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How do phenomena diagnosed as mental illness

impact upon personal identity?

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A thesis submitted in partial fulfilment of the requirements of

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Candidate's Statement

This thesis is founded on an original idea arising from discussions between myself and my supervisors. No other researchers have been involved in its production, apart from my wife's contribution as assistant in interviews.

Acknowledgements

The following parties deserve special mention for their input into this thesis:

I would like to dedicate this thesis to my wife, June; also my supervisors, Julie Repper and Gordon Grant. It was their support that enabled me to find a way out from the wilderness.

How do phenomena diagnosed as mental illness impact upon personal identity?

Abstract

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Degree for which thesis is submitted: Doctor of Philosophy

The central question of this study was to ascertain how phenomena diagnosed as mental illness impacted upon sense of personal identity. To facilitate the necessary research, the aims of this study were to examine the experience of mental illness from the perspective of service users.

Nine adult respondents (five men, four women) participated in a series of unstructured interviews, each lasting approximately one and a half hours. Some respondents were interviewed twice. Data from the interviews were transcribed by the researcher and subjected to four levels of analysis. Of these levels, the first was the act of transcription, the second conclusions following same, the third close scrutiny of the transcribed document, and the fourth deconstruction into 'idea units'. Integral to this exercise was the use of narrative theory to develop concepts of the respondents' personal narratives with particular reference to the respondents' mental health narratives.

Following the four levels of analysis, the personal narratives of the respondents were compared and contrasted in a cross-case analysis. With reference to narrative models developed for the specific purpose of this study, the conclusion was drawn that initial experience of mental illness has a profound effect upon the personal narrative. Thereafter, the resultant impact upon personal identity is influenced by a combination of personal and environmental factors. Some of these may lead to a re-evaluation of past experiences and associated understanding. Accordingly, the outcome of the illness experience may not necessarily be negative, but may be positive by virtue of insights gained. Implications for mental health practice and further research, including the personalisation agenda, are considered.

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Chapter One: Choosing the research question

1.1. Foreword

> If you want to know me, then you must know my story, for my story defines who I am. And if *I* want to know *myself,* to gain insight into the meaning of my own life, then I too, must come to know my own story.

> **(McAdams, 1993, 11: italics in original text)**

My name is Ray Wainwright. Since 1967, my life has been affected by phenomena diagnosed as mental illness. My diagnoses have been many and varied, especially in the years 1994 – 1996, when I suffered several episodes requiring hospitalisation. In the main, this was because my symptoms proved to be treatment-resistant: despite a wide range of anti-depressants, anti-psychotics, and E.C.T., my overall condition gradually worsened. At this time, it was believed that I was suffering from a complex form of bipolar I disorder, possibly schizoaffective disorder. During the dark days of my illness, my behaviour was erratic, irrational and, at times, extremely unpleasant. I was fortunate, therefore, that my wife was an Approved Social Worker and familiar with the manifestations of phenomena diagnosed as mental illness. Also, by a ghastly co-incidence, she was writing a PhD on the problems encountered by family carers of adults with severe mental illness. Accordingly, by virtue of my illness, she was obliged to declare her own experiences in her research topic. Undoubtedly, our marriage was under great strain at that time, both by virtue of my sometimes venomous ravings and because of the sheer intransigence of my illness. By 1996, it was mooted that I might need psychosurgery; alternatively, it was suggested that I could be given sufficient medication to render me 'manageable'.

My recovery from this nadir can justifiably be described as strange and unexpected. In 1996, I was, by then, receiving a 'cocktail' of drugs in an effort to break the increasing severity of my illness. For reasons that remain essentially unknown, I developed a serious skin condition that was eventually diagnosed as a combination of erythroderma and exfoliating dermatitis. Shortly after

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admission to hospital, I began to experience additional symptoms of diarrhoea. This was the first indication of lithium poisoning due to dehydration by virtue of my skin condition. Thereafter, I developed toxic confusion: by the time the cause was determined, it was necessary to place me on serum dialysis. In tandem with this, I was sedated with diazepam to prevent me pulling out the various canulae that were attached to me. By now, my condition had worsened dramatically: in addition to the risk of kidney failure and brain damage, I had also developed septicaemia due to the bleeding of my skin.

I have no recollections whatsoever of these events: this account is based on what my wife has told me. I remember waking up in an isolation ward to see a cheerful face of a female nurse and hearing, "Hello, Ray, you're in Dermatology." My rash had virtually disappeared apart from a small patch on my leg for which I continued to receive intravenous antibiotics. Additionally, the symptoms of my mental illness had largely dissipated. Why this was remains uncertain; at the time, my consultant explained that it was understood that a severe physical illness sometimes 'burns out' a mental illness. Thus, on recovering sufficiently to leave Dermatology, I was returned to a psychiatric ward for but a short period before discharge. However, I stress that this did not mark the end of my problems. My diagnosis was adjusted – or euphemised – to bipolar disorder, for which I have taken medication ever since. Sometimes I experience what I term 'florid periods' in which my symptoms return though, mercifully, these are short-lived. Similarly, I often undergo periods of a general malaise or depression. However, my mental illness has not led to any further periods of hospitalisation.

It is the variety of diagnoses that I have received that led to this thesis. Often, in the months and years that followed my recovery, I would express exasperation at the artificiality of naming systems. As a possible solution, I would speculate upon the concept of all mental illness being explicable by a single line continuum. However, this was never pursued past opining that, "There ought to be a PhD in this somewhere." As my health improved and I began to rediscover my former interests, my wife began to encourage me to stretch my horizons. Eventually, and perhaps inevitably, in 2001 she persuaded me to set out my

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ideas in a preliminary format, which she passed on to a work colleague who, in turn passed it on to Julie Repper, of Sheffield University. Following this, Julie met with me at the School of Health and Associated Research (SCHARR) to discuss my ideas.

I had believed that these were sound; however I was soon disappointed when Julie explained that she did not really follow what my aims were. In hindsight, this was not surprising: I had not attempted any comparable undertaking since achieving a degree in Applied Biology from Brunel University in 1973. However, Julie suggested that I try background reading with an aim to firming up my ideas. On our third meeting, we were joined by Gordon Grant, who suggested additional lines of exploration. However, in honesty, my ideas remained stubbornly insubstantial despite an undeniable truth that I was regaining a 'feel' for academic material. Thus, although I held on to my continuum project, our discussions also focussed on attendant issues. At some point in these, Julie suggested that I look at the 'effect of mental illness on identity'.

Immediately I became animated, even excited. It has always been a tendency of mine to feel that certain words or phrases within a text hold a peculiar resonance. Thus, my response was instinctive: somehow, this idea encapsulated my overall aim. Following this, Julie, Gordon and I formulated a working title: 'The impact of phenomena diagnosed as mental illness upon sense of personal identity." This remained as the title in the years that followed until a Ph.D. upgrade meeting in 2006, wherein it was decided that it should be amended to become a question. During the years 2003 – 2006, I immersed myself in background reading and made provisional plans for the original research that would be needed. The results of this were detailed in a 10,000 word proposal and presentation at the upgrade meeting. Following a successful outcome, I intended to pursue the interviews necessary for collection of data. Unfortunately, however, in this was delayed by two episodes of dermatitis, both of which required hospitalisation.

At this point I should draw attention to the two main forms of mental illness, namely *somatic mental illness* and *functional mental illness.* The former concerns mental illness which is associated with identifiable trauma to the brain, e.g. stroke, Alzheimer's disease. The latter concerns mental illness that is identifiable only by behaviour, including verbal utterances and/or description by the person experiencing phenomena. On the grounds of limiting the study to manageable levels, this research is concerned *solely with functional mental illness.* I close this foreword by reflecting upon the beginnings as I have described them, particularly the day when the course of this study was identified: an example of what Julie describes as a 'eureka moment'. As detailed above, my original ideas centred on explaining mental illness in terms of a single line continuum. However, my early forays into background reading, both academic and 'grey' (i.e. unsubstantiated) literature obtained through the Internet showed that this concept was too limited. Instead of applying a continuum to mental illness, I needed to apply it to mental health as a whole. Of the 'grey' references I obtained, many described experience of mental illness as a part of a story in which they were the central character (e.g. 'Louise', 2001)

Obviously, I recognized and empathized with some of the details of these stories through mutual experience. In particular, I recognized descriptions of bewilderment, lack of control and an overall sense of strangeness. Moreover, there was an undeniable truth that mental illness had become an integral part of their lives as much as it was a part of mine. Yet to what extent had this affected their personal qualities and how they saw themselves? Using myself as an example, I could only say that maybe some of them are influenced by my illness, or maybe not. Maybe my view of myself, as detailed in the first paragraph, is that of the real 'me', an inviolate self that persists despite all that I have experienced in the course of my life story. Or maybe that self has been moulded by my experiences; maybe my thought processes have been forever changed. How do phenomena diagnosed as mental illness impact upon personal identity? This is the question which informs this thesis, pertaining not only to myself, but to persons who have experienced them.

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1.2. The impact of my own experiences upon this research

Denscombe (1998) draws attention to the fact that no social researcher can achieve an entirely objective position from which they can study their chosen field. Essentially, this is because the concepts used to interpret our observations of the social world are shaped by our experiences of that world. Therefore, awareness of this relationship, termed *reflexivity*, should be an integral part of any research. Although this construct is explained in detail in Chapter Six, it should be stressed at this juncture that it is obvious that my own experiences, as detailed above, should be acknowledged. Concerning these, however, they are not only a source of potential subjectivity in interpretation: they also provide examples of concepts pertinent to discussion. Accordingly, where appropriate, sections of text will be preceded by my personal statements, of which the first opens the next chapter. In that it summarizes the dichotomy between an 'insider' (i.e. subjective) and an 'outsider' (i.e. objective) viewpoint, it illustrates the approach that will inform this entire study.

