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The Construction of Self-Identity in the Chronically Mentally Ill: A Focus on Autobiographic Narratives of Mentally Ill Patients in South Korea

Abstract

. A systematic policy for treatment and management of chronic psychiatric patients in South Korea was begun with the passage of the Mental Health Act in 1995. The mentally ill patients who were previously separated from the society now have opportunities to live in local communities under medication with the help of rehabilitation facilities. This study aims to understand how mentally ill patients deal with their new medical environment. An autobiographic narrative analysis is methodically applied in order to link the social and the individual levels. Autobiographic narratives of illness show how the patient's self-identity is formed and further developed according to the chronic conditions of his illness and the continual learning from experiences. In regard to the construction of self-identity, two aspects should be taken into consideration: First, medication is absolutely necessary before patients can leave the hospital and participate in rehabilitation programs. Secondly, social integration is usually evaluated by the return of the patient into a normal biographical stage. It turns out that medication deprives the patients of control over their emotions, their bodies. Furthermore, their social environments – including family, friends and the labor market – work against them. Under these circumstances, mentally ill patients are liable to adhere to their own interpretation of mental illness, and what they experience is far different from the expectations of experts in the field. The new mental health environment also contributes to the formation of patient communities. As a result, chronic psychiatric patients are able to build their own subculture and to see themselves through their own eyes. Further studies are needed to explore whether and to what extent the ongoing improvement of social conditions for mentally ill patients has an impact on autobiographic narratives and self-identity construction.

Keywords

Psychiatry; Chronic mental illness; Autobiographic narratives; Biographical methods

Over the last ten years the medical environment of South Korea has considerably changed, especially for chronic psychiatric patients (Kern and Nam 2005a). A systematic policy for the treatment and management of mental illness was introduced with the Mental Health Act in 1995 and was followed by further health and welfare measures (OECD 2002). In the past, mentally ill patients belonged to a group whose existence was concealed and largely ignored under the banner of economic growth. The Korean government took no responsibility for mentally ill patients, and patients' families had to shoulder the burden of their care alone. Due to the increase of nuclear families and rapid urbanization, most families could not afford to look after and provide sufficient care for their mentally ill family members. As a consequence, mentally ill patients were often abandoned and confined in asylums for many years, and in many cases, they were not clearly distinguished from other groups of deviant people.¹ These asylums were generally called welfare facilities and managed by profit-oriented, private entities that covered their expenses by billing patients' families, taking government subsidies for unidentified homeless people, and receiving donations from religious institutions. These so-called welfare facilities were usually located in the suburbs, separated from the cities, and there was little oversight by local authorities. Although in some institutions there were recurring cases of human rights violations, embezzlement, and corruption, such affairs were handled as individual crimes. Although responsible parties were punished, nothing changed on the institutional level (National Human Rights Commission of Korea 2003).

With the introduction of the Mental Health Act, a new concept of community-based rehabilitation was put into practice. Now mentally ill patients have opportunities to live in local communities under medication. In order to support the social integration of chronically mentally ill people, rehabilitation facilities such as mental hospitals, nursing homes, and group homes were established. Social workers have been trained and recruited to work in these facilities. However, the community-based rehabilitation concept turned out to be very difficult to establish. As there is not enough financial and social support to improve on the old practice of separation, "locking away" mentally ill people from the society is still widespread, and human rights violations are often reported in mental institutions. Against this background, it seems that psychiatric patients are faced with a serious dilemma. On the one hand, they are urged to confess their mental illness in order to get the chance to be rehabilitated and reintegrated in the community. On the other hand, the mistreatment in medical and welfare institutions is still going on.

The aim of this study is to explore how mentally ill patients react to a new situation. In order to connect subjectivity and social structure, the analysis of autobiographic narratives is a very useful tool (Bury 2001). Autobiographic narrative analysis is one of the biographic methods that are helpful in exploring the subjective dimension of mental illness (Strauss et al. 1963; Strauss and Glaser 1975). A researcher using biographic methods examines a variety of materials related to an individual's experiences, for example, letters, diaries, oral histories, and interviews. The researcher doing autobiographic narrative analysis shares with the researcher using biographic methods the assumption that patients are negotiating actors who create a new kind of social order. In this respect, the autobiographical narrative analysis is different from structural functionalism and labeling theory (Williams 2003). In the structural functionalistic tradition (Parsons 1951, 1957) chronic psychiatric patients are regarded as actors who comply with the instructions of medical professionals, while the labeling theory (Goffman 1961) considers them to be objects of re-socialization in mental hospitals. In particular, the autobiographic narrative

analysis is based on oral renditions about the life history of the narrator. Autobiographic narratives can, therefore, offer a first interpretation of the situation as interpreted by the subject.

Bury (1982, 1991) elaborated on and expanded the biographic method of Strauss and Glaser to develop the autobiographic analysis. In discussing the autobiographic narratives of chronic illness, Bury (2001) distinguishes three forms of narratives that he labels contingent, moral, and core. Contingent narratives show how the patients reconstruct the causes of their illness on the basis of their own experiences, without exactly following biomedical explanations provided by modern medicine. Contingent narratives help the patients to understand and accept their present situation by allowing them to reconstruct the past on the basis of subjective experiences (Nam 2001). Moral narratives help the patients to construct their identity by evaluating their social environment. The society that they have to deal with after the onset of the illness is not the same as before. In moral narratives they interact with a new societal situation, keep social distance, and evaluate the society. Finally, core narratives raise the issue of intervention on the societal level. Core narratives refer to the cultural level, delving into the deep meanings behind pain and illness. The patients reveal their critical view about the society beyond the personal experiences of their illness. These three forms provide a useful framework in order to understand the patients' subjective perception and definition of their situation.

