfhood. The increasing emphasis on non-biomedical conceptualizations of recovery in approaches to mental health care thus raises critical questions about how the paradigm of recovery, its logic and its discourses, shape individual experiences of illness and selfhood.

In the following sections, I demonstrate how Clubhouse members took up ideas about recovery and how these ideas entered into the ways members thought about and enacted selfhood within the program space. I show how the discourse and practices of recovery at the Clubhouse shaped possibilities, real or imagined, for autonomous selfhood – for some people, the recovery paradigm offered ways of thinking about themselves as determined and workable and oriented towards the future, while others spoke about recovery with a deep ambivalence that reflected uneasily in ideas about the self, in the

present and through time. Furthermore, I argue that the act of return to the Clubhouse produced for members often-contradictory forms of selfhood by conditioning dependency upon a program that, paradoxically, expected the very opposite as part of the logic of recovery and self-determination.

Tuesday, January 28th: Interview with Lonnie. Ten minutes into our interview, Lonnie tells me, suddenly, "I don't wanna do this." "No more questions?" I ask. "No," she says, with a half smile that's almost a smirk, "I'm shy." I close my notebook and watch her stand up. Lonnie stretches, and then shoves her hands into the front pocket of her sweatshirt. She makes for the door, then turns back to look at me. "When you come here, do *you* recover? What do you get out of this? Hanging with all these crazy people?" I'm caught off guard and can't find an answer for moment. "I like the company," I tell her, weakly. She's halfway out the door by the time I say this and she stops and laughs. "The company? Ha! I do *not* enjoy the company! As soon as I get a job I am moving the fuck on up OUTTA here!"

"Recovering what?"

I first met Lonnie when I began volunteering at the Clubhouse in October 2012. She had only been a member for a few months by then and was working next door at the DMHS reception desk as part of the Transitional Employment program. Like many other members, Lonnie had spent years in and out of prison and had been taken to "Receiving" (as members referred to the psychiatric unit at Detroit Receiving Hospital) more than once. For Lonnie, the Clubhouse seemed to be a place she both relied upon and resented; she often spoke disparagingly about the program and complained about staff and other

members, yet she continued to return regularly, even after her position at the reception desk ended.

Before she cut short our interview, Lonnie told me that coming to the Clubhouse every day kept her motivated, "staying on my toes." When I asked what the idea of "recovery" meant to her, she responded sarcastically, "Recovering what?" Then she told me, "Taking your meds on a regular basis, talking, seeing your doctor on a regular basis." Lonnie explained that she wasn't "completely recovered," because she still needed "a little help in some areas." When I asked if she thought it was possible to completely recover, she responded, "No, I don't think you can. I don't know. Yeah, you can. I think you can. *I* can, yeah. Eventually."

While members thought about and talked about recovery in different ways, the conversation I had with Lonnie spoke powerfully to how ideas about recovery formed, and entered into ideas about the self within the space of the Clubhouse. In particular, our exchange reflected the contingent and often-contradictory terms in which ideas about recovery took effect in how members envisioned possibilities for the self and the future. During our interview, Lonnie had talked about recovery in terms of therapeutic self-management by describing behavior – taking medication, seeing a doctor – that happened elsewhere, outside of the Clubhouse. However, our exchange afterwards and Lonnie's question to me – did *I* recover by coming to the Clubhouse – did more than point to the precariousness and ambiguity of my own role there; it illustrated how ideas about recovery and possibilities for the self were entwined with the act of returning to the Clubhouse space. Lonnie continued to attend the Clubhouse every day, in part because she wasn't "completely recovered" and in part because it kept her motivated. At the same time, she

couched possibilities for herself – such as getting a job – in a strong desire to break from the very space to which she chose to return daily. As a Clubhouse member, Lonnie was encouraged to act as a responsible and self-determined subject – yet, the very possibilities for doing so were limited by her own ambivalence regarding the possibilities for recovery. Thus, by continuing to return to the Clubhouse each day, Lonnie came to model a precarious and paradoxical form of subjectivity in which agency, independence, and choice became contingencies, rather than givens of selfhood.

Turning and Returning to the Self

> Most everybody here has a "former," a person they
> don't want to get back to.
> —Chase, Clubhouse Member

In his essay, "Is a Pedagogy of Healing Possible?" Georges Canguilhem writes that the idea or possibility of a cure illusorily gestures to "an end to a disturbance and a return to an anterior order" (Canguilhem 2012, p. 55). He follows by pointing out the conceptual trouble inhered in the prefix "re-"[9] in terms like "recovery" – namely, that "re-" suggests in illness and disease a quality of reversibility not only in their organic process, but in how they form (and inform) categories of experience. For Canguilhem, there is no return, only the establishment of new norms by way of healing, distinct from cure, as an individual and subjective process.[10] Particularly in the experiential landscape of chronic mental illness, where pathology remains elusive and treatment regimens resolve to manage rather than

---

[9] According to the *Oxford English Dictionary*, the original sense of *re-* derives from the Latin for 'back' or 'backwards' and is used "with the general sense of 'back' or 'again'" as an English prefix ("re-, prefix." *OED Online.* Oxford University Press, June 2013. Web 22 July 2014).

[10] In *The Clinic and Elsewhere* (2013), Todd Meyers elaborates and clarifies this distinction between healing and cure through his ethnographic account of the therapeutic careers of opiate-dependent adolescents and the pharmaceuticals they used. Meyers suggests that "[t]herapeutics can be understood though the forms of speech taken up in the clinic, and the objects this speech adheres to" (p. 10). Language of the clinic, Meyers argues, has the potential to conflate healing and cure.

eliminate disease and its constituents, the idea of return to a prior way of being represents a conceptual chimera.

While the conceptual framework of recovery emphasizes 'regaining' what has been 'lost' through experiences of chronic mental illness, members often spoke of recovery in terms of potential and possibility. Paradoxically, the idea of return to a 'former' self is somewhat antithetical to the logic of recovery, which posits a realization and fulfillment of unmet potential. Often, members spoke of recovery as "making up for lost time" and "just now getting stuff going" – enacting themselves in ways they had felt unable to prior to joining the Clubhouse. Asher explained, "I have a lot going for me, and I just squandered it. Yeah, I can still make something out of what's left of my life." Asher felt that recovery was an "everyday process you go through" as well as something he could "use" to battle the challenges of day-to-day living. He felt that recovery was ongoing and in a sense, asymptotic - he explained that if a person became "recovered" it could open the possibility "to slip back into some garbage." In this way, Asher envisioned recovery as a prophylactic *against* return to an anterior way of being that he felt threatened the possibilities for working upon his present self and working towards an imagined future.

Ideas about recovery took shape, in part, through affective and rhetorical measures enacted by staff. References to recovery were often used as a way of reinforcing expected norms of behavior among members, deployed as encouragement, coercion, or admonition. Neri, the Clubhouse Director, typically invoked the word "recovery" during meetings, often in reference to the program's rules, policies, or structure. When changes took place in the Clubhouse (which was often), and particularly when the changes were effected

without consulting the membership for consent (which, despite the emphasis on self-governance, was often), "recovery" and its discourse of empowerment, self-improvement, responsibility, and progress were used in explanation or defense. After a set of staff layoffs initiated by the DMHS administration, Sandy Ware, the Clinical Director from DMHS attended a Wednesday meeting. When members voiced anger at the decision to fire staff, and frustration at the process by which the decision was made (without them), Sandy responded by using the language of recovery and empowerment. Referring to the staff who were let go, she said: "You have allowed them to empower you with strengths you didn't have before. Use those strengths to deal with change. That's what life is about, change. Without change, it's death. Like a flower, always growing. If it stops growing, it dies." She continued, "That shows progress. Bianca, Neri, whoever it is, they offer you things, but *only you can empower yourself*." By using metaphorical language and the rhetoric of empowerment and progress, Sandy thus attempted to reconfigure members' feelings as opportunities to enact the self within the paradigm of recovery.