With direct reference to interviewing, the fact of my illness may have played a significant role. As will be explained in Chapter Five, this was due to the fact that potential volunteers were, in the main, sought from the membership of a volunteer group of which my wife was a member. Accordingly, although I was an infrequent visitor, persons knew of my illness. Whether this encouraged them to participate in this research is a moot point. Certainly, one respondent implied that they believed I would not be judgemental in any way by virtue of my own experiences.

Associated with this is the question of whether or not respondents were more willing to talk frankly to me than they might have been to a complete stranger. Again, I submit that this is a moot point. However, it is important to mention two factors that I believe to have contributed to the dynamics of the interview. The first is that all of the respondents save one *wanted* to talk of their experiences, including personal issues that may have contributed to, and/or derived from, their illness. The second is that at the time of the interviews I had been a volunteer advocate, latterly a 'befriender', for over ten years. In this time, I had

learnt to maintain an outwardly relaxed but inwardly vigilant approach to conversation at all times. For instance, if my 'partner' was depressed and uncommunicative, one of my personal rules was never to ask more than two questions in a row. My third sentence would be a comment about something inconsequential: the weather, a personalized car number plate I had seen recently, and so on. Moreover, I had learnt *to be silent,* that it was better to wait than to force conversation. Accordingly, I found interviewing to be a 'natural extension' of practices that I had already acquired, particularly that resisting the temptation to interrupt. Nevertheless, lest I appear pompous, I must stress that my interview technique was developed after consulting several academic sources, particularly Fox et al (2001) and Terkel (2004).

Finally, and perhaps most importantly, there is the question of the degree of which my experiences of illness may have influenced my interpretation of the data. As explained above, no researcher can be entirely objective. However, to attempt analysis of one's own subjectivity creates a paradox in that this analysis will also be partly subjective. Therefore, it becomes evident that reflexivity can be acknowledged but not entirely eliminated. Concerning this research, my own technique, as explained later in Chapter Six, was to submit the data to four levels of analysis, of which the second challenged the finding of the first, and so on. By this method, I hoped to obtain a consistency of interpretation when re-reading the conclusions of the fourth and final level.

1.3: The life story

As described by Linde (1993), most persons view themselves as the central character in their life story:

> .....a life story is something most people have, something they have created, and something that, for both personal and social comfort, must be created in a coherent fashion. *This is a culturally warranted, non-problematic assumption in our culture.*
>
> **(Linde, 1993, 3 - 4) [Italicised by author]**

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These descriptions, particularly the concept of a 'non-problematic' assumption, are fundamentally useful in that they appeal to common sense. Nevertheless, they cannot be viewed as a privilege or as a convenient short cut. Thus it must be stressed that inherent in the construct of a life story is that it begins *with something*: that is, an individual is born with the potential to develop physically and mentally. In the main, this study concerns mental development: in Western Society, most persons believe thoughts and emotions are enabled by an entity termed the *mind,* which is situated in the brain. It is the mind, through the capacity of *consciousness,* which interprets and remembers all perception of the inner and outer environment.

As will be explained in Chapter Two, through consciousness we perceive ourselves as thinking beings, as possessing a mind and, thereby, a self. Dennett (1987a, 161) reduces human consciousness to 'two sets of considerations' detailed as 'from the inside' and 'from the outside', the very simplicity of which is extremely useful in underlining the essential nature of consciousness. *From the inside* details our own consciousness: our awareness of experiences, including the knowledge that much will be happening of which we know little or nothing. *From the outside* details our own part in observing the reaction of another person to those stimuli. However, we can never *know* for certain what that person is experiencing: we can only surmise via observation of their reactions plus our own knowledge of similar experience. Given this difference, it becomes appropriate to extend Dennett's definitions as follows: 'from the inside' means, literally, inner awareness and reaction to experience:

> ....*what it is like to be me*
>
> **(Dennett, 1987a, 161 [italics in original text])**

Similarly, 'from the outside' means the events that are experienced, including the reactions of other parties. Always, the nature of awareness is the same: 'from the outside' can be observed and interpreted by 'from the inside', but the converse can never be true.

1.4: The unique nature of personal consciousness

A foundation of this study is that the consciousness of any one person is *entirely individual*: that is, it cannot be *directly* shared with any other person. In exploring this, Laing (1990:15 – 16) employs increasingly complex word-knots which, although convoluted, are ultimately helpful in stressing the ultimate unattainability of another person's thoughts:

> I see you and you see me. I experience you, and you experience me. I see your behaviour. You see my behaviour. But I do not and never have and never will see your *experience* of me. Just as you cannot 'see' my experience of you.
>
> **(Laing, 1990, 15)**

The descriptions by Dennett (above) and Laing are in accord with much earlier observations regarding the nature of consciousness, such as those of the nineteenth-century philosopher William James:

> My thought belongs with my other thoughts and your thought with your other thoughts. Whether anywhere in the room there be a mere thought, which is nobody's thought, we have no means of ascertaining, for we have no experience of the like. The only states of consciousness that we naturally deal with are found in personal consciousness, minds, selves, concrete particular I's and you's.
>
> **(Edelman, 2004:5 – 6, quoting William James)**

However, it is also true that in more recent texts a sense of subjectivity has been supplanted by a more detached, scientific view. For example, the views of Dennett, expressed in the second edition of *The Oxford Dictionary of the Mind* (2004), differ markedly from those in the first edition:

> There are many properties of conscious states that can and should be subjected to further scientific investigation right now, and once we get accounts of them in place, we may well find that they satisfy us as an explanation of what consciousness is.
>
> **(Dennett, 2004:211)**

Were the 'from the outside' and 'from the inside' categories abandoned because they were considered too simplistic in the overall context of the 2004 article? Possibly- but in their simplicity was an elegance that ably summarised the

essential difference between outer and inner knowledge. Moreover, the cautious tone of the 1987 article can, possibly, be considered as more representative of humanity as a whole. Throughout the world's population, many persons may be unfamiliar with scientific theory or may choose to reject it. For it is an integral part of self-awareness that an individual may choose to believe or reject some of the conclusions derived by others from observed experience. This is the essential difference between objectivity and subjectivity.

1.5: Thesis Plan

Concerning any research, Wengraf (2006) describes the primary objective as the *Central Research Question.* Thus the Central Research Question informing this study is "How do phenomena diagnosed as mental illness impact upon personal identity?" To explore this question fully, I will explore biological and philosophical aspects of the major constructs involved, including the analysis of original data gained from interviewing persons who experience, or have experienced, mental illness. With regard to the early chapters of the thesis plan, my primary concern is continuity as I progress from an objective view of the self and personal identity to embrace subjective understanding gained through the life story.

In Chapters *Two, Three, And Four*, I draw from relevant literature plus occasional personal experiences. In *Chapter Two*, I begin with a brief review of consciousness in terms of the foundation upon which all constructs of the self are created. Thereafter, I progress to scrutiny of an objective view of the self and personal identity to embrace subjective understanding gained through the life story.

Concepts of the life story are developed in *Chapter Three* to include *narrative,* the means by which we accord our experiences with the coherent structure necessary for interpretation and understanding. In this way the life story becomes a *personal narrative,* of which *personal identity* is an integral part. Originally, deeming *phenomena diagnosed as mental illness* to be a discrete topic, I had intended to discuss this in Chapter Two. However, after reflection

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and experimentation, I feel that it should be emphasized in terms of a group of experiences within the personal narrative. Accordingly, this topic will be the subject matter of *Chapter Four.*

Chapters Five, Six, and Seven are all concerned with the obtaining of original data. *Chapter Five* discusses the methodology of the study, including the strategies deployed in my literature review, the recruitment of interviewees and the protocols required. In all, nine persons – five men and four women – were interviewed. *Chapter Six* details the theories and practice associated with analysis of transcripts. Finally, *Chapter Seven* explores in detail the constructs that will be applied in interpretation of the analysed data.

Chapters Eight, Nine and Ten present and analyse the transcripts of the nine interviewees. With reference to academic literature (Boisen, 1971; Breggin, 1991) I decided that I would designate severe experience of phenomena as *overwhelm.* Associated with this, I term details of the personal narrative before overwhelm as *prologue;* and details of the personal narrative after overwhelm as *recovery.* Each stage is the subject matter of a separate chapter: Chapter Eight discusses *prologue,* Chapter Nine *overwhelm,* and Chapter Ten *recovery.*

Chapter Eleven integrates the previous three chapters by comparing and contrasting the experiences described. In doing so, it will meet the requirements of the Central Research Question.

Chapter Twelve has three main functions. The first is to critique the methodology of the study including my own role as researcher. The second will be to recommend possible avenues for future research. The final part seeks to to suggest ways in which the findings of this study could be incorporated into mental health practice.

1.6: Conclusion: The self, personal identity, and phenomena diagnosed as mental illness

My approach in the empirical chapters acknowledges the tension between science and romanticism. Through science there can be a belief that, ultimately, all will be explained in terms of natural processes. Through romanticism there can be a conviction that some matters will never be understood, that even the most rarefied knowledge can be tempered by a sense of wonder. Together, these constructs create the fundamental basis of the self and personal identity: although limited by understanding, they may be limitless by virtue of imagination.

At this point, I posit a fundamental definition of phenomena diagnosed as mental illness as *phenomena that affect the workings of the mind.* Concerning these, it is incumbent to note that biological constructs of the mind detail complex neurophysiological processes (e.g. Armstrong 2004). However, after consideration, I feel that such detail, whilst fascinating, is ultimately unnecessary. Similarly, I do not intend to dwell on theories of mental illness that centre on environmental causation. This is on the grounds that generalized theories of aetiology could prejudice the analysis of the data gained from the interviews. Instead, the focus should be entirely upon the experiences of the nine respondents in the context of their life stories. In this way, concepts of aetiology, whether biological or environmental, can be scrutinized as an integral part of personal understanding.