Method

In this study, the autobiographic narratives of patients who are suffering from chronic mental illness will be analyzed. The fieldwork mainly focused on rehabilitation facilities established in order to support the social integration of the patients. The aim was to explore how chronically mentally ill people are dealing with the new mental health environment. In order to deepen my understanding of their spheres of action, I also visited other institutions like asylums, mental hospitals, and marriage counseling agencies for the disabled. The chronic psychiatric patients I met have been strongly integrated into the new mental health system. In other words, they were staying in a group home or with their family at the time I saw them, utilizing the rehabilitation facilities in order to take the prescribed medication. Most of them were schizophrenic, their ages ranged from the 20s to the 40s, and they belonged to the middle or lower classes (beneficiaries of Medical Aid and Livelihood or other social aid) (Korea Association of Community Mental Rehabilitation Centers 2002).ⁱⁱ

The field study was carried out in the city of Seoul from March to May 2003. By using snowball sampling techniques, I called rehabilitation facilities located near my neighborhood in the city quarter of *Seodaemun-gu* until one of them gave me permission to visit. While the telephone conversation about the rehabilitation programs with the experts went well, my visits to the facilities with the aim of conducting participatory observation was complicated by cautious administrators. When I visited the institutions, I was usually allowed to see the patients in rooms assigned for specific activities. In this way, I visited a classroom where patients were being taught, a workroom where they were doing a wrapping job, a canteen where they were eating their lunch, and a leisure room where they were playing ping-pong. It was very helpful for me to see how patients act under medication, how the patients socialize, and how they communicate with the staff members, mostly social workers.

During the fieldwork, I was usually in the presence of staff members. This means that my meetings with the patients were almost always in a supervised setting.

Therefore, my rapport with the patients was not satisfactory. Nevertheless, I had to accept that the duration and extent of the contacts largely depended on the cooperation and openness of the staff members. When I finished with fieldwork in one facility, I asked the social workers there to recommend another facility for my research. They usually suggested one or two facilities. These institutions had close ties because they exchanged clients (patients who visited them), organized regular athletic events, conducted similar projects, or exchanged information. Accordingly, I was convinced that accepting their recommendations was a good way to follow the action space of psychiatric patients. I successively visited the Welfare Center for Disabled people, the Mental Health Center, and the training Facility for the Disabled, all located in *Seodaemun-gu*. I also went to the *Taiwha* Fountain House, the *Sekwang* Mental Sanatorium, and the Seoul National Hospital.

My fieldwork was primarily conducted in the *Taiwha* Fountain House, one of the rehabilitation facilities. This was the only place that was willing to give me an opportunity to establish a rapport with the patients. The staff members (social workers) and patient members (chronic patients) in the house allowed me to attend the house activities for one month as a volunteer and researcher.ⁱⁱⁱ The facility has three floors, each with a relatively open structure. On the first floor, the entrance is under surveillance and the office for social workers is located, while the remaining floors each have one huge open place where the members are allowed to walk, stand, sit down, or talk with each other. At the edge of the open place, there are small rooms such as guest-rooms, computer rooms, a library, and a billiard hall. I was able to talk to everyone on the spot. The architectural structure helped me to establish a rapport and come into contact with the members without making prior arrangements and appointments, which would restrain the spontaneity of clients.

During my fieldwork, the *Taiwha* Fountain House had about 113 registered clients, while the average number of daily visitors was about 78. In April 2003 I paid a visit to the facility every other day and participated in the regular activities. These activities were divided into three sections: education and information on the first floor; office work and administration on the second floor; and shopping and cooking on the third floor. The program of every section consisted of meetings, tasks, and leisure activities. Every Monday, the clients were asked where they wanted to participate that week. A meeting was held on every floor in the morning. One or two social workers who were assigned to the section helped the patient members decide who would be chief for the week, who would take the minutes for every meeting, and who would perform other tasks. The sections were intended to help members to reintegrate into normal everyday life by experiencing various activities. Clients were already used to the routine, and many of them participated in their favorite section for weeks. Unlike them, I changed the section every week in order to get an impression of the atmosphere on different days. On average, about 20 people participated in one section. Every day, I communicated with approximately 30 people, including several members whom I met by chance in the dining hall or the leisure rooms.

As mentioned earlier, the priority of the research was to have a rapport with the members on the basis of spontaneous involvement. In light of the fact that most patients lived in fear of being identified as mentally ill by the others, I did not record my conversations with patients. It seemed to be inappropriate and disturbing to take out a technical instrument during informal and improvised situations. Therefore, I carried out the fieldwork without auxiliary equipment for recording (i.e. recording machine, photo camera, or video camera). Instead, I kept a diary during the course of the fieldwork and documented observations or conversations as soon as possible

after they occurred. I tried to understand and interpret the findings, and repeated this process. Owing to the cooperative staff and patient members in the *Taiwha* Fountain House, I proceeded with my research until I came to the conclusion that the fieldwork had reached a state of theoretical saturation (Strauss and Glaser 1967).

By participating in the activities of the different sections (e.g. cleaning a room, selling secondhand clothing, taking minutes, cooking, serving dinner, selling in the snack bar, folding letters, etc.), I slowly established a rapport with the patient members of the house. Starting with the people who had been favorably disposed toward me and told their stories spontaneously, the fieldwork entered the stage of narrative interviews. The attributes of those respondents who are cited in the following narrative analysis are listed in the table below.

Table: Basic information about cited respondents (2003)

Name ^a	Sex	Age	Diagnosis	Years ^b	Situation
Bae	F	late-20s	Schizophrenia	4	Started with temporary job
Cha	M	mid-40s	Schizophrenia	25	Participated in an education program
Cho	F	mid-20s	Schizophrenia	7	Participated actively in the section's assignments
Han	M	late-30s	Schizophrenia	22	Well-rounded human relationship
Jung	F	early-30s	Depression ^c	23	Participated actively in department assignments
Ko	M	mid-30s	Schizophrenia	16	Desire for other's attention and social recognition
Kwon	M	early-40s	Schizophrenia	11	Need for counselor's role, good writer
Lee	F	early-50s	Schizophrenia	34	Worked independently, active character
Min	M	late-30s	Schizophrenia	18	Played a leading role in a small group
Mun	M	mid-20s	Schizophrenia	9	Head of a section, vigorous activity
Park	M	late-30s	Schizophrenia	19	Relationship with only a few people
Roh	M	mid-30s	Schizophrenia	11	Laborer, active character
Seo	M	early-40s	Schizophrenia	28	Independent dwelling, need for support
Sin	M	mid-40s	Schizophrenia	21	Worked independently, steady religious life
Son	F	early-40s	Schizophrenia	12	Daily presence in the facility, strong self-expression
Song	M	mid-20s	Internet addiction	1	Focused on personal relationships, active character
Sung ^d	M	mid-50s	Schizophrenia	25	Tried to get a job many times, steady religious life
Yang ^d	F	late-30s	Schizophrenia	7	Jobless, bad economic situation, active character
Yeo ^d	F	late-20s	Depression	2	Cohabitation with a lone parent, looked for a job

^a All of the names are fictitious to allow maintenance of anonymity.