While some members had clear ideas about what recovery meant and clear ways of defining it (e.g. "Living life on life's terms!), others, like Lonnie, displayed ambivalence or uncertainty about how to define or enact recovery. Lorraine, a long-time Clubhouse member told me that recovery meant "learning how to control my temper; talking to people more about my anger." When I asked if she thought it was possible to recover she responded, "I'm trying, but I don't think it's working correctly." Later, when we spoke about goals, Lorraine told me that she had been working on building her self-esteem. "Is working on your self-esteem part of recovery?" I asked. Lorraine shrugged and looked

confused. I asked the question again and she told me, "I don't know. No one ever explained it to me, what recovery means. Never."

Thus, despite the definition of the Clubhouse Model as a recovery-oriented support program and constant references, subtle and explicit, to recovery and its associated discourses, recovery eluded any singular or set of shared definition. Rather, ways of understanding and speaking about recovery indexed ways in which members thought about the self. In particular, ideas about recovery took on a temporal dimension that perpetuated in ideas about the self through time. For Clubhouse members, as well as staff, ways of thinking and talking about recovery rendered it a variable and contingent category of experience.

"I can't"

One Wednesday when it came time to read the Clubhouse general policies and rules of conduct, Neri suggested that the members try and list the policies and rules from memory, instead. Someone called out, "Everyone has to participate in a work unit." Neri corrected this statement, telling everyone, "Actually, that's not true. No one *has* to participate. I mean, it's crappy, but it's voluntary."

According to the Clubhouse Model, participation in all program activities is voluntary. In keeping with the International Standards for Clubhouse Programs, which states that there must be "no agreements, contracts, schedules, or rules intended to enforce participation of members" (ICCD 2010), the Clubhouse general rules and policies were framed as prohibitive guidelines, such as "do not beg for cigarettes or money," rather than requirements. Members were ideally empowered, as self-determined subjects, to define, choose and enact the ways in which they participated in the Clubhouse program.

The voluntary nature of Clubhouse participation aligns with the logic of self-determination central to the recovery paradigm. However, it often produced tensions and frustrations between members and staff and among members themselves. Discussions about participation were a cornerstone of Wednesday meetings and often entailed general entreaties for increased member attendance and involvement in Clubhouse activities. As stated in the International Standards and echoed in the Clubhouse Handbook, membership is without time limits – once you become a member, "you are a member for life!" (Revised 2013 Clubhouse Handbook). However, lifetime membership had its caveats. To be considered an "active" member at the Clubhouse, minimum attendance is four hours per week. Members who failed to meet this quota on a regular basis risked being flagged as "inactive," which had consequences with regard to inclusion in program activities, such as outings and special events, and access to services or resources, such as bus tickets. There were also social consequences to sporadic attendance, which took form in expressions of disappointment and resentment on the part of staff and members towards individuals who come infrequently or irregularly. Despite the acknowledgement that many factors, financial, logistical, social and personal, contributed to people's ability to attend the Clubhouse, the emphasis on attendance and participation privileged those who came often over those who did not.

Participation thus entailed ways for members to enact the self within the prescribed norms and expectations of the Clubhouse program. Attendance formed a minimum category of participation and the lower limit of what was expected or accepted as possible for members by staff and other members. For some people, attendance entailed simply *being there* – the act of showing up and being physically present at the Clubhouse.

Particularly for long-time members, *being there* did not necessarily represent an agentive or performative choice to participate in the Clubhouse program; rather, attendance was part of a broader system of caretaking in which they were already enrolled. Members who lived in AFC homes, for example, were dropped off and retrieved daily – while Clubhouse membership was voluntary, attendance was often required by AFC homes or necessary for members to obtain or preserve other supportive housing arrangements.

For example, Mario and Clyde were two members who lived at the same AFC home, and whether by virtue of this fact or the fact of empathy, whose relationship was one of caretaking. Clyde, who was blind in one eye, walked with a cane and had no long-term and little short-term memory, often helped Mario who was fully blind and did not speak – though, he responded to questions directed at him (e.g. "Mario, did someone bring you lunch?") by nodding or shaking his head. Clyde spoke, though the troubles with his memory made conversation difficult to sustain. I spoke with Clyde on occasion, and staff would sometimes make efforts to engage him, but I rarely saw him interact with other members except for Mario. The two of them would often spend the mornings and afternoons together in a pair of chairs against one wall of the common room, with Mario usually dozing and Clyde staring quietly out into the room as the day unfolded around them.

Throughout the day, when he was not sitting against the wall, Mario sat at tables, arms pulled through the sleeves of his shirt and crossed over his chest, stretching the material to create a kind of cocoon into which he could retreat and burrow his face. As the WOD began, he was moved from chair to chair, table to table, where each time he resumed this position. Mario appeared to sleep most of the time, though I often wondered

if he was sleeping or if he was merely floating in and out of consciousness, and how his consciousness was constructed at all. When Mario needed to be moved, Clyde was often the one to do so, rousing him from his apparent unconsciousness and redirecting him to another space where he could continue to be out of the way. The demands on Clyde and Mario by staff and other members were few and remained in the realm of caretaking – Clyde was responsible for moving Mario from place to place, out of the way and Mario was responsible for complying, which he always did. Neither were asked or told to do much else beyond constantly relocate their bodies within the Clubhouse space until it was time for them to be picked up and taken home at the end of the day. For Clyde and Mario, Clubhouse participation entailed little more than *being there* as the limit of possibility for enacting the self each day.

To understand the parameters of what is possible for the self within the Clubhouse space, what is *not possible* must also be considered – what is assumed not possible, what is decided upon as not possible, what is *made* not possible through the mutual projections of members and staff. The International Standards state that all members have "equal access to every Clubhouse opportunity with no differentiation based on diagnosis or level of functioning" (ICCD 2012). Yet, I often observed how perceptions held by staff and members with regard to level of functioning – including self-perceived limitations and potentialities – shaped expectations about Clubhouse participation that constrained or altogether foreclosed possibilities for enacting the self. Recall Caleb's repeated assurance that he was doing "the best I can" as facilitator of the Wednesday meeting, a refrain I heard repeated by members at different moments.

Personhood, Pathology, Place

At the end of the weekly clubhouse meeting, Lorraine remained seated while the other members dispersed, her face showing visible upset. When I went over to ask if she was okay, she plunged her head down into crossed arms and shook it back and forth, then began to cry at the table. Concerned, I asked Lorraine if she wanted to talk but she continued to shake her head, shoulders heaving, until I asked if she wanted to be left alone, to which she nodded yes. Though other members appeared to notice Lorraine's distress, only one person came over to ask if she was okay and after receiving a similar response, shrugged and walked off. I stood by the table for a moment, unsure of whether to step back or to press Lorraine further. Soon, Neri approached and motioned me away, leaving Lorraine seated alone.

Later, at lunch, Lorraine sat down beside me and apologized for crying. She explained that she was feeling sad because one of the staff at her AFC home was going on vacation for a few days and because she missed her father, who passed away a few years ago. Lorraine then added, "But I'm getting my shot tomorrow, so I'll calm down." I was struck by Lorraine's apology and by the coupling of her explanation with the assurance that she would soon be medicated. I asked the name of the shot, and without hesitation, she told me, "Prolixin."[11] I nodded and our conversation carried on, leaving the subject of Lorraine's emotional display behind.