This consideration amply summarizes my approach to the obtaining of original data. Above all other considerations, it was essential to appreciate a respondent not as a subject, *but as a person.* Only then would it be possible to gain insight into the possible impact of phenomena diagnosed as mental illness upon personal identity.

Chapter Two: Personal identity

2.1: Introduction: defining the self and personal identity

This chapter explores the very real issue of whether or not an individual possesses an understanding of their person in terms of a 'self', and the degree of that understanding. As will be explained, the 'self' can be viewed in terms of a generalized construct of social interactions processed by neurophysiology, or in terms of a *self-system*, a complex nexus of interacting constructs. Associated with this is the concept, detailed by Leary and Tangney (2003), of an 'experiencing thing', one that is a unique entity:

> Most people have the sense that there is an experiencing 'thing' inside their heads that registers their experiences, thinks their thoughts, and feels their feelings.
>
> **(Leary and Tangney, 2003:7)**

Such a construct can reasonably be termed a 'subjective self'; a quality that enables 'personal identity'. However, this is a complex question in its own right. For example, Vesey (2004) chooses to discuss personal identity by way of Descartes, Hume, Locke and others. Although preferring Hume's concept of a 'felt bond' among 'perceptions', he eschews a firm conclusion in favour of highlighting continuing debate. In comparison, the approach of Kerby (1986) is to view the self through the medium of language, for which purpose he makes an initial definition of the self as '...the subject that I am'. Following passages posing many complex questions similar to Vesey's concerns in that they explore philosophical viewpoints, he resorts to humour:

> The self or subject is one of those types of beings of which one might say, with Augustine: "Sure I know what it is, as long as you don't ask me to explain it."
>
> **(Kerby, 1986, 212)**

Perhaps surprisingly, the author then quotes the phenomenologist William Dilthey in suggesting that identity poses much less of a problem:

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We seem to have no trouble with identity over time, for as Dilthey has said:
"The knowledge of the course of one's life is as real as experience itself"

<div align="right">**(Kerby, ibid)**</div>

Thus, whereas the concept of a self is considered nebulous, difficult to explain clearly, Kerby unequivocally links identity with life experiences. Supported by Aleksander's (2004:32) statement that the term 'personal' is indicative of ownership and individuality, this view leads to a provisional description of the difference between self and personal identity:

> **Self** is innate, being founded upon genetic complement. Becoming increasingly complex as the person ages, its bio-mechanisms are the means of gaining and retaining experience.

> **Personal identity** is actuated by the self. It is both an objective and a subjective construct derived from understanding of experiences gained in the course of one's life.

I conclude this introduction by observing that development of the self and personal identity should properly be understood as continuous throughout a person's lifetime. However, it is in the early years, in childhood, that the rate of development is greatest. Initially, all depends upon possession of *consciousness,* the capacity to interpret sense-perception.

2.2: Consciousness
2.2.1: Defining consciousness

Exploration of the workings of the mind raises issues of reflexivity that cannot be ignored. As a scientist, I want rigour; I want well-founded constructs that will withstand rigorous scrutiny. As a person who has experienced phenomena diagnosed as mental illness for over forty years, I have asked whether or not it was all inevitable, if 'I had been dealt a poor hand'. And I also want to retain a sense of wonder; I want to be the same person who, as a boy, marvelled at the stars on a frosty night. If I am truthful, the idea that a phenomenon may never be completely explained is reassuring.

<div align="right">***Personal statement***</div>

Edelman (2004) identifies two forms of consciousness- *primary consciousness,* and *higher-order consciousness:*

Primary consciousness is:

> '....the state of being mentally aware of things in the world, of having mental images in the present. It is possessed not only by humans but by animals lacking semantic or linguistic abilities whose brain organization is nevertheless similar to ours.
>
> **(Edelman, 2004, 9)**

By embracing the basic construct of sensation combined with perception, primary consciousness is described by Edelman (ibid) as enabling complex responses to stimuli but *not* a concept of self:

> Primary consciousness is not accompanied by any sense of a socially defined self with a concept of a past or future. It exists primarily in the remembered present.
>
> **(Edelman, ibid)**

In contrast, *higher-order consciousness* enables an individual to be aware of their own existence. Possibly controversially, Edelman asserts that this capacity is present to 'some minimal degree' in higher primates and is most developed in humans:

> Higher-order consciousness involves the ability to be conscious of being conscious, and it allows the recognition by a thinking subject of his or her own acts and affections.
>
> **(Edelman, ibid)**

Later in Edelman's text, this construct is amplified to include concepts of time:

> Higher-order consciousness confers the ability to imagine the future, explicitly recall the past, and to be conscious of being conscious:
>
> **(Edelman, 2004:58 – 59)**

In this context, Horner and Westacott (2000) describe consciousness as 'intentional' in the sense that it is always directed: thus, in accordance with Edelman's schema, higher-order consciousness is directed towards *itself.*

> Just as we cannot be seeing without seeing something, nor hearing without hearing something, so we cannot be conscious without there being something we are conscious of.
>
> **(Horner and Westacott, 2000:90)**

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Curiously, Edelman does not mention child development in connection with his constructs. However, Stern's (2000) assertion that 'some senses of the self do exist long prior to self-awareness and language' is highly suggestive of primary consciousness. Thereafter, the following detail is obviously of higher-order consciousness:

> Another change in sense of self is seen at about age nine months, when suddenly infants seem to sense that they have an interior subjective life of their own and that others do too.
>
> **(Stern, 2000, 9)**

Accordingly, Stern's observations in tandem with Edelman's definitions lead to the possibility that primary consciousness and higher-order consciousness are aspects of the same mental mechanism. In effect, as a person develops, so primary consciousness becomes sufficiently complex to actuate higher-order consciousness.

An intriguing aspect of consciousness is that not all experiences are committed to memory. Similarly, and rather more complex, are instances of experiences being forgotten until recalled at a much later event; also of experiences being influential without the person realizing this. This leads to the positing of constructs within consciousness, of which one, the *unconscious*, can justly be described as compromised by hearsay and misunderstanding. Therefore, although detail will be brief, it is essential to examine these in their proper context.

2.2.2: Constructs within consciousness

When I was aged nine, I went into hospital to have my tonsils removed. Perhaps two days later, before I was discharged, I noticed ants crawling on the locker beside my bed. When I told the nurse, she said, "Don't be so silly." The next time I was given orange juice, I did not drink it all but left some in the polythene cup on top of the locker. Later, when I checked it, it had four dead ants in it. However, when the nurse saw it, she said nothing. Absolutely nothing. She did not say, "I see, you were right after all," or words to that effect; she ignored me totally.

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The fact that I can remember this incident vividly bewilders me. Is it important?
If so, why? Maybe it has coloured my perception of 'authority figures', maybe
not: the truth is, I do not know and probably never will know.

Personal statement

2.2.2.1: The unconscious

Unconsciousness can be applied to two areas of consciousness, of which the
first can be colloquial: unconsciousness is *a state of not being conscious.*
However, when used in a neurophysiological sense, it is a state wherein *an*
individual is not conscious of being conscious (Edelman, 2004:9), of which the
most common form of this is sleep (Oswald (2004: 847 – 8). The second area of
unconsciousness is the extremely vexed concept of the *unconscious mind*, an
entity that exists alongside or, more appropriately, within the conscious mind in
terms of a reservoir of imaginations, memories, and emotions. Inextricably
associated with this construct is the development of psychoanalysis by Sigmund
Freud (Gregory, 2004a:926; Zangwill, 2004:357 – 8). However, further
discussion of this field is, ultimately, not helpful to this study. Instead, it is
sufficient to state that the construct of the unconscious mind can be distorted by
the popular imagination into a baleful and malignant force within the mind. This
observation also applies to a similar construct: the subconscious.

2.2.2.2: The subconscious

Although the *unconscious* and the *subconscious* are so closely related as to be
synonymous, no reference to 'subconscious' was found in the later references
used in this study. However, this term was used by authors of older texts
detailing psychopathology (e.g. Boisen, 1936, 1971). Of all the constructs
associated with consciousness, it is probably the most contentious:

> The word subconscious has a dubious sound; and those to whom it brings
> slight illumination associate it with phenomena of rare occurrence and unusual
> significance. It should be a homely term; and its place is close to the hearth of
> our psychological interests.
>
> **(Jastrow, 2005 [1906]: vii)**

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Notably, in casual discussion with friends who have experienced mental illness, also with some of the interviewees, I have learned that all believed in the subconscious. Accordingly, I believe that this term persists in colloquial use. On inspection, it appears so close to the Freudian model of the unconscious mind as to be synonymous. However, any further speculation is unhelpful: if appropriate, this subject will be reviewed with reference to the transcripts of the interviews.

2.2.2.3: Nonconsciousness and the Implicit Self

Nonconsciousness, as described by Edelman (2004:87-96), is synonymous with implicit memory, described above on page 26:

> With practice, conscious attention is not required, and acts become automatic [...] At such a point, brain scans show much less involvement unless novelty is introduced, requiring further conscious attention.
>
> **(Edelman, 2004:93)**

Associated with this capacity is the construct of *the implicit self*, described by Rudman and Spencer (2007) as follows:

> ...aspects of the self that are represented in memory via routinized associations (e.g. between self and evaluation, attributes, or social identities) that may not be readily available to introspection.
>
> **(Rudman and Spencer, 2007:97)**

However, the authors extend the boundaries of the implicit self beyond memory in subsequent discussion, which includes the following applications (ibid, 98):

i)   Measurements of implicit self-esteem with reference to possible psychological dysfunction.

ii)   Investigations into the role of the implicit self in automatic emotion regulation.

iii) Effect on the individual of high implicit self-esteem/low explicit self-esteem disparity

iv)   Effect of social interactions on the implicit self

Thus this understanding of the implicit self serves to combine an overview of the constructs above, particularly unconsciousness, the sub-conscious, and non-consciousness. This is by virtue of being able to implement and regulate actions without necessarily being aware of doing so. Obviously, given the details above, understanding of this construct may have an important role in investigations into phenomena diagnosed as mental illness (see Chapter Four).