^b Years since the first diagnosis.

^c She is also diagnosed as mentally retarded.

^d A registered member of the Mental Health Center. The staff of the Mental Health Center disapproved individual interviews with the members. Therefore, the dialogues took place outside the institution (e.g. in a dining room for members, etc.).

As expected, it was not easy to make contact with the patients spontaneously. Most of them were unwilling to talk with a researcher unknown to them. Besides, some people were not capable of talking with me due to heavy medication. Despite difficulties, I succeeded in making small talk with some members. The conversation with the psychiatric patients usually started with mutually exchanging information like the following: Who are you? What are you doing here? How old are you? Are you married? Do you have any children? But small talk did not ensure that they would tell me their own medical stories. As soon as I began to talk about their medical history, the patients tended to show a resolute attitude towards me, either cooperative or rejecting.^{iv} Some people showed an indifferent attitude and avoided talking with me; others willingly answered my questions about the history of their mental illness. According to my principle of spontaneity, the patient's reaction was respected.

The construction of self-identity

Contingent narratives

It should be assumed that nowadays chronic psychiatric patients are well informed about their disease from a biomedical point of view. Since the start of the mental health reform process in South Korea, professional knowledge is incessantly conveyed to the patients. First, whenever mentally ill patients are hospitalized or pay a visit to a hospital for their medication, they get the advice of experts. Secondly, if they come to stay in a nursing home or utilize rehabilitation facilities, some information is provided by the professionals who are in charge of them. A third source is other psychiatric patients who come together again and again in mental institutions. What is important in reference to contingent narratives is how patients take the information into consideration when they tell about the causes of their illness.

Chronic psychiatric patients tend to begin their stories by introducing a failure at school or a character flaw. *Roh* (in his mid 30s) had been going to a day hospital for 11 years due to schizophrenia. He talks about how he went there for the first time in the following words:

When taking an examination in high school, I felt confused, and I could think of nothing. I had learned my whole stuff before. But whenever I took a look at an exam paper, I could not remember the answers to the questions. It made me quite crazy. So I began to go to the mental hospital regularly.

In many cases, a bad record in examinations was subjectively perceived by the patient as a symptom of mental disorder. *Cha* (in his mid 40s) says also that he had trouble concentrating on learning since the 3rd class of high school and gradually lost his memory. After he failed in a college-entrance exam, he went to a mental hospital, holding a consultation with a psychiatrist. *Cho* (in her mid 20s) says that she went to hospital due to excessive clinging to her school achievement in high school. In light of the so-called "education fever" (Seth 2002) in South Korea, it is no surprise that those who were diagnosed prior to the Mental Health Act (*Roh* and *Cha*) as well as after the reform (*Cho*) have suffered following a bad performance at school.

At the beginning of the illness, the subjective story about the disease seems not to be in conflict with the biomedical explanation. On the contrary, the latter helps the patients to believe that their symptom is just a functional disorder from a hormonal

disturbance, not from madness. With the help of medical measures, they accept the promise that they will be able to improve their competence and get back to a normal life. However, their belief in modern medicine does not last long. Against all expectations, most patients found they were chronically ill, not temporarily ill. They slowly become aware that the drugs that they had taken with the onset of their mental disorder would probably accompany them all their lives. The effects of medication seem to be foremost in their minds instead of a functional or mental disorder. *Cha* was suffering from schizophrenia for 25 years.

By the year 1978, I took medicine for the first time. On the following day, I felt sick at the stomach, twisted in my body, and so on... In the meantime, drugs have been changed little by little. There are also drugs that help with the side effects. I got used to being put into a mental hospital because the side effects were too serious. In the past, drugs were very painful for me. These days, however, good drugs have been developed.

Cha's physical state is dependant on a medication, and he has no influence on its development or side effects. In other words, his body is helplessly subject to an uncertain state, and he has no self-control. His illness narratives give the impression that the initial pain he suffered from a bad school record had now been supplanted by a necessary evil, namely drugs. According to *Park* (in his late 30s), a schizophrenic patient for 19 years, the medicine has not affected him any more than sleeping tablets. However, he takes one of the pills every day. Though taking medicine could bring on a painful or uncomfortable state, most of the patients accept it as a necessary part of being a patient. They understand that a relapse caused by a lack of medication could bring on a worse situation than they are experiencing in the present. A relapse means that they have to take more drugs that put them in a zombie-like state. They have to leave their home, and they are confined in mental hospitals or nursing homes for a long time. The skepticism about medical treatment extends to therapies that are usually positively considered as modern and humane.

I had an auditory hallucination... Therefore, I had been at a day hospital for 11 years. There, I received cognitive rehabilitation therapy, music therapy, and art therapy. At the beginning of the therapy, the psychiatrist told me that I would be cured completely. But just now, he asked me if I could accept my hallucination as it is. I was simply aghast at his words. I received therapy for as many as 11 years, and then he told me to live a life like before. (*Roh*)

Considering the fact that he began with his therapy before the reform, it could be assumed that his state was not serious, and his family felt they could get along with him without putting him in an asylum or long-term mental hospital. As his expectations for a complete cure have evaporated, *Roh* does not hesitate to criticize the hollow promises of the doctors. After all, he has landed in the rehabilitation center like other chronic patients who are mainly treated with drugs and hospitalization without therapies. It shows that the new medical measures had no impact on the patients' skeptical attitude towards modern medicine since they are not free from the disease. Chronic psychiatric patients are sticking to the proximate cause of their mental illness and continuously raising questions about the effects of medical treatment and doctors.

The precarious coexistence of two beliefs – that the patients' illnesses were triggered by specific social circumstances, and, at the same time, that their illnesses should be controlled by medicine lifelong – is endured only because they fear that

worse things will happen and seem to have no hope that things will get better. From the moment they see themselves as chronic and not temporary despite their obedience in following a painful medication regimen, the patients are likely to rely on their subjective belief about their condition instead of the medical expertise. However, although chronic patients try to emancipate themselves from the patients' role, they perceive themselves with a medical perspective. Their self-awareness becomes quite uncertain and obscure. In other words, the patients are thrown into an unstable coexistence between subjective causes of the illness and professional knowledge. The self-perception is not changed until the chronic patients recognize how their circumstances have altered while they suffer from the mental illness.