---

[11] In the form of Fluphenazine Decanoate, Prolixin is an injectable drug used to stabilize people experiencing acute psychosis and as a long-term maintenance therapy to control symptoms of schizophrenia. According to the NAMI website, where a list of general information regarding medications is readily

Whether or not Lorraine was familiar with the hormonal recalibration that Prolixin effected daily in her brain was unclear; what *was* clear was that Lorraine associated her ability to manage her emotions with the time-bound effectiveness of the medication. As a maintenance therapy, Prolixin is generally administered every 2-3 weeks. Lorraine's assurance that she would "calm down" after her shot conveyed a sense that she perceived the range of her emotional acuity to coincide with the trajectory of the injection she received. Despite the context she provided in her explanation to me, crying in the space of the Clubhouse appeared to signal to Lorraine that she required pharmaceutical treatment in order to maintain, or return to, her regimen of emotional self-management.

Lorraine's apology for crying also conveyed to me that she viewed her feelings and outward expression of sadness as somehow inappropriate or out of place in the Clubhouse space. My interaction with Lorraine while she was upset had unsettled me, partly because her expressed desire to be left alone appeared at odds with her public display of distress in the common room and partly because my instincts to approach her seemed at odds with what was seen as appropriate by staff, other members, and by Lorraine herself. At that point, I had known Lorraine for more than a year and a half, ever since I had first become involved with the Clubhouse. Over that time, we had spent many hours sitting and speaking together and I felt that we had developed a strong rapport. Yet, my experience with Lorraine that morning called into thinking the possibilities for empathy and care in our relationship and made me consider the ways in which I enacted my own emotional register in interactions with Clubhouse members. As well, it raised questions about the

---

available, Fluphenazine is a first generation antipsychotic that "works in the brain" where it "rebalances dopamine to improve thinking, mood, and behavior" (www.nami.org).

ways that emotional self-management was expected or conditioned to occur within the Clubhouse.

Wednesday, March 5th: Clubhouse Meeting. During Issues and Concerns, a member named Amalia raises her hand and announces that she's been feeling a "disconnect" with the staff lately, which has affected her desire to attend the Clubhouse. "I arrive and everyone's barking orders, 'Do this,' 'Do that,' and no one says, 'Girl, how you doing today?'" she explains. "We got cooking classes, we got Talia, we got outings, but the connect with the staff is missing. We got no emotional contact."

Today, Sandy Ware, the Director of Clinical Operations from "upstairs" is at the meeting, an overture as part of her efforts to ease discontent among members following recent Clubhouse staff layoffs. She stands up from her chair by the door and opens her arms, walking towards the center of the room. "Are you connected to case managers and therapists?" she asks, sounding rhetorical in her tone, looking around at everyone seated at the tables. "That's where you need to get serious emotional contact and support." Sandy reminds members that her door is always open, and walks over to a different member, resting her hand on his shoulder. "Right, Josiah?" she says. He nods, without looking up. Sandy returns to her seat and the meeting continues.

"We all have mental illness"

Although a diagnosis of severe and persistent mental illness is a prerequisite for membership, within the Clubhouse Model psychiatric pathology is seen as distinct from and often, peripheral to personhood. The separation of the self as mentally ill from the agentive, rational, and self-determined subject is reflected in the International Standards, which prohibit "medication clinics, day treatment or therapy programs" within the

Clubhouse structure as incongruent with a focus on the "strengths, talents and abilities" of its members (ICCD 2012). Further, the Standards require that the Clubhouse be a physically separate and institutionally autonomous entity that is "impermeable to other programs" of care or service provision (ICCD 2012). Members are expected to seek care and manage the self as chronically mentally ill *elsewhere*, in clinical and therapeutic settings disconnected from the Clubhouse.

Thus, as Sandy Ware made clear, expectations for self-management require members to recognize and categorize certain feelings – such as Lorraine's sadness and Amalia's sense of emotional disconnect with staff – as outside the parameters of rational selfhood and inappropriate or out of place in the Clubhouse. In order to so, members must continuously monitor and assess their emotions and make choices about how (and where) they should be managed. Strong emotions, such as distress, anger, sadness, or agitation, were often interpreted by staff and members as "warning signs," or cast as symptoms of mental illness.

Over the many months I attended the Clubhouse, I found references to illness and medication to be a regular feature of conversations that I had with or observed among members. During Women's Group, Andrea wondered to me if her irritation at noise in the computer room was just "part of my illness." Corinna, describing feeling especially tired one morning, told me she thought her medication was making her more sleepy. At weekly Clubhouse meetings, I often heard members say things like, "we're all on medication" or "we all have mental illness" when discussing issues, concerns, and other agenda items. During meetings, these statements usually came as preamble, seeming reminders to themselves, one another, and staff that despite the emphatic separation of pathology from

personhood, enactments of self within Clubhouse space were indivisible from the fact of living with illness and the effects of pharmaceuticals. Once, during a heated conversation about changes to transportation, members began interrupting one another and a few individuals grew visibly upset. Harriet put up both her hands and said loudly, "Remember, we all got a mental illness, we gotta have respect when we speaking to one another." Another time, the issue of members sleeping during Clubhouse hours was raised. Neri pointed out that although there was no explicit rule against sleeping, it was a behavior strongly discouraged by staff and frustrating to other members. Ted raised his hand in protest, "But some of us are on medication that enable us to be in and out [of sleep], that's the difference," he argued. Another member agreed, "No one's trying to sleep intentionally." One of the older staff responded swiftly, "When we were a day-treatment program, it was a break from the hospital. But the Clubhouse is different. You're in deja vu. You gotta be used to your medication."

Declarations or reminders that indexed psychiatric patienthood at time served as caveats, and at other times as defenses; these speech acts held rhetorical power as language of self-reference. Summerson Carr (2010), in her ethnography of the ways in which speech practices are learned and strategically performed as acts of self-representation by clients at a drug-rehabilitation program, argues that by engaging an institutionally imposed language of self-reference, people come to inhabit certain identities and "speak effectively from these designated locales, in politically efficacious ways" (Carr 2010, p. 154). Within institutional settings, Carr claims, "semiotic processes" produce learned ways of speaking about the self that allow individuals to present themselves as "particular kinds of people' (pp. 53-54) and in doing so, both reify and resist established

roles as social actors. The performance of self in this way thus becomes a metalinguistic act of agency by which individuals can leverage power to gain access to resources, both material and symbolic. Importantly, Carr examines what happens when language travels *between* institutional settings and shows how, through the "co-constitution of ideologies of language and personhood," ways of being are constructed and defined (p. 224).

Others have taken up the ways in which personhood is made, enacted, and bestowed in institutional spaces where various therapeutic technologies are at play (Martin 2007; Biehl 2005; Luhrmann 2000; Desjarlais 1997; Rose 1996, 2007). By interrogating the often-conflicting imperatives of care and management in these spaces, medical anthropologists and other scholars have shown how personhood can be "disconfirmed and denied" through rhetorical measures (Desjarlais 1997), and "unmade and remade" through processes of social abandonment linked to pathology (Biehl 2005).

In the non-therapeutic space of the Clubhouse, members were expected (and conditioned) to speak in terms of self-reference that aligned with the recovery discourse of empowerment, independence, and responsibility. In general, self-identification as mentally ill or medicated fell outside the parameters of acceptable speech practices within this space – the pathological and pharmaceutical selves were seen as adjacencies rather than constituents of self-determined subjectivity encouraged by the Clubhouse Model. Yet, the frequent choice to identify as mentally ill spoke to the difficulty members faced in envisioning and enacting the self as divisible (recall Austin's expression of concern about his ability to manage both his skills *and* his conditions amidst changes to the daily structure). Following Carr, I suggest that by reminding themselves, each other, and staff of a shared identity - "we all have mental illness" – members were able to strategically

reconfigure expectations for ways of being set out by the Clubhouse program. Further, by selectively choosing to mobilize and inhabit the identity of a mentally ill and medicated subject, members modeled a form of agency and selfhood that, paradoxically, both fulfilled and undermined the logic of self-determination.