This section concludes examination of consciousness. In summary, it is the interface between the person and their environment: the means by which experiences are perceived, interpreted, and understood. As such, it is arguably the foundation upon which the self is constructed.

2.3: The central character in my life story: overviews of the self

Who am I? Within the various exterior aspects that I present to the outside world I believe that there is an inner, private person that only few people see: the 'real me'. Unfortunately, this statement seems redolent with melodrama, of wanting to be seen as more than I actually am. Such is not my intention: instead my claim derives from the essentially unknowable qualities of the mind. I might know who I am but I might never know my self.

Personal statement

2.3.1: Early constructs of the self

The first psychological description of the self is usually credited to William James in 1890:

> James not only laid a strong foundation for the study of the self but also touted the importance of the self for understanding human behaviour and set a strong precedent for regarding the self as a legitimate topic of scholarly investigation.

(Leary and Tangney, 2003:4)

Holstein and Gubrium (2000) quote several sources explaining that James extended the view of the self from a metaphysical realm into a social environment. This was through his construct of the *'Empirical Self'*:

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> Whatever I may be thinking of, I am always at the same time more or less aware of *myself*, of my *personal existence.* At the same time it is I who am aware, so that the total self of me, being as it were duplex, partly known and partly knower, must have two aspects discriminated in it, of which for shortness we may call one the *Me* and the other *I*.
>
> **(James, 1961 [1892]:43, quoted by Holstein and Gubrium, 2000:22. [Italics in James' original text])**

In a rather colloquial context, the authors note that the 'empirical self' is subdivided into the 'material me', the 'social me' and the 'spiritual me' (2000:23). After James, the next major advance was Charles Horton Cooley's (1902) construct of 'The Looking Glass Self', the name of which derives from the concept that the self operates in the imagination, reflecting upon and reacting to real and imagined others (Bowling, 2002; 130; Hill, 1998:103; Holstein and Gubrium, 2000, 24-27; Leary and Tangney, 2003:5). On examination, this is extremely close to the concept of the self as the central character in a personal life story (Chapter One): to be self-aware and assess our own actions, it follows that we must possess some form of self image. From basic feelings, the self is constructed through social experience:

> What is original for us as human beings, then, are the visceral sensations of our individuality, according to Cooley, and this provides the bodily underpinning for stimulating our activities as social entities.
>
> **(Holstein and Gubrium, 2000:26)**

By virtue of noting social interaction, Cooley's 'looking-glass self' can be regarded as a 'bridge' from the pragmatic stance of James to the later interactionist constructs posited by George Herbert Mead in 1934 (Bowling, ibid; Holstein and Gubrium, 2000, 27 -35; Kerby, 2001:133). These place far more importance on the formation of the self through social interaction, particularly symbolic interactionism, whereby concepts are shared between persons through mutually understood symbols, including language and actions. Accordingly, they are highly important in that they enable consideration of the relation of significant others to the person.

2.3.2: Goffman's dramaturgic self

Later constructs of the self can be viewed as refinements of interactionist theory, particularly Goffman's role-play or dramaturgic self (Hill, 1998:103;

Holstein and Gubrium 2000; 35 – 37) and Roger's humanistic approach (Hill, 1998:8). The latter construct stresses those aspects of individuality that Hill details as uniquely human:

> The humanistic approach aimed to investigate all the uniquely **human** aspects of **experience** such as love, hope, creativity, etc. and emphasised the importance of the individual's reaction with the environment.
>
> **(Hill, 1998:8) [Bold type in original text]**

Goffman's 1959 construct provides the vital link between generalized models and the uniquely private qualities of the individual self. Not only does he retain a pragmatist's view of the 'I' and 'Me' self (Holstein and Gubrium 2000:36), he also explains that individuals engage in 'performances' designed to accomplish the desired outcomes in social interactions. With reference to this, McAdams (1993) refers to any one individual maintaining many selves as 'the juggler':

> The juggler is especially skilled at what sociologist Erving Goffman called "the presentation of self in everyday life." According to Goffman, the modern man or woman is like a performer enacting roles in order to manipulate the impressions of others.
>
> **(McAdams, 1993, 125)**

However, the author finds Goffman's model 'deeply unsatisfying':

> ….because he fails to discern an integrated sense of self – an identity – behind the many different roles we play.
>
> **(McAdams, 1993:126)**

Whether or not this charge is justified depends on an overview. It must be stressed that the role-playing of the self is both inward and outward: inward, perceived only by the individual via personal consciousness, and outward, perceived by the individual and other individuals via perception. If, as explained by the constructs outlined above, the self is constructed as an integral part of communicative action, then it follows that this is also inward and outward. Whilst an individual could, theoretically, maintain awareness of an extremely complex integrated construct of self, the various role-plays involved might be viewed as separate entities by outside observers. Accordingly, although Holstein and Gubrium (2000:36) successfully defend Goffman's claim of similarities between 'theater and real-life' *[sic]*, I believe that it would be an error to over-use the

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dramaturgic construct. Used incautiously, role-play could be applied to create an impression of life as a continuous calculation, every action carefully managed to yield maximum advantage. Instead, it should be used to explain how individuals react according to the circumstances they find themselves in, whether anticipated or unexpected, rehearsed or unrehearsed.

2.3.3: Later developments: perception of subconstructs of the self

By acknowledging the essentially personal nature of consciousness, later developments of the self-construct are associated with the confusion that arises from the dichotomy between subjectivity and objectivity:

> Awareness, or consciousness, also includes notions of **self** – notions, which although real and meaningful for each of us, remain nebulous and ill-defined. Few topics lend themselves less well to scientific research or logical analysis.
>
> **(Le Francois, 1983:58)[Bold type in original text]**

Some twenty years later, when summarizing the status of the term 'self', Leary and Tangney (2003) use words that are almost uncannily coincidental:

> From the beginning, the topic has been bogged down in a conceptual quagmire as muddy as any in the social and behavioral *[sic]* sciences.
>
> **(Leary and Tangney, 2003:6)**

Le Francois (ibid) explains that the problem arises from the essentially intangible nature of the self:

> A self cannot be observed objectively; it can only be felt subjectively. [...] Self is at once part of my immediate functioning and separate from it. In other words, although I feel that myself is directly involved in what I am now doing, I cannot rid myself of the notion that there is some indefinable, elusive part of me that can somehow stand apart from what is happening.
>
> **(Le Francois, ibid)**

However, if unconstrained, this viewpoint could result in a return to the metaphysical concepts cited with reference to James. Instead, it appears to have been integrated into understanding of the self-construct. Concerning this, Leary and Tangney (2003:5) note three developments beginning in the late

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sixties: empirical interests in self-esteem; a 'cognitive revolution in psychology' leading to research into self-awareness, self-regulation, and identity; plus development of interest into the functioning self. Deriving from these, the most notable aspect of present viewpoints is that emphasis has moved from a generalised, overall construct of the self to the investigation of sub-constructs:

> More often than not I find myself ignoring any occurrence of the term "self" and substituting whatever connotation the writer is explicitly or (more often) implicitly making. The strongest conclusion I can make is that the term 'self' has no place in psychological theory.
>
> **Katzko (1993:110)**

Katzko's argument (ibid) is that the term 'self' should *always* be qualified in order to make clear what aspect or functions are being referred to. Certainly this concept appears to be applied with reference to articles in the journal *Self and Identity*. Leary (2004), as editor, notes:

> ....a wide variety of self-related constructs (such as self-awareness, self-construal, self-regulation, self-rumination, self-compassion, self-efficacy, self-categorization, self-enhancement, self-concept and identity)
>
> **(Leary, 2004:1)**

In her first editorial as editor of the journal *Self and Identity,* Carolyn Morf (2005) stresses her affinity with her predecessor:

> ...I am in accord with Mark Leary that it is not useful to employ self as a synonym for person or personality, as these constructs encompass more than just a person's self-system. Instead, I reiterate his plea for people to think carefully about what they mean by the term self and to use more precise terms in its place...
>
> **(Morf, 2005:99)**

In this context, a 'self-system' represents re-integration:

> Conceived as a coherent organized self-system, however, one can understand what guides the interactions of the various self-processes and how they work.
>
> **(Morf, ibid)**

Nevertheless, this overall process of re-definition feels unsatisfactory. This is because in solving one problem, that of specificity, another appears to have

been created. Instead of the term 'self', an overview is called a 'self-system'. In effect, this construct is circumlocutory: is there a self-process which is aware of the self-system? If so, what should it be called? This leads to the questions of an intrinsic self and personal identity.

2.4: Self and Personal Identity: Inter-related and Inter-dependent

The recollection of the ants in my orange juice illustrates the myriads of singular experiences retained by memory. In tandem with my innate genetic complement, these combined memories confer uniqueness upon me: thus do I possess a sense of personal identity.