Moral narratives

Since the advent of mental health reform, the patients are no longer held in asylums and long-term hospitalization. Now patients can stay in contact with the outside world, including their family, friends and community. However, the following narratives show how the patients in the new medical environment are socially separated. The separation from what they are used to begins in the family. In South Korea, the family is valued as a resting place from the cradle to the grave. This is supported by the Confucian tradition, on the one hand, and reinforced by the lack of a welfare policy by the modern state on the other. Against all expectations, the families are incompetent or reluctant to take responsibility for mentally ill family members. *Song* (in his mid 20s), who received treatment in a mental hospital last year due to Internet game addiction, looks back upon the disappointment with his family's reaction to his illness:

One day, my parents told me, 'Let's go to hospital!' Without doubting them, I followed them. After arriving at a hospital, my parents told me, 'Wait a moment! We will come back soon!' I waited and waited, but they did not return. Then a nurse came and said that my parents would be there if I would have an injection and take a rest. I believed it. I woke up from a long and deep sleep after the injection. However, I was still alone in the mental hospital. What's that? I was suddenly confined. Immediately, I ran to the locked door and cried out. How could my own parents send me to the mental hospital? When I told my parents, 'I want to leave this place,' they always said, 'We will take you out of here only if you get well.' So I stayed there for six months.

According to his story, *Song's* parents did not inform him about their intentions, to say nothing of asking for his approval. The behavior of *Song's* parents indicates that hospitalization might happen without the patient's acceptance both before and after the mental health reform. Thus, it is not surprising that a hospitalization is usually described as a blackout in the patient's memory, mostly with expressions like "by ambulance in a compulsory delivery" after "suddenly falling unconscious." They emphasize their helplessness and complaints about their families. Their family relations are broken.

The bad relations continue after the psychiatric patients are discharged from the mental hospital and sent back to their families. The place they return to is not the same anymore. The family relations are not only emotionally stressed and strained, but their families are also financially burdened. *Jung* (in her early 30s) came to Seoul two years ago and stays now with her widowed elder sister. She remembered:

Last year I applied for a welfare card for disabled people. As I belong to the needy class, I receive 100,000 won [about 107 dollars] per month, perhaps

a little bit more these days. However, my sister takes all of the money without giving me any. But it's my money, not hers.

A subsidy from the government can cause trouble in the family. If patients had been confined in a welfare facility, the subsidy would most probably go into the account of the facility owner. After the reforms, more and more families started to manage the money. What the family hopes for is to minimize the damage and burden caused by the ill family member, if possible. Many times the family tells no one about sending the ill person to the institution. Sometimes, the mental history of the patient is known only by the parents. Since hospitalization at a mental hospital is limited to three months, there are also families who transfer the patient to another mental hospital shortly after the release from the first. This happened in the case of *Park*. If the patients are fortunate enough to stay at home, they are not socially integrated. They are increasingly distant from family and friends and bored to death.

As soon as they recognize how their social environment deals with them, the patients are prone to feeling great anxiety about the outside world. *Han* (in his late 30s) has suffered schizophrenia for 22 years. After the mental health reform, he decided to register himself as disabled. Then one day he received an official notice from the Driver's License Agency. It said that he must retake an aptitude test for the driver's license due to his disease. His registration must have been sent to the agency. Since then, he is afraid of further disadvantages caused by his registration as disabled.

If I go out of the doors, I am afraid that other people could recognize me. Therefore, I tend to avoid trouble with other people in advance, if possible.

In response to doing his best to follow the new mental health policy, *Han* has encountered further disadvantages. His reaction illustrates well how anticipated stigmatization changes individual behavior (Angermeyer et al. 2004). Psychiatric patients who lose their self-confidence and self-control over their bodies become susceptible to another's opinions (Kleinman 1988). Although the social circumstances are unfavorable or hostile to them, the patients try to close the distance by conforming to given social norms.

What keeps them from despair seems to be an increasing control over their medication. As stated earlier, the issue of medication gradually moves to the center of their attention after the onset of the mental illness. As time goes on, the chronic patients learn how to deal with the drugs. As they get used to various side effects of the medicine dispensed by a psychiatrist, the patients are capable of requesting that dosages of drugs be changed in compliance with their wishes. Therefore, they can add or avoid specific effects of the medicine. By allegedly having the control of their own bodies – in other words, the control over the side effects of drugs – they become more self-confident and think that they might be able to enter a more normal life as student, employee, or married person, for example. Their self-confidence is sometimes so strong that they insist on leaving the treatment program and do not accept being constrained. *Park*, who has suffered from schizophrenia for 19 years, says:

I had no time to keep company with a woman while shuttling back and forth between the mental hospital and society for many years. Anyway, if I would like to marry, I had to get a job, first of all... There are a lot of people who marry without responsibility, but, they are wrong. A man may marry only if he has a job and takes full responsibility for a married life.

Park says that he is single because of his unemployment, which is due to his illness. In light of his long state of illness, it is presumed that he will remain unemployed and single all his life. Instead of complaining about his future, he sets high moral standards for himself and follows social norms. He turns his forced inferior social position as an unmarried and unemployed young man into a socially accepted state from an ethical point of view. In this sense, he ironically acts as a supporter of a value system that is hostile to his needs (Yoshida 1993).

In addition to wanting marriage, psychiatric patients are keen on earning a livelihood, if possible. However, the labor market is almost closed to the mentally disabled. After the mental health reform, every company with over 300 employees is forced to hire 2% who are disabled. The reality is that the companies often prefer to pay a penalty. Meanwhile, some jobs are temporarily and irregularly arranged by rehabilitation facilities on a part-time basis. The jobs consist of low-wage work such as wrapping, making shopping bags, setting gems, inserting strings, and distributing leaflets. There are not enough jobs for all applicants (i.e. patient members in facilities who want a job). Accordingly, the patients have to wait for their turn to get even a small job. Besides, the work is mostly conducted in the rehabilitation facilities or at a sheltered workshop, where they are kept apart from regular workers. This means that in terms of wages or work experience, it's not worthwhile getting a job. The search for a job means that patients want to show they are willing to adapt to the working society.