The inability of members to separate out the pathological self from the self as a whole – or, rather, the ability of individuals to strategically foreground certain identities – reflected, in part, the blurred and porous boundaries between the non-therapeutic space of the Clubhouse and the therapeutic spaces located elsewhere. Todd Meyers (2013), in his ethnography of drug-dependent adolescents in Baltimore, shows how, as patients and pharmaceuticals together move between clinical and non-clinical institutional spaces, possibilities for care (and self-care) conform to the demands of these spaces, thus complicating ideas about individual agency and choice in caring (p. 72). In the following section, I describe the ways in which the spatial and administrative interconnectedness between Clubhouse and DMHS produced an elision – and sometimes, confusion – between therapeutic and non-therapeutic spaces, and how the relationship shared by the two institutional settings acted as an apparatus of selfhood formation for members who moved back and forth between them.

Stories

"If I have an attitude or whatever, I can go upstairs and write it in my book."

"Is this just y'all mess upstairs?"

"I'm growing up. I'm growing up to be a woman. And living my life. I'm trying to get an apartment, like upstairs. But they're saying it's too difficult for me to be up there."

"Lotsa people come in here and in this place [the Clubhouse] and just be taking advantage…y'know, sayin' something that they done told them upstairs they gotta do or say so they can get something else. They got a master plan."

"They made me a Clubhouse member, the staff upstairs."

From a bird's eye, the floor plan of the Clubhouse looks as though it was cut from the top corner of a beveled picture frame – one long hallway stretches from the front door to meet the other hallway, which extends out in perfect perpendicularity towards a door that is always locked, marked "Emergency Exit." This door leads to the DMHS lobby, which shares the first floor with the Clubhouse. Along the left sides of both hallways are a series of rooms housing the staff office, the Environmental Control Unit supply room, Member Services, the Literacy Program, the kitchen and the Member Lounge. The right sides of each hallway make up two walls of the Clubhouse common room, a large open space that functions as a meeting place and a recreational space for group activities. In one corner of the common room, a small enclave holds the Snick Snack Shop, which has a window counter that opens out onto the lobby, like a portal connecting two disparate worlds.

In keeping with the International Standards, the Clubhouse is technically an autonomous entity, though it operates under and shares a building with DMHS. *Under* refers both to the relative place of the Clubhouse within the organizational structure of the agency as well as to its location in space: the clinical and therapeutic services, housing and employment programs, clothing room, and administrative offices of DMHS are distributed throughout the five stories stacked above the Clubhouse. Many Clubhouse members are clients of DMHS and move back and forth between the space of the Clubhouse and various parts of the building throughout the day. However, the apparent irony of the locked "Emergency Exit" door reflects the symbolic separateness of the spaces – members

are required to enter and exit the Clubhouse from the street, even if they are coming from or leaving to attend appointments, meetings, or groups "upstairs" at DMHS.

While Clubhouse members and staff sometimes used "upstairs" to refer to DMHS as a whole, it was more often used as a sort of metonym for the range of services offered on each floor of the building. Members would tell me they had an appointment "upstairs" or that they needed to attend, check, or get something "upstairs" – often, members simply said they were "going upstairs" without specifying exactly where, or for what purpose. Staff too, used "upstairs" as a collective referent, directing members there for administrative purposes or when situations arose that were deemed outside the programmatic or philosophical parameters of the Clubhouse. In addition to indexing spatiality, "upstairs" also gestured to the bureaucratic dimensions of the relationship between DMHS and the Clubhouse. According to the International Standards:

> The Clubhouse has an independent board of directors, or if it is affiliated with a sponsoring agency, has a separate advisory board comprised of individuals uniquely positioned to provide financial, legal, legislative, employment development, consumer and community support and advocacy for the Clubhouse (ICCD 2012).

Within the organizational makeup of DMHS, "the Board" (as staff and members called the Board of Directors) was effectively in charge of the Clubhouse, a reality that produced inevitable and ongoing tensions in moments of daily operation and in Clubhouse governance more broadly. Much of the tension derived from the fact that the Board held ultimate responsibility for decision-making regarding Clubhouse matters, such as funding allocation, billing procedures, approval for activities, transportation policies, and staff layoffs. In many cases, changes to the Clubhouse structure and organization came from or went through the Board. In much the same way that "upstairs" became a referent that took

on different, yet mutually understood meanings, "the Board" could refer to the Board of Directors, other decision-making bodies, or the DMHS administration as a monolith. Often, Clubhouse staff were conduits for changes as liaisons between members and DMHS administration and the Board, and bore the brunt of reactions from members. When changes were made without member consent, staff often deflected blame and frustration by referring to "the Board" or explaining that whatever decision preceded the change came from "upstairs." Of course, the Board was made up of a group of varied actors who met occasionally, and did not reside "upstairs" – yet, feelings of powerlessness and frustration (often shared by members and Clubhouse staff) were directed to the symbolic "upstairs" which seemed to bear down upon the Clubhouse, exerting ultimate decision-making power from above.

Paul Brodwin (2013), in his ethnography of ethical dilemmas and decision-making by front line providers of community psychiatry in the United States, argues that staff responsible for managing their mentally ill clients must mediate between different institutional settings, often with conflicting goals. Staff must manage and "advance the interests of both disenfranchised clients and powerful institutions, even when these contradict each other" (Brodwin 2013 p. 68). On one hand, clients of Assertive Community Treatment (ACT) programs require assistance from their case managers in non-clinical and non-therapeutic ways, while on the other hand, their diagnosis of mental illness weds them to psychiatric institutions upon which they depend. Brodwin describes how, as clients move between institutional settings (hospital, psychiatrist's office, ACT agency), front line providers are often tasked with making difficult decisions that call their desire and ethical obligation to provide particular forms of care into question. Further,

bureaucratic processes and technologies of care force staff into relationships of dependency with the same institutions upon which their clients rely.

Though the Clubhouse Model enforces a physical and symbolic separateness between its program and other institutions of service provision and treatment, members were often enmeshed in relationships of dependency with these institutions that blurred the boundaries between the medicalized, psychiatric self – as patient, consumer, or client – and the self-determined, autonomous self expected in the non-clinical space of the Clubhouse. Earlier, I argued that for Clubhouse members, the pathological and pharmaceutical selves are indivisible from the self as a whole, despite the emphasis on illness as isolable from personhood that figures centrally in the logic of recovery. For members who were also clients of DMHS, the spatial arrangement of the building meant that moving between the Clubhouse and "upstairs" served to further blur and conflate the distinctions between forms of selfhood. At the same time, as in Lorraine's case, the proximity of therapeutic to non-therapeutic space offered possibilities for self-management that allowed members to enact the self as agentive and empowered within the Clubhouse by choosing to seek services elsewhere, "upstairs," while forgoing possibilities for autonomy. In a way, the building itself was a metaphor for the hierarchical and fragmented structure of service provision and the possibilities for self-management and autonomous selfhood for individuals who became part of the Clubhouse and DMHS system of care.

Friday, March 14th: Member Services Lounge. Malik comes into the Member Services room with Miss D. – actually, it's more like Miss D. is *bringing* Malik in, almost like you'd bring a forgotten child to the principal's office after school. She tells Neri: "This

young man needs a referral for next door." Neri looks at them and says firmly, shaking her head, "I absolutely can't do that." She explains that Malik needs to see his case manager upstairs, but he tells her that he doesn't have one. Sounding a mix of desperate and earnest, Malik tells Neri that he used to be "over at [the homeless shelter next door]" when he was a teenager and adds, pointing at the monitor on her desk, "They should have me in the computer already, my SSI, Medicaid, everything." Neri asks for his date of birth and full name. Malik tells her both, and in the same breath says, "I'm in there. I'm legit." While she types in the information, he repeats himself over and over again: "I'm legit. I'm legit."