Personal statement

Throughout this exploration of the self, the impression gained is that despite scientific rigour and philosophical argument, researchers and academics feel obliged to recognize the concept of some kind of inner entity. Although highly subjective and conjectural, the idea of 'an experiencing thing inside their heads', as described by Leary and Tangney (see previous chapter) is too useful to abandon. In simple terms, the existence of a central point – a unique self – is both in accord with and a necessary part of the concept of oneself as the central character in a life story. As detailed above, this raises the question of whether this entity is a part of a self-system or a subjective expression of that system in entirety. In answer, it is helpful to reprise the earlier discussion. Any self-system requires a starting point: one that, once potentiated, can perceive and process events so that they can be memorized. As posited previously (see Foreword), such a system is almost certainly a function of genetic complement: *this is the self.* As such, it is innate; its components being comprised of the mind and its sub-constructs, viz:

i)   Mechanisms of sensation and perception
ii)   Primary consciousness
iii)   Higher-order consciousness
iv)   The potential to memorize events processed by means of the above processes (experiences)

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Genetic complement is constant in that it cannot be changed. However, the resultant self-system is imbued with the potential for increasingly complex development. Sensation and perception lead to experiences, the acquisition of memory; the processes of learning and, ultimately, introspective thought. Stern (2000, 11) divides development of the self into four stages:

i) *Emergent self* (0 – 2 months)
ii) *Core self* (2 – 6 months)
iii) *Subjective self* (7 – 15 months)
iv) *Verbal self* (15 months +)

Of these stages, the first two are best summarized as gradual development in cognition. As explained in Chapter One, the third stage, the detail of the *subjective self* suggests the actuation of higher-order consciousness. The fourth stage, the *verbal self*, indicates the beginnings of linguistic abilities, so enabling the full potentiation of the self-construct. Within these processes, the objective concept of a genetically defined *self* becomes imbued with subjectivity: knowledge and understanding of this system with reference to the self as the experiencing entity is *personal identity*, of which an integral part is the concept of something indefinable, unique to oneself.

To explain this overall construct, I believe that it is helpful to apply an illusion called the *Kanizsa Triangle* (Gregory, 2004b:442: Edelman, 2004:36 -37). In Gregory's opinion, this is the most famous of the 'fictional' figures developed by the Italian artist-psychologist Gaetano Kanizsa. As shown in Diagram 2.1 overleaf, the arrangement of the six outer elements creates the illusion of a distinct white triangle. From an objective point of view, it does not exist; however, from a subjective point of view it does exist. In noting that 'most people' see this illusion, Edelman (ibid) states that some see an increase in apparent luminance within the triangle.

Realising that this exercise could be interpreted as an intellectual gimmick, I stress that it is a serious attempt to portray how a wholly subjective entity can exist independently within the self-system. Although a paradox, a function of the interaction of the other elements, the white triangle is nevertheless an integral part of the overall system.

Figure 2.1: Kanizsa Triangle
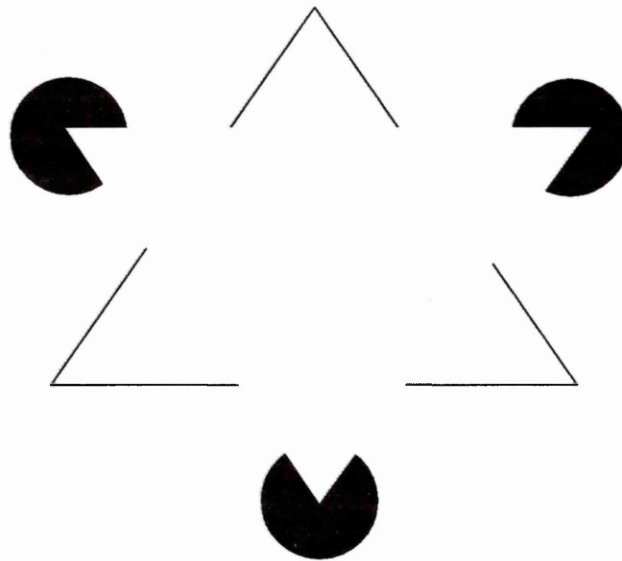
Thus it is an ideal vehicle to illustrate how a whole can be more than the sum of its parts, of how the parts of a system may create another as a result of their interaction. From one point of view, the created part is an entity in its own right; from another it cannot exist independently; from yet another, the whole system cannot exist without creating it. Thereafter applied, by annotating the various elements the system with reference to the various constructs discussed in this chapter, the Kanizsa Triangle can be used to represent the innate self-system, on which personal identity is founded. The first stage in this exercise is to annotate the symbols that will be used in construction of a self-system diagram:

i) The three incomplete triangles represent elements of *primary consciousness*:

∠   ∠   ∠
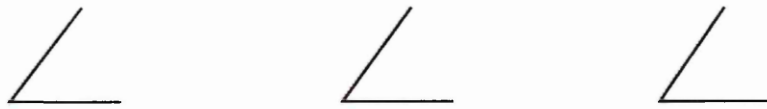
ii) The three incomplete circles represent *higher-order consciousness:*

As explained in Chapter One, through *primary consciousness,* perception is processed and analysed, leading to the memorising of experiences. Thus potentiated, the nascent self-system is formed and begins to develop further, as suggested in Stern's descriptions of the emergent self and the core self (See above). However, in this, the earliest stages of life, it is reasonable to speculate that *higher-order consciousness,* the mechanism that enables a subjective sense of self, has yet to form:

Figure 2.2: **Development of a nascent self-system by primary consciousness:**

Through primary consciousness the person perceives their environment.
The beginnings of retention of experience by memory are shown by the outer dotted
circle. The nascent self-system is represented by **this entire construct.**

Retention of experiences by memory

Primary Consciousness
Perception of my environment
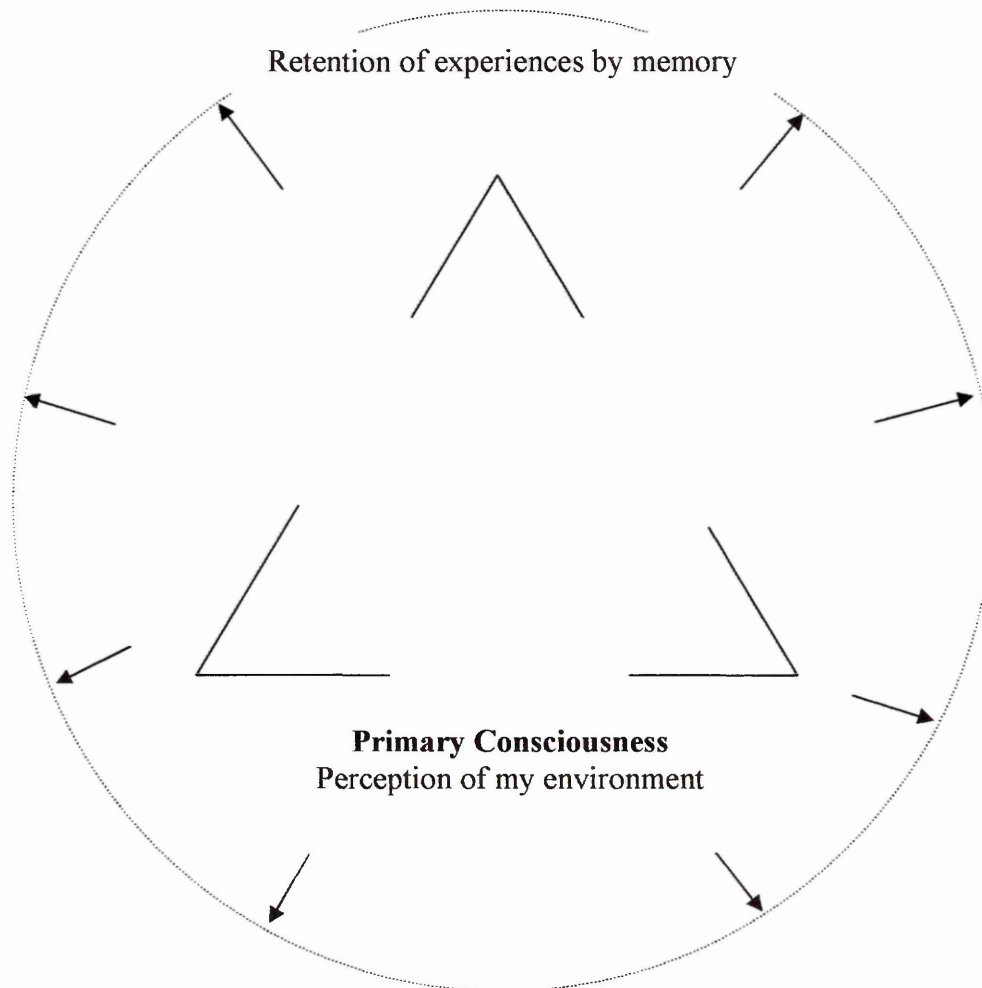
The second in this series of diagrams shows the actuation of higher-order
consciousness, so enabling subjective conception of the self as a thinking
entity:

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Figure 2:3   Developing self-system facilitated by actuation of higher-order consciousness