If patients really try to become economically independent by starting their own businesses, they are confronted with institutional barriers. *Sung* (in his mid 50s) became a sailor in his early 20s in order to earn a large sum of money in a short time. But one day he collapsed on board and was delivered from the ship to a mental hospital by a helicopter. After a while, he left the mental hospital and wandered from place to place. Finally, he was found as a homeless man on the street and once again delivered to a mental hospital as a schizophrenic. He could not get out of the mental hospital because he had no known relatives. After 14 years, he fortunately succeeded in finding the address of his younger brother. With his brother's help, *Sung* could leave the mental hospital. After being discharged, he tried to found his own business many times.

I am a beneficiary of the Livelihood Protection who gets 246,000 won [about 263 dollars] monthly from the government, in addition to being the recipient of the first category of the medical aid... Putting both benefits together helps pay for medicine; it seems that I spend about 1,000,000 won [about 1070 dollars] monthly for this. I make an effort to get a job, but it doesn't work out. If I had an income, I could get no money from the government.

Despite his 25-year medical history, he does not give up on getting his social life back. His hope for economic independence conforms to social norms and expectations. The patients are incessantly prodded to make an effort to return to a normal life in public. However, their willingness to work is not enough to help them attain the goal. Patients are hardly able to gain social recognition by their achievements: One of them tried every job, but always on a part-time basis (*Cha*). Thus, it was impossible to make a plan for his future. Another one graduated from the "Open University" and received a teaching certificate, but he has no teaching practice so far (*Seo*, in his early 40s). Another one took the *College Scholastic Ability Test* three times during her illness, but she did not go to a university (*Cho*). She is now aiming at rising to the challenge once again.

Experiencing these frustrations, psychiatric patients increasingly move away from being seen as a temporary patient towards being looked at as a “loser” who deviates from social norms. In South Korea, the characteristics of a loser’s biography usually consists of being suspended from school, being forced to live as a single person, childlessness, homelessness, dependence on parents, incompetence, long-term unemployment, exemption from military service, and so on. In addition, they are often excluded from getting a driver’s license, having a cell phone, or getting life insurance. Such signs of deviation are not only reflected in their social economic status (SES) but also in their lifestyle (irregular everyday life, laziness, obesity, avoidance of personal relations, etc.).

In the new environment, the patients are allowed to expand their sphere of action without restrictions, as long as they take their medicine. In reality, the ability to act is limited in many respects for chronic psychiatric patients. They can go to a mental hospital in order to take medicine weekly or monthly or utilize social rehabilitation facilities. *Bae* (in her late 20s) shows how patients deal with repeated changes while going to different institutions. Four years ago she was delivered to a mental hospital by her family after losing consciousness. Before that, she had been kept at home all day long for six years after graduating from high school. Since her first hospitalization, she has been going in and out of mental hospitals and rehabilitation facilities.

So I continued going to the mental hospital and then leaving there, again and again. Is it called ‘the revolving-door syndrome’? Something like that? One day, they gave me permission to leave a mental hospital, but I didn’t like to go out. At that moment, sunlight flooded into the ward. It looked very peaceful. I said, ‘I won’t go out.’ In the end, I went out, saying to myself, ‘Sunlight is not only here, but also elsewhere.’

In order not to come here (to the rehabilitation facility), I tore up my application and documents. However, I had to come here against my own will. Here is a sort of narcotic. If I come here, I don’t need to work. If I am at home alone, I am really bored. Here, I can at least talk with other people, so I feel comfortable.

Her narrative demonstrates that *Bae* does not act as a passive object that is delivered and placed in a ward. She tries to put herself at the center of the story as the decision-maker. She knows that the release from the hospital does not mean that she will be free from being a patient. Furthermore, the outside world might not always be better than the hospital. She is under the pressure of decision-making and becoming aware of her own motives in order to make a decision.

Cho with a seven-year medical history also shows a strong tendency towards self-observation and self-reflection. These days, she tries to find a job through a rehabilitation facility in order to earn her own money. With the money, she is going to enroll at an educational institute or university. She talks about her own spiritual world very calmly:

It seems that it is also advantageous to be caught by a disease. Since I became mentally ill, I think about my relationship to other people and reflect on it. The worse the disease becomes, the more I reflect on myself. Normal people do not do so, do they? I didn’t think so much about it until I was sick.

Spending time wandering and loafing around all day, chronic psychiatric patients have ample time to review and consider their everyday lives. From this reflection, she comes to the conclusion that her spiritual world might be superior to

that of the others. This means that she accepts her illness as it is and starts to build up her identity as a patient.

One of the greatest effects of the mental health reform is to make possible a sort of patient community. Chronically mentally ill people have a similar space of action as well as similar interests (Strauss et al. 1963). This enables them to form their subculture. In their subculture they share their own rules and stories. First, they develop their rank order. Following the Korean manners, they call each other elder/younger or sister/brother. Also, there are extraordinarily respected persons among them. The reasons for respect are different from those in the outside world. What is important is the courageous action against authorities and prescribed rules. One respected patient once used violence in a mental hospital and was punished by having his hands tied. Another one swallowed as many as 30 pills. There are also conventional reasons for respect such as fluent speaking and a university degree. Some people acquire new self-confidence in the process of being recognized. It might happen that one's competence in leisure activities like table tennis, basketball, billiards, or writing is valued inside mental hospitals and rehabilitation facilities.

Secondly, there are some in-groups in the patient community. Informal members of an in-group are used to inviting each other to smoke cigarettes or drink coffee, go out drinking, or come to a birthday party. Members in a group can share their stories about the pain and suffering from their disease. Furthermore, they often diagnose each other on the basis of their own experiences, saying things like "you are getting better" or "you are getting worse." In their subculture, insider information about mental institutions (e.g. characteristics of the mental hospital and social rehabilitation facility, hospital charges, conditions and treatments) are steadily exchanged and transmitted to others. The collected information helps them to choose a suitable facility or to adapt to a new environment. *Mun* (in his mid 20s) started going to a mental hospital due to his anthropobia. He got his disease after being hit by an elder student who stayed with him in a self-boarding room during his schooldays. Now he is with his father, while his mother is remarried and lives elsewhere. In the meantime, he has also been in other rehabilitation facilities.