Managing oneself as a Clubhouse member often entailed participation in a continuous game of institutional pinball: within various networks of service provision, individuals bounced between different spaces of care and social assistance, returning over and over again to these same spaces in order not to fall into the metaphorical "drain" and out of the system. Elsewhere, others have written about the "revolving door" effect in mental health care, and the "institutional circuit" (see Hopper et al., 1997) where psychiatric patients cycle in and out of networks of care through repeated short-term admissions to hospital. Programs such as the Clubhouse and ACT are designed to prevent or reduce the potential for hospitalization by providing alternative (and comprehensive) models of care that deliver possibilities for "normative stability" (Brodwin 2013, p. 89). Since a diagnosis of mental illness and a treatment plan were prerequisites for membership, all Clubhouse members moved regularly between at least two institutional settings – the psychiatrist's office, hospital, or mental health agency, and the Clubhouse. In most cases, Clubhouse members were also receiving forms of welfare assistance and

accessed myriad services from a broad range of social organizations and government programs. Thus, they were continuously required to enact themselves as different subjects within each institutional setting and inhabit the identities expected of them.

Time Out of Place

> One of the schools of Tlön goes so far as to negate time; it reasons that the present is indefinite, that the future has no reality other than as a present hope, that the past has no reality other than as a present memory. Another school declares that all time has already transpired and that our life is only the crepuscular and no doubt falsified and mutilated memory or reflection of an irrecoverable process. Another, that the history of the universe — and in it our lives and the most tenuous detail of our lives — is the scripture produced by a subordinate god in order to communicate with a demon. Another, that the universe is comparable to those cryptographs in which not all the symbols are valid and that only what happens every three hundred nights is true. Another, that while we sleep here, we are awake elsewhere and that in this way every man is two men.
> —Jorge Luis Borges, "Tlön, Uqbar, Orbis Tertius"

Late one morning, during the lull between the completion of WOD tasks and the start of lunchtime, I took a seat at one of the round tables in the common room, where a few others members filled the remaining chairs. We talked together lightly for a while, when suddenly a new member, Debra, interrupted to ask the time. "Ten to twelve," Linus told her, pointing to the clock above her head. He joked around, asking why she needed to know the time - did she have an important date or something? She shook her head and then told him confidently, "Knowing the time of day is part of normalcy."

As part of the Clubhouse Model, time and its governance was a crucial feature of the program's structure, which gave shape to the everyday unfolding of the Clubhouse world. Though members could come and go as they pleased, daily Clubhouse activities moved along in time according to the Work-Ordered Day schedule, and weekly events such as the Wednesday meetings gave semblance of chronology to the way days followed one another. However, members measured and thought about time within the Clubhouse walls in different ways and to different ends. Throughout the day, time was *spent* and time

passed – time was *marked* by activities or events that followed one another, such as Unit Time, or lunchtime. In this way, time also *moved*, and members moved through time. Yet, moving through time did not necessarily entail a sense of moving forward, that is, of cumulative temporality. Rather, within the Clubhouse space, time often became truncated, elongated, interrupted or suspended for members in ways that entered into and shaped possibilities for selfhood.

Rotating with the Earth

One morning, I came into the Clubhouse common room and sat down next to Martin, a regular member with whom I often spoke. As usual, I asked him how he was doing. "Rotating with the earth," he responded with a smile, leaning back in his chair. The idiomatic force of his answer struck me powerfully. For Martin, as for other Clubhouse members, thinking about the self often entailed a departure from conceptions and experiences of temporality as linear or progressive. Rather, as Martin's expression of "rotating" suggests, there was a sense of circularity and recurrence in how members envisioned and enacted the self in relation to time within the Clubhouse. In this setting, where individuals were required to manage the present self while continually anticipating an imagined future self, experiences of chronic illness bumped up against expected trajectories of progress to produce ways of being and thinking about the self in time that often challenged or eluded linearity.

Often, when I greeted members and asked how they were doing, their responses indexed temporality as way of talking about the self. Members often answered that they were "Just taking it a day at a time," or "Taking it day by day." Sometimes, I would phrase my question differently by adding, "What's new?" which was met with similar responses.

Linus, who lived next door at the homeless shelter, told me once, "Nothing new, different, or better. Hitting the same bases, every day." Sarah, who also lived at the shelter and attended the Clubhouse every day, always paused to consider carefully before answering, "Nothing much," and would then add that she was still living at the shelter and recite the number of days she had left until she could move out from the shelter into supportive housing. Corinna, who lived in an AFC home and had attended the Clubhouse daily for five or six years, would usually tell me she was, "just managing" or "just doing the best I can." Sometimes she would apologize for not having anything to tell me, as though she felt my query, "How are you?" was posed to elicit a certain type of response.

More than other members, Corinna often spoke to me about the past. Over time, I became familiar with her meandering style of storytelling, and the seamlessness with which she would switch between recollecting events and talking about her thoughts and feelings in the present tense. One day, Corinna explained to me that she had never gotten married because she had the "wrong attitude." She continued, "I missed my chances, but I don't want to get married, either. I don't see anyone here that I want to marry. I just want to continue living." When I asked what she meant, she said, "Get up and do the day activities, and then go to bed after the activity, get up, do the day activity, go to bed." Corinna added, "It's all I can do here. I'm 65 years old, and I'm not in the mood to marry anyone. I just do the best I can each day."

Desjarlais (1994) has described the temporal order of life for residents of a homeless shelter in Boston as "purely episodic" (p. 897) in that events do not build to a greater whole of experience; rather, ways of being take on finite forms outside of linear progressions of time. Desjarlais argues that experience requires certain conditions and

entails "an aesthetics of integration, coherence, renewal, and transcendent meaning" (p. 896) that is often absent from the daily unfolding of shelter life. Thus, for residents, experience is "a possibility, not a given." In the world of the shelter, Desjarlais claims, ways of being in time often comprised forms of living that were distinct from the act or process of experiencing.

While in the everyday world of the Clubhouse, the unfolding of events in time took on a quality of repetitiveness similar to that of life in the shelter, I argue that rather than foreclose the possibilities for experience, this temporal order instead shaped a particular form of experience. Away from Desjarlais, I suggest that though time at the Clubhouse unfolded in ways non-linear and non-cumulative, the act of return to the program produced for members a sense of ontological security that insured experience as a given – a predictable, reliable way of being in the world day-to-day - and not merely a possibility. For example, Martin's sense of "rotating with the earth," described a temporal order in which the self in time was envisioned as existing daily, rather than along a progressive or cumulative trajectory of living. Yet, "rotating" in existential orbit indexes a certain quality of givenness in the possibilities for daily experience. Similarly, Corinna's desire to "continue living" by enacting the self in the same way each day spoke to a form of experience in which the future could be anticipated and relied upon as indistinct from the given present. For Martin, as for Corinna and others, existing daily entailed a form of living that perhaps eluded cumulative linear progression – yet, existing daily was for them, a given experience.

Present Futures

During interviews and casual conversations, I often asked people how they thought about the future. Some people, particularly newer members, described the future in terms of achieving concrete goals, such as finding housing or stable employment or owning a car. Others spoke of the future more abstractly, in terms of *becoming*, or arriving at ways of being different than the present. Often, members conveyed ideas about the future in which ways of being coincided with, or were predicated on the achievement of concrete goals. Asher, who had been coming to the Clubhouse for four months, told me when he thought about the future, he wanted to have "no worries":

> I just wanna be like, independent and stable. Comfortable living. Housing. Lights, gas paid. Food in the refrigerator. Things like that. Being able to go in your refrigerator when you wanna get something to eat, and have a selection instead of nothing but *this*. Then you living life okay.

When I asked, Asher told me that he had always planned for the future, and described the present as "part of my future I have to go through – *this* – to get where I need to be." Asher felt that his arrival at the Clubhouse had marked off a sort of division between the past, and a present and future that he imagined as somehow folded into one another. For Asher, coming to the Clubhouse each day was a way for him to enact the present self *as* the future self, and to engage in a continuous process of *becoming* his future self.