Stern (2000) suggests that the development of the core self is followed by the sense of a 'subjective self' (between the age of seven and nine months). These processes suggest that higher-order consciousness has been actuated, so enhancing the self-construct. This development in mental potential enables interactions within memory, so leading to understanding, as represented by the arrows in the outer circle.
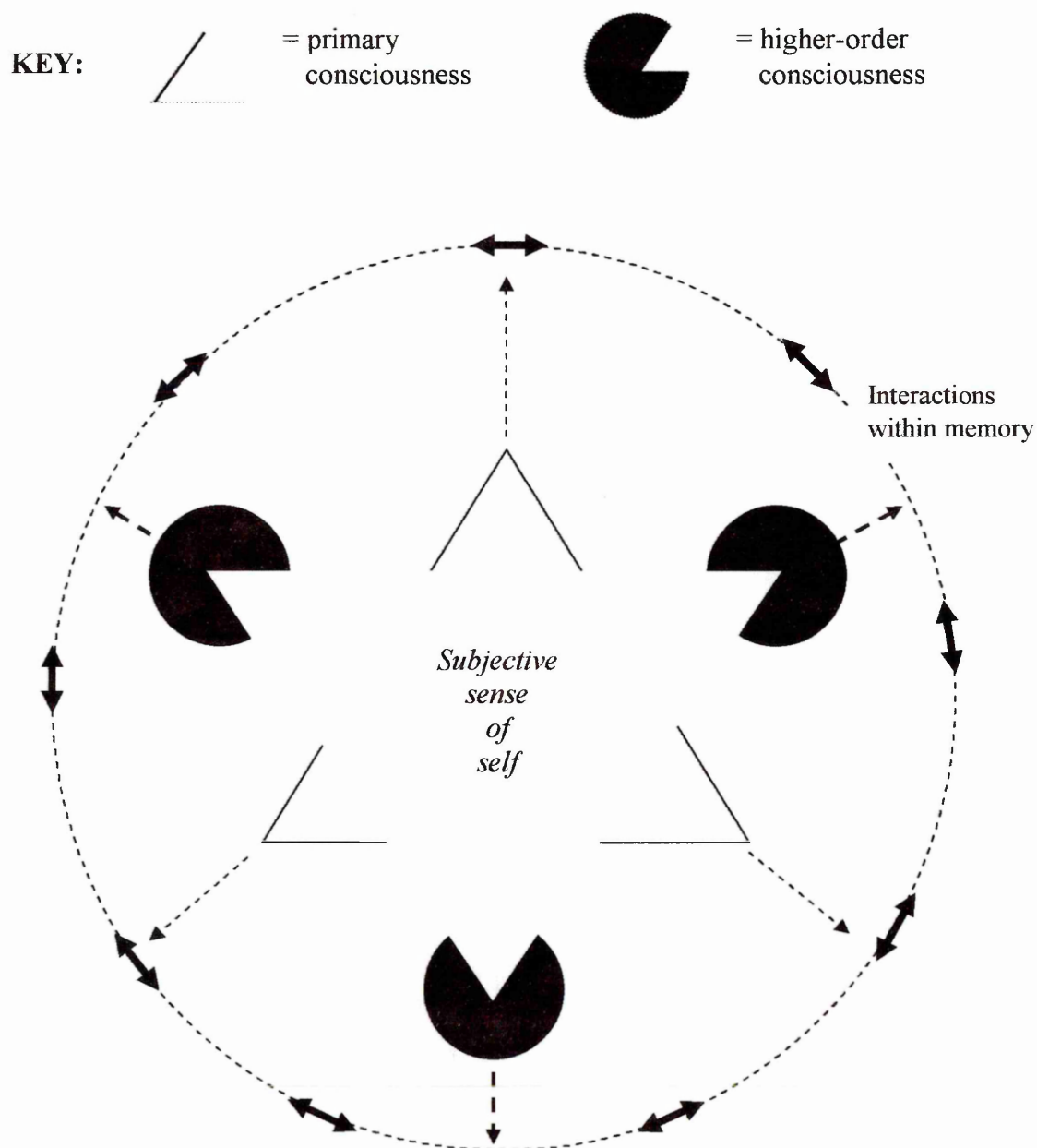
The developing self is a nexus, an interactive construct incorporating 'Who I am' (self), 'What I have experienced' (memory', 'What I understand' (evaluative processes), and 'What I will come to do' (intentionality). Concerning this construct, it is essential to recognize that it is *continually growing,* becoming ever more complex as experience is garnered. Thus, as an integral part of the nexus, the subjective sense of self will also become more complex until, at an indeterminate point, personal identity is potentiated. Subsequently, through social interaction, concepts and understanding of all aspects of the self-nexus – both subjective and objective – become enhanced. Central to this process is the acquisition of language, whereby knowledge outside the realm of personal experience can be conveyed.

Ultimately, within the objective and subjective overview of a human being possessing physical form and mental capacity may be engendered the subjective concept of an intrinsic self: an ultimately indefinable part of the mind which is the wellspring of emotions and feeling.

This continuing complexity is depicted in Figure 2.4 overleaf, which is the final diagram in this chapter. However, the series will be developed further in the following chapter.

Figure 2.4:   **Development of the self-system to show subjective sense of self and personal identity**

As shown by the increased size of the outer circle, the self-system rapidly becomes more complex through social interactions. Personal identity derives from continuous appraisal of the self's role in, and understanding of, continuing experiences; i.e. the life story.

KEY:
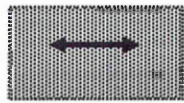
Memory as an interactive construct, incorporating perception
= and understanding of new experiences with understanding of
previous experiences, including the role of the self in same

◀ – – ▶   = interactions between consciousness and on-going experiences,
including review of memories and revision of understanding
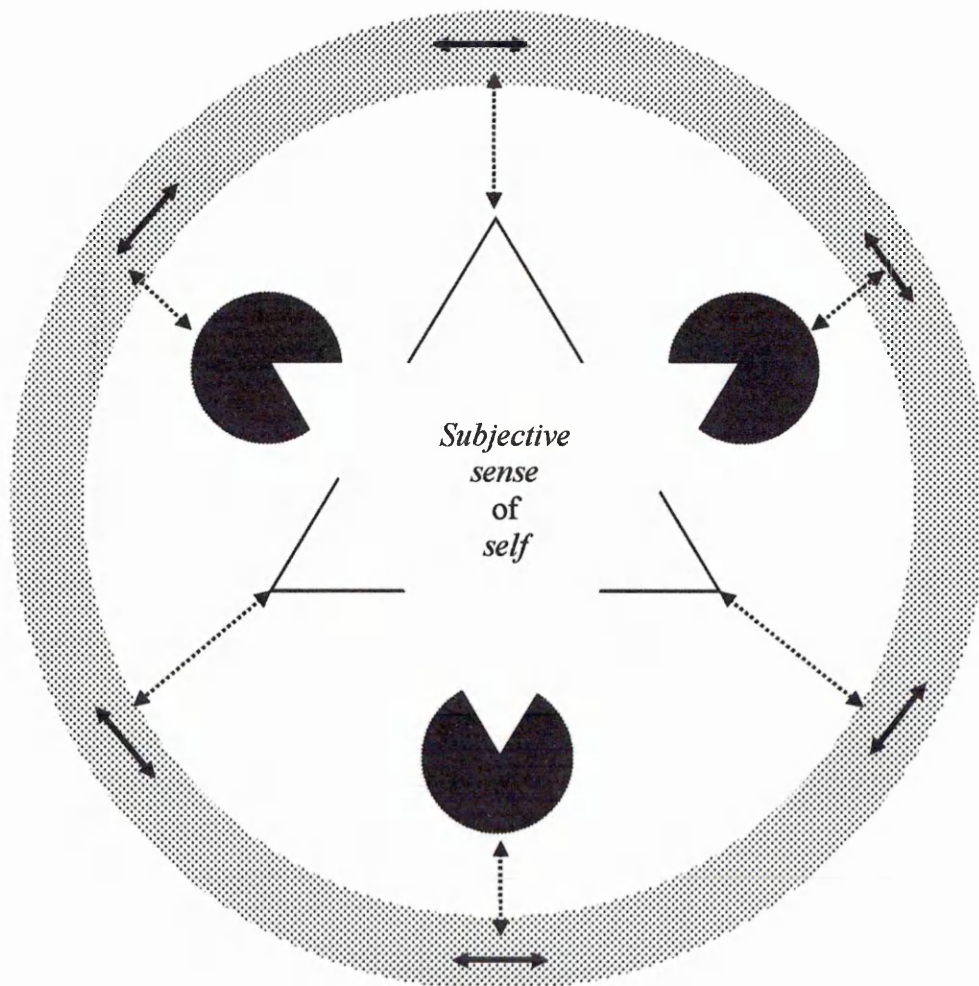
2.5. Conclusion: the foundations of personal identity

This chapter has elaborated upon the first by concentrating upon the development of the self and personal identity in terms of a potential, yet to be fully realized. Up to this point, discussion of self and personal identity has been mechanistic, being concerned with constructs and processes, theories and interactions. Yet I make no apology for taking this stance: rather my intention was to examine the 'raw template' upon which the life story is imprinted. Implied, but not explored, were some of the many social and cultural influences that contribute to and enable this potential to be realized. The following chapter explores these with the aim of achieving a fuller overview of the ways in which experiences are memorized and understood. It is time to move from constructs to persons.

Chapter Three: **If you want to know me..... personal identity and personal narrative**

3.1: Introduction: And if I want to know myself

On two occasions I have received cognitive therapy as part of the treatment for my illness. Much of this consists of looking backwards, to try and identify significant trends and events that might explain some of my present beliefs and motivations. It is important to recognize that this should not be regarded as an exercise in apportioning blame. Rather it is an attempt to gain understanding of the complex of events within and without my life story. For my life story is not solely about me, it is about all that has influenced me, all that influences me now, and all that will influence me.

Personal statement

In the closing pages of the previous chapter, I acknowledged that my intention had been to explore the 'raw material' upon which personal identity is founded. For the purposes of clarity, I reaffirm my conclusion that personal identity is a nexus, an interactive construct incorporating 'Who I am' (self), 'What I have experienced' (memory), 'What I understand' (evaluative processes), and 'What I will come to do' (intentionality). The purpose of this chapter is to focus on the 'outside': the sources of experience that are essential to the shaping of personal identity. In colloquial terms, I intend 'to put the flesh on the bones'. In academic terms, I intend to explore generalized aspects of social and cultural influences, the processes within which the beginnings of personal identity evolve into a life story. Initially, it is essential to make brief reference to emotional and cognitive development from child to adult. One reason for this is to lay a foundation for the later examination of the various influences involved. Another is to gradually introduce the phenomenological aspect of the self, so that an understanding of *what it is or might be* can be combined with *subjective feeling.*

3.2: Emotional development from child to adult
3.2.1: Attachment

With specific reference to developmental psychology, *attachment* describes a strong, long-lasting emotional bond between two individuals (Hill, 1998). Of particular importance is attachment between infant and parent: thus it is pertinent that McAdams (1993) chooses to employ the term 'love' in contrast to Hill's pragmatism. Whilst I do not intend to explore attachment theory in detail, it should be noted that secure attachment at age one is associated with stability in later childhood (McAdams, ibid). Therefore, this topic will be raised again later in this chapter with reference to social interactions.