When I was in a mental hospital, I said that I would go to this facility after my release. Someone there told me not to come into contact with a specific person in this facility if I would like to avoid his/her bad influence on me. When I came here, I deliberately avoided the person. So he/she doesn't talk to me either. It's very comfortable.

This scenario implies that the so-called revolving-door syndrome triggered by the new medical reform has had an unintended effect. By repeated visits to institutions and contacts with the other patients, psychiatric patients are learning how to behave in order to cope with their lives. In other words, the revolving-door phenomenon offered a favorable condition under which they could build a patient community.

Even though the patient community is comfortable and relaxed, self-satisfaction is not welcomed. The patient members are continuously reminded of the naked truth – that they are not allowed to be happy in the rehabilitation facilities because they are supposed to be in just a transitional space, and they must once again enter into society. Their ultimate goal is to return to society. *Lee* (in her early 50s), one of those considered to be a model patient, had once been in the facility. After a while, she got a job and presently works on her own. Once she visited the facility and had a pleasant chat with old friends. Despite a good atmosphere, she never misses reprimanding some patients about their attitudes and habits. She tells them:

You have to leave this place as soon as possible. This is also expected by the facility. The first time I came here, I found myself in a paradise where everyone speaks fluently and listens considerately and where teachers (i.e. social workers) treat me well. So I walked around in the crowds, drinking and inviting others... Society is quite different from here. You would be immediately expelled from society if you behave like you do here. Do you know? After getting a job, many people lose it and come back to the facility ... How difficult is it to continue working...? Assignments given from here are not exactly worth mentioning as a job. If you go outside, you must be clever and cunning. Nobody wants those who are as stupid and dull as you here.

The rehabilitation facility must have been a kind of paradise for *Lee*, who spent more than 20 years under the old mental health environment. She enjoyed the patient's community until she recognized that the comfortable state would not lead to the normal life that she was pursuing. *Lee's* critique of her old acceptance of life in rehabilitation is so severe that she discourages the patient members from enjoying their life in the rehabilitation facility and causes them anxiety. She makes clear that the discrepancy between the patient community and the normal society is considerably broader than she expected. Unlike the rehabilitation facility, she says, the society is hard and intolerant towards backward people.

A warning against naive optimism is offered by *Sin* (in his mid 40s), another model patient. He had been in the rehabilitation facility and used to work in a sewing factory. He is married and works at a parking lot. On a visit to the facility, he gave his companions some advice on the basis of his own vocational experiences:

While working, there is a moment when I'd like to talk about my mental disease. But you should never talk frankly to your friends even if they are nice. No way! After they hear about your mental illness, they say it's no problem, but that's not true. I have experienced so many times that, if something bad happens, they always put the blame on us.

The fact that these warnings come from insider patients makes them hard to take. Although they have achieved their goals of getting married and having a job, their agony hasn't ended. The society won't be pleased with the patients even after they have adapted to social norms. The anxiety and frustration lead the patients increasingly to stay in the patient community.

Core narratives

In light of the desperate situation of chronic psychiatric patients, the question is whether they can transform their frustration and disappointment into a social problem. The narratives indicate a turn inwards. Instead of criticizing social circumstances, the finger of blame is often pointed at one's self. The autobiographic narratives become pessimistic or tragic. *Min* (in his late 30s) has been suffering from a thought disorder and a sleep disorder since high school. He wants to become a pastor of a church for the disabled. His comments about the members of the facility are quite pessimistic:

Look at the people here! All of them are at rest. They should forget the past and stand up, but they are still resting. Maybe one of them is capable of getting on his feet again... However, they have no patience, in other words, neither concentration nor consistency. That is their fatal weakness. Once they stand up, they relapse... and relapse.

In his view, they have no power to start again. *Min* does not attribute the pessimistic situation to the medical treatment or the social discrimination. Instead, he is looking to religion to console the patients. He seems to have found the hope that will not be destroyed by relapse. However, his hope does not lie in this world.

Compared with *Min*, some people find an exit from hopeless desperation in another way, by committing suicide. Most of the patients have already seen some suicides in mental hospitals or facilities. According to *Min*, a few people commit suicide every year in the *Taiwha* Fountain House. Because such tragic incidents are quite usual, psychiatric patients are becoming more and more indifferent to the whereabouts of other patients.

There are members that disappear for a while. Some of them never come back. But I am not curious about what happened to them. I have no time to worry about others because we are all suffering from sickness... First of all, I am always exhausted. After a few years, we could meet again in a mental hospital or rehabilitation facility. (*Han*)

Han assumes that the other patients are on the same track of life. All of them are suffering from mental illness, are transferred to similar mental institutions, and are concerned about their futures. In this sense, everyone could commit suicide. *Han* seems to be insensible and apathetic to his own feelings in order to avoid self-pity and to distance himself from the tragic incidents.

In contrast to the pessimistic narratives, cynicism and mocking seem to give the chronic psychiatric patients energy in order to manage their lives. There are lots of expressions to show how the patients laugh at themselves. *Yang* (in her late 30s) visited the Mental Health Center for a few years. When I mentioned that she looks very young, she made a cynical comment:

The reason why we look young is that we are taking 'antiseptic' medicine. Due to the antiseptic effect, we look young without getting rotten. Thanks to medicine, we are always happy and quiet, aren't we? Those who are taking medicine look so young.

Yang confesses that her body and her emotions are under the influence of drugs. From the self-perception that her body doesn't belong to her, she begins to treat her body like an object. In doing so, she can observe herself under the influence of drugs without losing self-consciousness.