For those who, like Asher, were able to envision and speak about the future, it was often conceptualized as a temporal landscape that the present self was passing through or a temporal anchorage at which the self would arrive. Yet, for others the ability – or choice – to forecast beyond the present moment fell beyond the parameters of possibility for envisioning the self. Often when I asked how people thought about the future, members told me simply, that they didn't. Instead, they spoke about living "one day at a time,"

"day-to-day," or "making through one day." Particularly for long-time members, ideas about the future were elusive or did not move beyond iterations of the present.

While I observed differences in how newer members and long-time members spoke about the future, the difficulty in forecasting displayed by the latter was not simply a direct or explicit outcome of involvement with the Clubhouse. Rather, the ways in which ideas about the future were expressed were the corollaries of how ideas about recovery became incorporated into forms of selfhood. Somewhat paradoxically, the intersection of chronic illness experiences and regular return to the Clubhouse space closed off possibilities for imagining a future distinct from the present – the present itself became a predictable future. Members who attended the Clubhouse every day over time could rely on the fact of return as an almost-certainty; the daily unfolding of life in relation to the Clubhouse thus became a reiterative temporal process whereby the past, present, and future were elided.

Tuesday, March 12th: Computer Room. After I'm done helping Alexander type up the how-to guide for the photocopier, we sit quietly, both looking at the computer screen. After a moment, I ask if he thinks he'll come to the Clubhouse forever. He says, "For a long time, yeah." He tells me he won't be doing anything else, and I ask how he knows that. He shrugs. What about work, I ask – will he ever work? He tells me "No work!" because then he'll lose his disability and food stamps. Then, almost as an afterthought he looks at me, and then looks up at the ceiling and says, "I don't know what work I can do, what I could work at." I ask if he's ever worked and he says yes, when he was younger, and tells me that the last job he had was at a restaurant downtown, but they let him go, though he's not sure why. Another pause. Alexander isn't looking at me; he's focused on

the computer screen, clicking the mouse around in circles on the desktop at nothing, just clicking. I decide to take the leap and I ask him if he ever thinks about the future. He keeps his eyes on the screen, and answers, "Never. Just worry about today. Tomorrow I'll worry about tomorrow. Never." I ask how he knows he'll be at the Clubhouse for a long time if he doesn't think about the future. He shrugs, eyes trained on the screen, and says, "I ain't gonna be doing nothing else. Nothing else important gonna come up."

For Alexander the future was both certain and uncertain; he was sure it held "nothing else" – nothing different from, additional to, or besides what the everyday of his present life entailed. While at first glance this assurance appears to foreclose possibilities for enacting the self, the sense of a present that repeats itself indefinitely insures against change. Alexander did not need to "worry about" – or think about – the future because he was certain it would be no different than worry about today.

Another member, PJ, had been coming to the Clubhouse for three years, though he described his pattern of attendance as sporadic – sometimes he came every week, "the majority of the time" and sometimes he partied too much and might miss a few days. PJ described how he thought about coming to the Clubhouse:

> That's the thing – it ain't really a different day, it's still the same old routine, like you goin' to the same job, eatin' the same thing over and over – it's a new day but you still doing the same thing. Like, maybe you eat a different lunch or something, but still, it's the same thing, over again, the same thing.

When I asked PJ to think about the future and where he saw himself in a year, he told me "alive." Later, when I asked where he saw himself in a month, he told me: "Don't really think that far. I think about the day that I'm in."

The sense of the future as elusive or indistinct from the present expressed by Alexander, PJ, and other members, spoke to the ways in which ideas about the self in time

were conditioned by participation in the Clubhouse program. While the recovery paradigm assumes a trajectory of progress wherein the self is continuously engaged in a process of change, the predictability and givenness of daily experience within the Clubhouse space – "the same thing, over again, the same thing" – ran counter to possibilities for enacting the self as transformable or transformed.

Déjà Vu

Over the 17 months I came to the Clubhouse, I probably attended between 40 and 50 Wednesday meetings. Initially, coming to the meetings each week had offered a sort of entryway into the Clubhouse world, through which I hoped I could observe and slowly begin to understand how things "worked." I'm not sure I can recall what I expected to learn – perhaps, some things about group dynamics or governance, or the formation of social identity within community mental health care settings. Instead, as I continued to attend the meetings each week, I became struck by the distinct quality of givenness they engendered and the ways in which members presented and enacted the self within and against this codified temporal space. The meetings acted as both anchor and anchorage for members; they offered a reliable point of return.

Wednesday, March 19th: Clubhouse Meeting. It's just before 10 a.m. when I arrive at the Clubhouse. Today will be my last day of fieldwork – in fact, I have come to the meeting in order to say goodbye. After I put my coat away, I head into the common room, where Lorraine hands me a copy of today's meeting agenda from her seat by the door. The room is already filling up with people, most of whom are sitting quietly in plastic chairs at the five or six large, round, grey-topped tables. A few folks are scattered across the extra

chairs that have been set up in rows to face the front of the room, like an audience waiting for a play to begin.

I find a spot beside Alexander, who smiles shyly and then nods when I ask him if I can sit there – after months and months of the very briefest of exchanges with one another, Alexander and I spoke at length for the first time only last week. As members continue to pile in and find seats, we sit together, not saying anything. Alexander fiddles with a green plastic cup, then abruptly stands up and goes over to the water cooler to fill it.

I look around and notice that a new whiteboard has been put up next to the "Wellness Centre" bulletin board, on the wall beside the door to the Snick Snack shop. It has "Quote of the Day" written at the top in black dry erase marker, and underneath a list of what appear to be today's activities. The board used to hang on a wall in the entrance to Neri's office and I briefly wonder what has replaced it. I've come to learn that empty spaces don't remain empty for long at the Clubhouse.

Pink construction paper hearts hang limply from the ceiling on white strings, like tired and exotic birds, between blue and gold corkscrew streamers that have been up since the holiday party in December. A single St. Patrick's Day decoration remains, an oversized green ball taped to the wall behind a tall plant that nearly died a few months ago for lack of care – no one had thought to check that it was real.

I also notice that the large picture frame showing the Member of the Month has been moved, and it too is nearly obscured by the same plant. In its old place by the sink, the Inspirational Board now hangs, plastered with religious literature, a list of the Alcoholics Anonymous Twelve-Steps, a few poems, and one crude drawing of a house.

The meeting is not yet underway, and Neri flits in and out of the room, calling out to and corralling members. Flora and Casey, who are running the meeting today, sit alone together at a table in one corner of the room, where the fish tank, microwave, and fridge are kept. Beside the fridge, Mario and Clyde sit in two chairs against the wall, both leaning to one side like twin brushstrokes on a canvas. Above their heads, the Clubhouse calendar looms large and colorful, nearly all of its days marked off with activities – outings, workshops, groups, holiday celebrations – and I see that Neri has drawn a flower for the first day of Spring, only a few days away.

Finally, the meeting starts and Flora and Casey struggle through the first part of the agenda, which requires them to explain the structure of the meeting and their own roles as secretary and facilitator. Next, new members stand and introduce themselves by name, and are welcomed with applause – today there is only one new face, a woman who looks familiar to me, even though I am sure I have never seen her before.

Following new member introductions, the summary of last week's meeting is supposed to be recited, which doesn't happen today because no one has typed up the minutes for Flora to read out. In fact, this is often the case – no matter how often Neri or Austin remind or plead with members to volunteer for this task, it is rarely completed by anyone but staff. Neri appears frustrated. Onto Old Business, the first order of which is printed on the agenda as an instruction, rather than a topic for discussion, though Neri interjects to reiterate the perennial reminder out loud for good measure:

"Progress notes to be done **immediately** after today's meeting"

She adds: "The point of a progress note is to make sure you're getting something out of coming here, and that you're making progress. I strongly encourage everyone to fill out their progress notes at least once a month." Ever encouraged, never required.