3.2.2: Agency and communion

In association with a philosophical overview of human motivation, McAdams (1993) cites the Greek philosopher Empodocles, who '....argued that two great forces – "love" and "strife" – rule the universe (1993, 70). Linking this dialectic with Freud, the author opines that 'a significant number' (ibid, 71) of psychologists have posited theories that encompass two general but opposing areas. In summary, one area embraces individuality in terms of autonomy, power and status, whilst the other is concerned with dependence in interpersonal relationships, particularly intimacy. With reference to these, the author favours terms applied by Bakan (1966), namely *agency* and *communion:*

- *Agency* refers to a striving to separate from others, to realise the full potential of the self

- *Communion* refers to the desire to be an integral part of society.

Whilst it appears obvious that these two modes are probably present in all persons, the relationship between them can be extraordinarily complex due to goals desired amid social and cultural forces.

3.2.3: 'Significant others'

A personal narrative does not begin in isolation but is influenced by parents and other family members. Later in childhood, the influence of other persons becomes apparent:

> Our parents, teachers, priests, and friends all play a role in our socialization and in doing so they impart values and instill [sic] ideas
>
> **(Novitz, 2001:154)**

Such a person is referred to by Anderson, Chen and Miranda as a 'significant other':

> ...an individual who is or has been deeply influential in one's life, and in whom one is or once was emotionally invested, including members of one's family-of-origin and people encountered outside of family relations.
>
> **(Andersen, Chen, and Miranda, 2002:160)**

In theory, a 'significant other' can come from any part of society; therefore I use this concept to compile the following list. In doing so, it is important to stress that a person may be an *active participant* in interaction with another person or persons; that is, they may contribute to the outcome.

- *At the immediate family level,* an individual is introduced by parents and elder siblings (if any) to social and cultural conventions.

- *At the extended family level,* the individual learns that parental beliefs are influenced by their own parents plus those of their siblings and other relatives.

- *Outside the family,* the individual is initially influenced by informal groups, namely friends and play groups. Later, this extends to formalized social activities such as sport, and formalized organizations including school and, possibly, religion.

- *At a local cultural and social level,* the family – and thereby the individual – is influenced by the state of the environment in terms of housing, plus community and civic institutions. This includes health provision, such as a person's GP and other health professionals.

- *At a national cultural and social level,* the family – and thereby the individual – is influenced by the 'law of the land', organized political movements, the economy, and the political climate.

- On reaching adulthood, *the influence of friends, social activities, religious belief and employment will continue throughout life.*

3.2.4: Cultural and structural influences

To summarise social and cultural influences in an easily accessible form, Thompson (1993, 2006) devised the Personal-Cultural-Structural system, (abbreviated to PCS). Specifically, this was designed to demonstrate the nature and sources of discriminatory environmental forces – especially negative forces – that might affect an individual. To demonstrate these, the author uses concentric circles to show the relation of the person to their environment, as shown in Figure 3.1 overleaf.

Given this specialized purpose, it becomes obvious that it can be used to indicate *all* environmental influences. However, on reflection, I considered the PCS diagram too generalized for the purposes of this study. In particular, there is the question of overlapping of influences, whereby a cultural influence may be highly structured. Thereafter, if one attempted to differentiate between local and national levels within the PCS diagram, it would become cluttered and difficult to follow easily. However, if the principle of PCS is combined with that of 'significant others', it is useful as a device to locate relationships between the person and their environment.

Figure 3.1: PCS System (Thompson, 2006)

P = Personal level

C = Cultural level
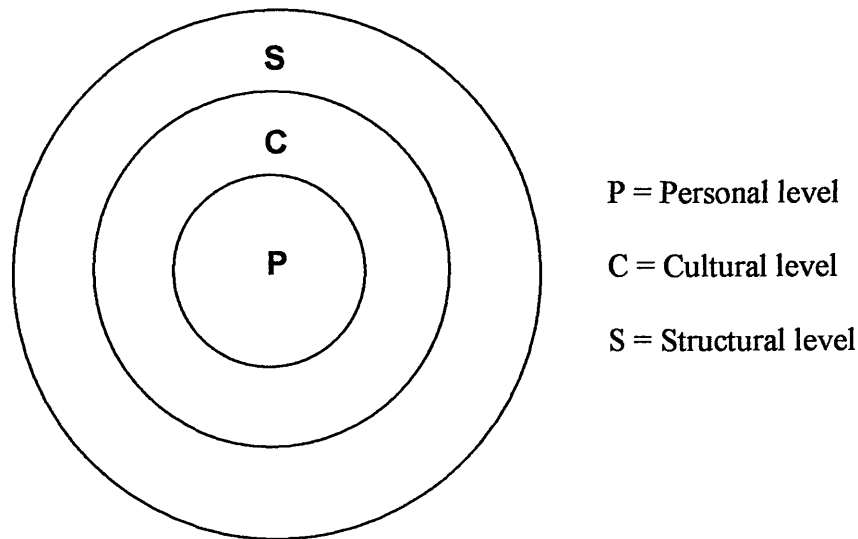
S = Structural level

The *personal level* is self-explanatory.

Cultural influences can be summarized as societal rules that apply to personal conduct.

Structural influences comprise the major forces governing the orderly function of a society, including civil law.

3.3: Cognitive development from child to adult

For the purposes of this chapter, a detailed scrutiny of cognitive development is unnecessary. Development is gradual, attaining sophistication in adolescence (Le Francois, 1983; Hill, 1998). Potential for refinement and increasing complexity may be realised throughout adulthood. Within the PCS system, and crucial in all stages of development, is *social interaction* with significant others. Associated with this, as explained in Chapter 2, is the acquisition of *language*: a system of mutually understood symbols that convey what has been stored in memory. If sufficiently sophisticated, it can describe *all* aspects of an experience, both subjective and objective, with extreme accuracy. To achieve this, language must be more than symbols; it must be able to create a coherent and observe a temporal sequence, wherein discrete events can be located with proper relation to one another and the whole event/experience. This is the essential function of *narrative:*

....the basic medium in which human beings speak, think, grow into selves and understand others.

(Freeman, 1997:175)

Understanding of narrative is integral to this thesis. Firstly, as will be discussed in this chapter, it is the means by which virtually all experiences and understanding is expressed. Secondly, as will be explained in Chapter Seven, analysis of narrative structure will be applied in the exploration of the interview data.

3.4: Narrative in experience and understanding
3.4.1: Defining narrative

The essential function of narrative is to describe a series of events with respect to what happened and their import to the person and/or their community. Central, and crucial to the discussion in this chapter, is the fact that narrative is a *social transaction.* The teller of a narrative is termed a *narrator;* and the person or person receiving the narrative are termed the *audience.* Notably, narration can be introspective, thus an individual person can be *both narrator and audience.* Concerning the act of narration, Bruner (2001) divides narrative into three elements:

i) Story –   'the abstract sequence of events, systematically related, the syntagmatic structure'

ii) Discourse –   'the text in which the story is manifested.'

iii) Telling –   'the action, the act of narrating, the communicative process that produces the story in discourse'

However, as noted by authors such as Riessman (1993) and Hinchman and Hinchman (2001), a precise definition of narrative, plus an unequivocal concept of its limitations, remains a subject of debate. Riessman's own definition (ibid, 2)

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is minimalist in that it underlines the basic function of narrative but provides little insight:

> '.....narratives structure perceptual experience, organize memory'.
>
> **(Riessman, 1993:2)**

Better is Hinchman and Hinchman's (2001) overview of narrative, in which they suggest that the many definitions of narrative necessitate use of the 'lowest common denominator':

> .....forms of discourse that place events in sequential order with a clear, beginning, middle, and end.
>
> **(Hinchman and Hinchman, 2001, xv)**

Similarly, Elliott (2005) draws on several sources in constructing the following definition of narrative:

> Perhaps the simplest definition of narrative, and one that has been traced back to Aristotle in his *Poetics,* is a story with a beginning, middle and an end.
>
> **(Elliott, 2005:7)**

In 1967, narrative was defined as a sequence of events with reference to language by Labov and Waletzky in what many scholars view as a seminal paper:

> .....one method of recapitulating past experience by matching a verbal sequence of clauses to the sequence of events which actually occurred.
>
> **(Labov and Waletzky, 2006 [1967], 8)**

Bewilderingly, the authors state that this definition is 'informal'. However, in reviewing this and a virtually identical definition in a later paper by Labov (1972), Linde (1993, 67 – 8) avers that it 'provides the most useful skeleton for studying naturally occurring oral data'. Importantly, she notes that the order of the narrative may not necessarily match the order of events, so drawing a distinction between the content of the narrative and the way that it is communicated. This raises questions of *meaning* and *coherence.* In this

context, Hinchman and Hinchman (2001) amplify their earlier summary to provide a more detailed definition of narrative:

> ...narratives (stories) in the human sciences should be defined provisionally as discourses with a clear sequential order that connect events in a meaningful way for a definite audience and thus offer insights about the world and/or people's experience of it.
>
> **(Hinchman and Hinchman, 1997: xvi)**

In that it acknowledges a need for intelligibility and coherence, this definition usefully informs the rest of this chapter. The following sections explore the role of narrative in memorizing and understanding the events of our life story.

3.4.2: Narrative in everyday life: the elements of our life story

Narrative lies at the heart of social interaction: it describes events and experience, and it can also inform the audience about the nature and meaning of same. Thus it is integral to all processes of development to adulthood. Noting the importance of narrative in autobiography, Riessman (1993, 3) notes that telling stories about past events is 'one of the first forms of discourse we learn as children'. In this context, it is important to recognize that such stories will include those we tell ourselves. Thus, in a joint role of narrator and audience, narrative is the means by which we make sense of ourselves and the world around us:

> We dream in narrative, daydream in narrative, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticise, construct, gossip, learn, hate, and love by narrative.
>
> **(Hardy, 1987, 1)**

On first examination, Hardy's summary may appear over-ambitious by claiming ubiquity. However, it becomes evident that even an extremely short statement can constitute a narrative, *by both what is said and by what is implied.* For example, if I ask, "What did you do yesterday afternoon?" to which you reply, "I went to the dentist", your answer is, within the definition given, a narrative. In a coherent and intelligible statement, you have summarized your experience. Thereafter, my prior knowledge of dental appointments allows me to either

guess the outcome, or I will choose to ask another question. Thus supported, Hardy's summary is pivotal to the understanding of a person's life story or *personal narrative.* Through narrative, a person is the central character in a complex sequence of events including not only that person's experiences but also their concepts, even their fantasies.