Considering that drugs are prescribed and given by psychiatrists, it is understandable that ironic attitudes are going to target medical professionals. It appears often that the patients amuse themselves with their sarcastic remarks about medical doctors. Since the implementation of the mental health reform, social workers are also subject to satire. The patients often make remarks like the following in small talk:

Hong Kong injection? Do you really mean Hong Kong injection? Oh! The injection is called so because one loses one's consciousness just after a shot.^v But do you mean that you have got as many as two shots? (*Park*)

The most comfortable physician among medical doctors is a psychiatrist. They don't even need to get their hands wet or to be strained. If a patient comes, they ask, 'How are you?' If he is getting better, then he is discharged; if he is getting worse, then he is hospitalized; if his condition is unchanged, then they give him medication. That's all. How easy it is! (*Son*, in her early 40s)

I said to the psychiatrist that I'm not a psychiatric patient. It's useless. The doctors also have to make money and live a life. The more patients, the more money! Right? (Yeo, in her late 20s)

Social workers are authoritarian in a sophisticated way. If one behaves obviously authoritarian, one will be criticized by the other staff members. Therefore, they are discrete in their behavior. (Ko, in his mid 30s)

Do you know the difference between a patient and a staff member? The answer is: A patient gives money, a staff member receives it. (Ko)

The comments show a somewhat challenging attitude towards the personnel in authority. The patients are laughing about immoral and wrong behavior of doctors and social workers. Medical doctors are portrayed as money grubbers who act in their own best interests. Social workers, who increasingly make up the staff under the new mental health system, are considered to be different from doctors. Patients are very sensitive to how social workers treat them. They are not sure which tasks social workers are doing. It could be concluded that chronically mentally ill people have no trust in medical institutions and the personnel assigned to help them.

Distrust and criticism towards authorized personnel is closely related with the self-confidence of the chronic patients. They begin to consider themselves not necessarily inferior to others, but equal or even superior. In their moral narratives the patients had already implied positive acceptance for their situations by insisting that they could be more responsible (*Park*) and self-reflective (*Bae, Cho*) than others. What they argue is that they could be more conforming to social norms than other people in the sense that they internalize and keep social rules and expectations faithfully and thoroughly. They are looking for self-recognition and self-confirmation from those in society outside the mental health system.

Conformity is considerably changed in the core narratives, which are called heroic narratives. *Kwon* (in his early 40s) has suffered from schizophrenia for over 10 years. He argues that he deliberately passed over the borderline from normality to abnormality. While showing me his own poems, *Kwon* told me about his past very proudly:

At the university, I was a member of a student club, the so-called under-circle^{vi}. For six years, I just wrote poems all the time... I believed that I could contribute to the reunification of Korea by means of my poems. I've had no job. I kept staying at home... One day I got drunk, and I was injured by a car accident. Due to brain damage, I was in neurosurgery. Next to the neurosurgery, there was an orthopedic department where a friend of mine worked as an orthopedist. He is a so-called psycho. One day I happened to meet him in the hospital, and he recommended me to a neuropsychiatrist next door. He said that a life inside the psychiatric ward would be more normal than outside. I went over there. The psychiatric ward was very interesting, and I felt comfortable. I stayed there for three months. But then again, I went in and came out, then again in and out... You should make yourself crazy in order not to be driven crazy in the crazy world. Therefore, I made an effort to drive myself crazy deliberately.

Instead of conforming, he interchanges the normal with the crazy. His friend and orthopedist is described as psycho, meaning a not normal person. The society where the friend lives is also depicted as crazy. Meanwhile, the people in the mental hospital are considered to be normal. In his view, he became mentally ill in order not to live in a crazy world. Comparing what he says with the expressions like "by ambulance in a compulsory delivery" or "suddenly falling unconscious" in the moral

narratives, his statement can be seen as rebellious. He describes himself as an active subject who holds his destiny in his own hands. Instead of complaining about the ignorant society, he replaces the normal with the mentally ill. In this way, the heroic narratives help patients to see and evaluate allegedly normal people from their own perspective.

Conclusions

This study attempted to understand how the chronically mentally ill construct their self-identity in the new medical environment. The process of constructing self-identity is explored by analyzing autobiographic narratives. The contingent narratives show how the patients explain the cause of illness. On the one hand, patients refer to proximate causes that are subjectively experienced. On the other hand, the patients are convinced of the biomedical model that they learn in the mental hospital and rehabilitation facility. The subjective explanation and the biomedical model coexist as long as the patient's condition is regarded as acute and temporary. As the patient discovers that his mental illness will not be completely cured, the biomedical explanation comes into conflict with the patient's subjective belief. It is at this point that the patients distance themselves from the professional knowledge and move closer to their own experience-based knowledge. As they accept themselves as chronic patients, they tend to deny being a good patient.

The moral narratives show how the patients cope with the outside society. With the progression of their chronic illness, patients learn how to deal with drugs and how to behave in society. The patients adhere more and more to the possibility and belief that they will recover from mental disease and return to a normal life (Williams 2000). However, members of the outside world, such as family and friends, do not help them or allow them to be a normal member of the society. In the beginning of their clinical history, they were called mentally ill and fitted into a medical viewpoint. As they realize the chronic nature of their disease, they differentiate normatively and functionally from normal people and become "losers" from the societal point of view (Manning 2000). Instead of achieving social integration, they come to live a life as a "pendular self," shuttled back and forth between being an inpatient and an outpatient (Yoshida 1993). Under these circumstances, the patient community emerges as a reaction against the ignorant society.

The core narratives show how the chronic patients construct their self-identity in a desperate situation. What they are able to carry into effect to overcome difficulties is quite restricted. They are not able to transform an attitude into action. In detail, they can deny neither going to a mental hospital nor taking their medicine. Although the patients can't leave mental disorder and social deviance behind, they no longer consider themselves to be passive. As cynical or heroic narratives illustrate, the patients are now regarded as active, and they are able to raise critical questions about professional advice and social discrimination.

If the community-based rehabilitation concept is to be improved and expanded in the future, there are two points for further discussion. The first one relates to the gap between the patients' and professionals' knowledge, and the second has to do with the patient community. First, psychiatrists offered professional knowledge to normal people and patients in order to fight against the conventional practice of separating the mentally ill from society. Their intention was that scientific knowledge

about mental illness should spread throughout society, closing the gap between the layman's and the professional's understandings. As a consequence, informed citizens would cooperate and work (Giddens 1990, 1991) with the experts. The community-based rehabilitation could be realized only if the personnel in authority and the chronic patients pursued a common end. However, things turned out differently than expected.