When it is my turn to speak, I introduce myself for the umpteenth time, and – it hits me, suddenly – the last time. I explain that my project has come to an end and that I will be leaving for a while, but I plan to return again as a volunteer. No one seems to register what I've just said as a farewell, which fills me with an odd mix of relief and the dawning realization that after today, when I leave this space to which I have returned for so long, my absence will be swallowed up and soon forgotten, like so many other changes that have come to pass here.

For the fourth or fifth week in a row, the issue of transportation is on the agenda and a lengthy conversation about van policies and procedures ensues. Today, members are focused on one particular point on list, which states:

"Riders with monthly income will be **encouraged** to donate $1/day"

Not surprisingly, members are concerned about how this suggested donation will be enforced, by and for whom, and how the money will be used, since the Clubhouse budget covers funds for transportation and members have never before been asked to contribute money towards this service. It isn't immediately clear to everyone, including myself, the logic behind the donation: the van is provided by DMHS and the gas, driver's wages, insurance, and repairs are included in this provision. Neri explains, "The Clubhouse Model encourages members to pay for things. We are not a hand-out program, we are a recovery program." Yolanda speaks without raising her hand, and instead crosses her arms indignantly, "No way I'm paying for transportation." Neri explains that she

doesn't have to, and repeats that the donation is "encouraged." Yolanda responds, sounding insulted, "I know what that means." Neri asks if she wants the word "encouraged" removed from the policies but Yolanda just shakes her head and repeats, "I'm not paying."

It's nearly eleven, and the meeting is adjourned once again without officially approving the van rules and policies. The conversation will resume next week, I imagine. I close my notebook and stand up as Brandon comes back into the common room and heads towards me with his chart in hand. He asks if I'll help him with his progress notes, as has become our regular practice over the past few months. I explain that I have to leave and Brandon nods, though I'm not sure he knows that I'm leaving for good.

CONCLUSION

> Recovery is getting so the illness is in the back of your mind, not the front of it
>   —Neri, Clubhouse Director

In the pages above I have suggested that for Clubhouse members, experiences of mental illness and psychiatric patienthood, and expectations for recovery set out by the program model – which rely on ideas about the self as empowered, autonomous, responsible, and transformable over time – were often at odds in ways that shaped and delimited the possibilities for selfhood. By becoming Clubhouse members, individuals were required to manage themselves in accordance with the program's structural and philosophical parameters, which posited a separation between personhood and psychiatric pathology, and to envision the self as workable beyond the boundaries of chronic illness and pharmaceutical dependency. Yet, the act of return to the Clubhouse conditioned for members ways of being and of thinking about the self that often paradoxically intervened in possibilities for autonomy. Throughout, I have attempted to take up this paradox and the tensions and possibilities it produced for members in how they thought about and enacted themselves.

Although the Clubhouse was an explicitly non-biomedical program and space, its very requirements for membership – a medical diagnosis and adherence to a pharmaceutical treatment regimen – tethered it inescapably to biomedical models of illness. Thus, self-management for Clubhouse members entailed murkily defined expectations for self-monitoring and moderating that often challenged the separation of pathology from personhood enforced by the logic of recovery. Nikolas Rose has written

that new norms require continual work "of the self on the self" towards the autonomous self – an ideal form of life. As I have explained, the autonomous self figures centrally in the paradigm of recovery, as an ideal outcome of its process of change.

At the Clubhouse, members were required to continuously manage and work upon the present self, while imagining and working *towards* a future self. Yet, for many members, the daily realities of living with chronic mental illness were often at odds with expectations for recovery set out by the Clubhouse model. Even program attendance itself produced contradictions in experience. Members were required to attend a minimum of four hours per week, but encouraged to attend more often – as often as possible. The act of return was thus a way for members to demonstrate investment in their own recovery and even, to enact recovery by participating in Clubhouse activities and tasks. Yet the Clubhouse program was structured so as to produce a space of stability, repetition, sameness, and predictability. The very givenness of the daily schedule, the Clubhouse meetings that occurred each Wednesday, the types of tasks performed throughout the day, and other forms of participation, created a space that simultaneously fostered dependency and stagnancy while encouraging members to engage in processes of change that ostensibly would take them away from the Clubhouse – to jobs, to other community engagements, to stable housing arrangements, to their families. Some members, particularly newer members, felt that coming to the Clubhouse each day made recovery possible, yet for many over time the regularity of return to the Clubhouse came to represent the limits of possibility for enacting the self. Thus, Clubhouse participation and expectations conditioned by the program simultaneously limited, or altogether foreclosed

for members the very possibilities for self-determination and autonomous selfhood upon which the logic of recovery relied.

For some, recovery was seen a process, for others an outcome – it could be something you "had" something you "used" or something you "went through" or were "in." It could be ongoing and perpetual, or a place you might arrive at some day, as "recovered." Some members defined recovery in ways that more closely aligned with medical self-management, such as seeing their doctor or therapist, "taking my meds" or, in contrast being off meds. Others had no definition at all, or could not define recovery until prompted. Some used language of self-improvement or language of self-help. I observed how recovery was invoked by members and by staff in conversations and in public forums, such as the Wednesday meetings or group activities. At first, I thought to categorize different definitions of recovery and look for patterns of idiomatic expression – after time, however, I began to see how recovery often became somewhat of a conceptual metaphor, a way for individuals to talk about themselves – and the possibilities they envisioned, or did not envision for the future.

I also considered how often references to illness and medication featured in conversations and found their way into other interactions and aspects of the Clubhouse world. Though I never asked people their diagnosis, members often readily volunteered that information, as well as information about what drugs they took and other aspects of their therapeutic regimen. The fact of living with mental illness did not disappear for members when they walked through the Clubhouse door, but they were discouraged by staff from enacting themselves in ways that signalled their illness. Rather than reflecting a lack of empathy or care on the part of staff, I came to understand these acts or moments of

enforced separation between pathology and personhood as reflective of the program model. Treating members as mentally ill was seen as a form of disempowerment – it put pathology before the possibilities for self-determination, responsibility, and autonomy. Yet, for members, the separation was illusory or blurry at best, and there were often moments when the psychiatric self emerged as indivisible from the forms of selfhood expected and accepted within the Clubhouse. I observed how the emphasis on this separation in the discourse of recovery was entirely at odds with forms of selfhood enacted by members – rather than enact a fragmented or discontinuous form of selfhood, where illness happened elsewhere and recovery happened there – the Clubhouse – members instead engaged ways of being that sutured together experiences of the self within the Clubhouse space.

Another point of inquiry into how experience and forms of selfhood were mutually shaped by conditions of the Clubhouse program was how members articulated ideas about time and the future in particular. I found that members indexed temporality often, in response to questions about how they were doing, in casual conversation, storytelling and in other moments. Time within the Clubhouse was both structured and elusive – the daily schedule repeated itself ad infinitum, it seemed, and the weeks often took the same shape, anchored around the Wednesday meeting, which often unfolded similarly each week. I became interested in how the daily return to the Clubhouse and the everydayness of mental illness worked into and against ideas about time – how the act of return produced a quality of repetitiveness in experience that countered ideas about progress, process, and change. In interviews and casual conversations, many members talked about living "one day at a time" "day to day" and expressed ambivalence or inability to forecast beyond the

present. For members who felt that life had a quality of sameness, the inability to forecast spoke less to a sense of giving up, and more to a sense of stasis and predictability – of givenness in daily experience.

Finally, the notion of return – to come or go back to a place or person – figures centrally in understanding how members experienced and enacted selfhood within the bounds of the Clubhouse space, and how experience and selfhood entered into and mutually shaped one another. The physical act of returning to the Clubhouse was shot through with ideas about other forms of return, to possible ways of being lost or elusive, to a 'former' idealized self, or, as a safeguard *against* returning to that self. I argue that even along trajectories of repetition, where existence is formulated as a daily return or re-arrival rather than a progression forward, experience is possible. Perhaps the episodic nature of time in experiences of chronicity, and the ways this bumps up against expectations for recovery – for continuously "working upon" and improving the self – demands that we rethink ideals of selfhood in the face of new ways of being in the world.

REFERENCES

Anthony, W. A.

 1993 Recovery from mental illness: The guiding vision of the mental health

   service system in the 1990s. Psychosocial Rehabilitation Journal 16(4):

   521–538.

Biehl, J.

 2005 Vita: Life in a Zone of Social Abandonment. University of California Press.

Brodwin, P.

 2013 Everyday Ethics: Voices from the Front Line of Community Psychiatry.

   Berkeley, CA: University of California Press.

Canguilhem, G.

 2012 Writings on Medicine. New York: Fordham.

Carr, E. S.

 2010 Enactments of Expertise. Annual Review of Anthropology 39(1): 17–32.

 2010b Scripting Addiction: The Politics of Therapeutic Talk and American

   Sobriety. Princeton: Princeton University Press.

Davidson, L., J. Tondora and P. Ridgway.

 2010 Life Is Not an "Outcome": Reflections on Recovery as an Outcome and as a

   Process. American Journal of Psychiatric Rehabilitation, 13: 1-8.

Desjarlais, R.R.

 1994 Struggling Along: The Possibilities for Experience Among the Homeless

   Mentally Ill. American Anthropologist, New Series 96 (4): 886-901.

 1997 Shelter Blues: Sanity and Selfhood Among the Homeless.

Philadelphia, PA: University of Pennsylvania Press.

Dickerson, F.

2006 Commentary: Disquieting Aspects of the Recovery Paradigm. Psychiatric

Services 57 (5) 647.

Doyle, A., J. Lanoil, and K. Dudek.

2013 Fountain House: Creating Community in Mental Health Practice. New York,

NY: Columbia University Press.

Estroff, S. E.

1981 Making it Crazy: An Ethnography of Psychiatric Clients in an American

Community. Berkeley: University of California Press.

Foucault, M.

1965 Madness and Civilization. New York: Random House, Inc.

Goffman, E.

1961 Asylums: Essays on the Social Situation of Mental Patients and Other

Inmates. Garden City, N.Y: Anchor Books.

Hancock, N., A. Bundy, A. Honey, S. Helich, S. Tamsett.

2013 Measuring the Later Stages of the Recovery Journey: Insights Gained from

Clubhouse Members. Community Mental Health Journal. 49: 323 – 330.

Hopper, K., J. Jost, T. Hay, S. Welber, G. Haugland.

1997 Homelessness, severe mental illness, and the institutional circuit. Psychiatric

Services 48 (5) 659 – 665.

Huneman, P.

2014 Writing the Case – Pinel as Psychiatrist. Republics of Letters: A Journal for

the Study of Knowledge, Politics, and the Arts 3 (2) 1 – 28.

Leamy, M., V. Bird, C. Le Boutillier, J. Williams, M. Slade.

2011 Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. The British Journal of Psychiatry 199: 445-452

Lilleleht, E.

2002 Progress and Power: Exploring the Disciplinary Connections between Moral Treatment and Psychiatric Rehabilitation. Philosophy, Psychiatry, and Psychology, 9(2), 167-182.

Luhrmann, T. M.

2000 Of Two Minds: The Growing Disorder in American Psychiatry. 1st Edition. New York: Knopf.

Meyers, T.

2013 The Clinic and Elsewhere: Addiction, Adolescents, and the Afterlife of Therapy. Seattle, WA: University of Washington Press

Murakami, H.

1997 The Wind-Up Bird Chronicle, trans. Jay Rubin. New York: Knopf.

National Registry of Evidence-based Programs and Practices (NREPP)

2010 ICCD Clubhouse Model.

New Freedom Commission on Mental Health,

2003 *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD

Pinel, P.

1806. A Treatise on Insanity, in Which Are Contained the Principles of a New and

More Practical Nosology of Maniacal Disorders, That Has Yet Been

Offered to the Public. D. Davis, trans. London: Cavell and Davies.

Porter, R.

2002 Madness: A Brief History. Oxford: Oxford University Press.

Propst, R.

1992 Standards for Clubhouse Programs: Why and How They were Developed.

Psychosocial Rehabilitation Journal 16(2): 25 – 30.

Raikhel, E.

2009 Institutional Encounters: Identification and Anonymity in Russian

Addiction Treatment (and Ethnography) in *Being there: the fieldwork

encounter and the making of truth*, ed. John Borneman and Abdellah

Hammoudi. Berkeley: University of California Press.

Rose, N.

1996 Inventing our Selves: Psychology, Power, and Personhood. Cambridge; New

York: Cambridge University Press.

2003 Neurochemical Selves. Society 41(1): 46–59.

2007 The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the

Twenty-First Century. Princeton, N.J.: Princeton University Press.

2009 Normality and pathology in a biomedical age. Sociological review 57: 66 –

83.

Scheper-Hughes, N., and A. Lovell

1986 Breaking the Circuit of Social Control: Lessons in Public Psychiatry from Italy and Franco Basaglia. Soc. Sci. Med. 23 (2) 159 – 178.

Schüll, N.

2006 Machines, Medication, Modulation: Circuits of Dependency and Self-Care in Las Vegas. Culture Medicine and Psychiatry 30(2): 223–247.

Scull, Andrew T.

1989 Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective. Berkeley: University of California Press.

Spitzmueller, M.

2014 Shifting practices of recovery under community mental health reform: A street-level organizational ethnography. Qualitative Social Work 13(1): 26 – 28.

Weiner, T.

2011 The (Un)managed Self: Paradoxical Forms Agency in Self-Management of Bipolar Disorder. Cult Med Psychiatry 35:448–483

Whitley, R., and E. Siantz.

2012 Recovery Centers for People with a Mental Illness: an Emerging Best Practice? Psychiatric Services 63(1): 10 – 12.

ABSTRACT

PRESENT FUTURES: POSSIBILITIES FOR SELFHOOD AT A COMMUNITY MENTAL HEALTH CENTRE IN DETROIT, MICHIGAN

by

TALIA GORDON

August 2014

Advisor: Dr. Todd Meyers

Major: Anthropology (Medical)

Degree: Master of Arts

Since the 1990s, recovery-oriented approaches to mental illness have become the dominant paradigm in contemporary U.S. non-clinical institutional settings. Central to the recovery paradigm is a discourse of self-determination that separates psychiatric pathology from personhood and expects those diagnosed to enact and manage themselves as autonomous subjects – as empowered, responsible, independent, and transformable. For many individuals, however, everyday experiences of illness are at odds with expectations for recovery, defined as a "process of change" through which the self is continuously worked upon and improved (SAMHSA 2011). One particularly popular non-clinical recovery modality is the Clubhouse model of psychosocial rehabilitation – a voluntary, community-based program for individuals diagnosed with severe and persistent mental illness. Drawing on four months of ethnographic fieldwork at a Clubhouse in Detroit, this paper examines the possibilities for selfhood conditioned by the program's principles and daily structure and the ways that ideas about recovery entered into ideas about the self and the future. I argue that within the Clubhouse space, members came to model forms of

selfhood that often eluded or ran counter to expectations for recovery, and in doing so called into question the possibility for self-determination and autonomous selfhood upon which the logic of recovery relied.

AUTOBIOGRAPHICAL STATEMENT

Talia Gordon received a BA in International Development Studies from McGill University in Montreal, Quebec in 2011, and began work toward an MA in Anthropology at Wayne State University in Detroit, Michigan in 2012. She is currently a doctoral student at the University of Chicago in the Department of Comparative Human Development. She can be reached at trgordon@uchicago.edu.