As the mental illness becomes chronic, the relationship between patients and doctors gets detached and tense. Patients are sometimes so self-confident that they believe only their own experience and oppose the doctor's knowledge (Illich 1976; Szasz 1957). There is a possibility that a patient's knowledge could be developed so that it complements or even challenges a doctor's expertise. Although there are unanswered questions about the extent to which a patient's view could differ from the professional's expertise, the narratives indicate a changing patient-doctor relationship as the rehabilitation concept changes.

The patient community should be closely examined. The key to mental health reform is the integration of chronic patients into the local community. However, neither housing nor working conditions are adequate for their integration. Families are often incompetent or reluctant to support their mentally ill family members. Alternative housing such as group homes is still in its infancy. The labor market for mentally disabled people is practically nonexistent. Meanwhile, the new mental environment makes it possible for patients to gather and spend time together unconstrained and uncontrolled in rehabilitation facilities. It offers opportunities for the patients to exchange information that they have acquired in the course of their illness, make friends, and come to share their beliefs about medications, medical personnel, and society. Capitalizing on this opportunity, a stronger patient community could be built up.

With respect to the aim of this study, much more attention should be paid to the medical history of those in a patient community. Roughly speaking, the patient members in the rehabilitation facility can be divided into two groups following mental health reform. The first group consists of the veteran patients who were diagnosed before the mental health reform and probably experienced asylums and long-term hospitalization. They often confound mental hospitals and asylums, as there was little difference between the two institutional types at that time. The second group consists of the newcomer patients who are diagnosed after the mental health reforms and probably experienced a revolving-door syndrome. The rehabilitation facility is a venue for veterans and newcomers.

The veterans have more experience and knowledge about drugs, which helps them maintain control over their own bodies. The knowledge on medication seems to be transmitted to and widely accepted by the newcomers. Meanwhile, the newcomers are used to the revolving-door phenomenon. This process raises the issue of their cleverness in dealing with the personnel in institutions and making friends in the course of time. This knowledge helps patients to plan where to stay next and how to behave in mental hospitals and rehabilitation facilities. Not only veteran patients but also newcomer patients can benefit from an exchange of information.

However, the newcomers do not always follow the veterans. In terms of the future, the latter is no model for the former. No matter how experienced the veterans may be, a life without a family and job is no future for the newcomers. The veteran patients have good reason to be satisfied with the present situation. They have left asylums and have found shelter in the new mental environment. Above all, the

veteran patients know well what could happen if they are abandoned in conventional asylums and what they risk if they make trouble or have a relapse. Veterans are usually in their 30s and 40s, while the newcomers are usually in their 20s. Most of them are unmarried, staying with their parents, and trying to get a job. They get used to visiting rehabilitation facilities and taking part-time jobs. Although the lifelong medication regimen makes them uneasy, they are able to learn how to deal with drugs. In the swing of the pendulum they have found so-called patient community and gained patients' knowledge in addition to professional knowledge.

The mental health reforms in South Korea make clear that the future of psychiatry should be based on the concept of community-based rehabilitation (Kern and Nam 2005b). Recently, complementary legislative reforms are being demanded by mentally disabled people and civic groups. In order to make a new law and revise an old one, much attention should be paid to the subjective experiences of chronic psychiatric patients who are at the center of the mental health reform process. The opinions and judgments of chronic psychiatric patients have to be taken into consideration with the aim of understanding how the reforms have worked so far and how they are perceived by the patients.

Assuming that the present mental health policy will be continued and improved, it can be expected that conventional asylums will disappear, rehabilitation facilities will increase, and the labor market for the mentally disabled will be extended. However, some questions are left unanswered: It will be interesting to discover whether the patients tell different illness narratives, whether the discrepancy between patient's and expert's knowledge can be closed, whether the distrust of the patients towards the professionals will be reduced, whether their cynical attitude towards society will change, and, finally, how the patients identify themselves within society. These questions should be explored in further studies using autobiographic illness narratives.

Endnotes

- i After the Korean War (1950-1953) in South Korea, a variety of asylums were set up for orphans, juveniles, vagabonds, the aged, the mentally retarded, the physically disabled, and the poor (Ministry of Health & Welfare 1954-1999).
- ii The characteristics of the research object largely comply with the total statistics. According to clinical results (2002) of the *National Seoul Hospital* (renamed in 2002), the largest hospital specializing in mental illness in South Korea, 25.0% of the patients are between 25 and 34 years old, 31.5% are between 35 and 44, 17.8% are between 45 and 54. In addition, the share of schizophrenic patients is 50.7%; the average number of days of hospitalization for schizophrenic patients is 149 days, which exceeds the average number of days of hospitalization for other illnesses by more than one month (116 days) (National Seoul Hospital 2002). According to the *Epidemiological Study of Mental Disorder* (Ministry of Health & Welfare 2001), more than 70% of schizophrenic patients in South Korea (total 170,000 persons) live in poverty.
- iii I am most grateful to social worker Mi-sun Lee who made the first-ever contact with the *Taiwha* Fountain House possible. Also, I am indebted to all social workers who gave me invaluable comments and suggestions during the fieldwork. I want to acknowledge all members of the facility who allowed me to

- stay there and readily told their stories despite the uncertainty of the research results.
- iv The patients' prompt reactions to the inquiry seemed to result from their past experiences. Psychiatric patients get used to the inquiry process when they consult medical doctors and social workers, fill in questionnaires in mental hospitals, talk with student apprentices majoring in social welfare or researchers and volunteers. In other words, they know very well, which questions will follow, and what their dialogue partners expect (Williams 1984). In this respect, several questions are still unanswered: to what extent do inquiry experiences have an impact on illness narratives, and how are illness narratives changed by the routinely repeated interview situations. The questions should be taken into consideration in further studies using autobiographic illness narratives.
 - v For a long time, South Koreans have regarded Hong Kong as a symbol of a modern city with decadence as well as freedom. Therefore, "Go to Hong Kong" in Korean slang means entering a state of ecstasy caused by sex or dope.
 - vi "Under-circle" refers to forbidden circles of university students under the dictatorship of the 1980s in South Korea. At that time, the Korean government and university administrations didn't allow students to read books critical of the government or the existing political order. Consequently, students secretly organized so-called under-circles and demonstrated often against the dictatorial regime. From a historical point of view, the members of the under-circles contributed significantly to the process of democratization in Korea, and further to the discussion about the unification of the two Koreas.

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