Concerning these, McAdams (1993:29) notes that Bruner (1990) described two modes of thought, namely the *paradigmatic mode,* which encompasses logical proofs, analyses and empirical observation; and *the narrative mode,* which describes 'human wants, needs, and goals.' However, it must be stressed that *both* modes of thought are to be found in a personal narrative: this is by virtue of the latter, more fanciful, thoughts often being grounded in the practical detail of the former. To elaborate, it is instructive to note Linde's (1993) distinction between a *life story* and other constructions of the self such as autobiography or psychological life history. Adopting a 'nontechnical' definition, she explains that a life story is more than a collection of individual stories and explanations: it includes the relations between them. In tandem with this, she suggests that a life story does not begin to be developed until adolescence, thereby implying that it is a sophisticated construct requiring complex thought processes. Associated with this description, the author draws attention to the fact that a life story is constantly evolving: that when a new story is added, it must not contradict existing themes. In consequence, there is constant revision within the life story in order to enable expression of our current understanding:

> This property permits the life story to express our entire sense of what our lives are about, or our sense of what kind of people we are, without necessarily forming a single narrative that organizes our entire lives.

(Linde, 1993, 25)

Much care must be taken concerning this statement. By stressing its composite structure, Linde describes a life story in constant flux; able to absorb new concepts and, perhaps most importantly, to proceed according to free will. The following sections incorporate the sense of self into this construct, so enabling the life story to become the personal narrative.

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3.4.3: Nested narratives: narratives within narratives

At this point, it is useful to begin scrutiny of narrative constructs with a view to their eventual application in analysis. As explained above, the personal narrative that describes a life story can be regarded as being comprised of a multitude of interlinked narratives. Within the large narrative is a complex of smaller narratives; within each smaller narrative is a complex of still smaller narratives; and so on until, ultimately, a single narrative pertains to a single 'unit' of experience. The general term applied to a narrative within a larger narrative is a *nested narrative* (Gergen and Gergen, 2001). From one point of view, nested narratives are separate and distinct in that they pertain to a particular event or chain of events. Thus nesting can be compared with Russian *matryoshka* dolls: within a large doll is a small doll, which contains a smaller doll, within which is a yet smaller doll, and so on. However, this analogy is unsatisfactory in that a *matryoshka* doll is composed of discrete units, whereas nested narratives should be recognized as being intertwined and interactive within the personal narrative.

Nested narratives can be large, complex narratives within the personal narrative or much smaller. Unfortunately, there does not appear to be a consistent term to describe an individual nested narrative, no matter what its size. Perhaps the most obvious candidates are *macronarratives and micronarratives*; however, these are employed by Gergen and Gergen (ibid) with specific reference to the 'temporal continuum'. In their schema, a *macronarrative* refers to events spanning broad periods of time, whilst a *micronarrative* can span a brief duration (ibid). Accordingly, I believe that the most logical course is to name a given nested narrative by the phenomenon it describes. For clarity, I illustrate this overall construct with reference to myself as an example:

i)   The course of my life is described by my ongoing *personal narrative.*

ii)   One of the narratives nested within my personal narrative is my ongoing *health narrative.*

iii)   Within my health narrative are two smaller but still complex nested narratives, namely my ongoing *physical health narrative* and my ongoing *mental health narrative.*

iv)   Nested within my mental health narrative is an ongoing *bipolar-disorder narrative.*

v)   Nested with my bipolar-disorder narrative are discrete *hospitalization narratives,* each defined by a known time period.

Objective and subjective categorization of nested narratives is similarly informal. However, as will be shown in the next section, application of the term 'significant' is unequivocal. Therefore, as will be explored in Chapter Seven, the term 'significant narrative' will be used to refer to any narrative of importance.

3.4.4: Developing my personal narrative: evaluation and re-evaluation of experience

As previously noted, any one person, through introspection, can be both narrator and audience with respect to narration within their personal narrative. Included in this action is the potential for review:

> The life story is thus comprised exactly of the most significant narratives of a speaker's life, which are told and retold, reinterpreted and reshaped for different situations.
>
> **(Linde, 1997:283)**

Whilst Linde suggests that 'radical alteration' due to changes in understanding is 'more rarely' applied than changes in description to suit a given audience, it follows that this is not necessarily true in all instances. Many experiences, including the learning of concepts, may be incompletely understood at the time of committing to memory. However, in the course of introspection amid recall, an experience may be reviewed in the light of new experience. In this way, a given nested narrative may be reinterpreted several times in a person's lifetime

as various understandings are accepted or rejected. Included in these may be –
though not necessarily – insights into personal motives and/or actions
concerning a particular event or sequence of events. Thus the personal
narrative is more than the raw data of accumulated experience: it is a constantly
reviewed understanding of that data and associated emotions. This extremely
important aspect of narrative is shown in Figure 3.2:

Figure 3.2: Reviewing of experience to include new experience

New Experience	Details and understanding of related experiences
Sensation, Perception, Interpretation	MEMORY
	Recollection and reconstruction leading to understanding
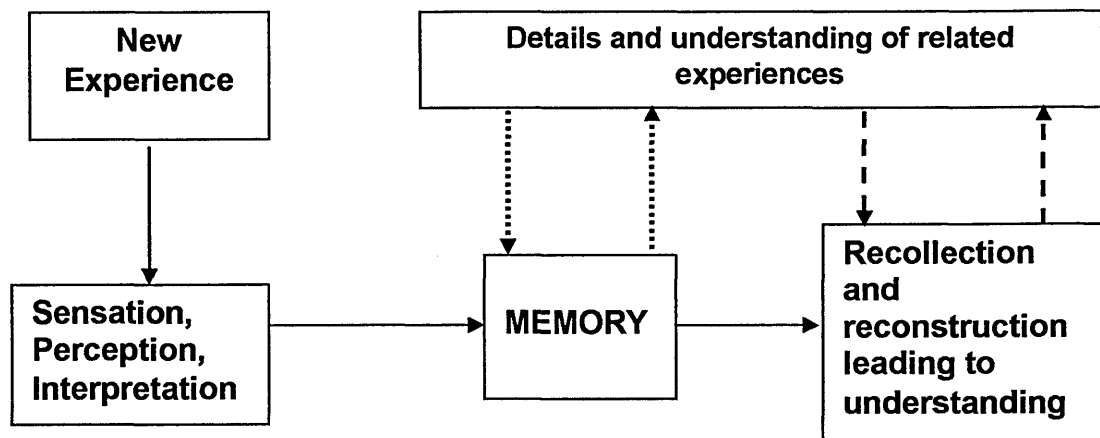
A precise application of this model to development from child to adult would be
highly conjectural. All that can be safely stated is that, assuming that the
person's emotional and intellectual development is normal, the processes of
assimilation and review of experience will continue throughout life. This means
that the entire personal narrative is a construct of truly massive complexity.
Comprised of many nested narratives and the linkages between them, it is also
protean: ever-changing due to re-evaluation, ever evolving as linkages are
broken and new ones formed. Novitz (2001) states:

> Our individual identities and ideals of personhood are constructs produced in
> much the way that works of art are produced.
>
> **(Novitz, 2001:143 – 144)**

As intimated in the conclusion of the previous chapter, I believe that
descriptions of the self and personal identity are, ultimately, meaningless if they

fail to convey the essential humanity of an individual: the *personal* aspect of a *person*. Novitz's metaphor is superbly apposite: if a work of art is deconstructed into types and quantities of components, then its meaning is lost. Indeed are individual aspects relevant, but only as a part of a unified whole. Moreover, an integral part of constructing any artwork is entirely subjective, being derived from the sense-impressions of the artist. Thereafter, the interpretation of the completed work may remain entirely personal or become a product of social interaction by virtue of input from other persons. This is the way of the personal narrative: taken in isolation, a nested narrative has but limited meaning, but as part of an integrated whole, its importance may be pivotal.

3.5: Narrator-audience interactions
3.5.1: Telling my story: social transaction and negotiation

The formation and maintenance of a personal narrative is not a neutral exercise. Rather, it is dependent on complex objective and subjective interactions with significant others within the PCS system. These interactions contribute not only to a person's role and status within society, but also to their personal conceptions of those roles. As such, they are vital in sustaining self-esteem and other constructs associated with self-image and personal identity. The first part of this section is to explore the act of narration, which is extremely important to this research in two ways. Firstly, for the reasons given, it is an integral part of attaining and maintaining status in society. Secondly, with direct reference to methodology, it pertains to the way an interviewee may respond to a researcher's questions (Riessman, 1993).

Observations on the interaction between narrator and audience, particularly on the role of significant others, lead to vexed areas. Possibly the most balanced summary is that by Linde (1997):

> ...close associates can have storytelling rights to critique the speaker's stories, correcting facts, interpretations, and evaluations. Life stories are thus a means for socially transacting an individual's memory.
>
> **(Linde, 1997, 283)**

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In comparison, Gergen and Gergen (2001) describe exchange of narrative in terms of an intricate political process which they call *social negotiation*. This is explained with reference to an individual's actions thus:

> ...whether a given narrative can be maintained depends importantly on the individual's ability to negotiate successfully with others concerning the meaning of events in relation with one another.
>
> **(Gergen and Gergen, 2001:177)**

All is founded on an assumption so basic that it is easily overlooked. That is, *a narrator seeks the acceptance of their narrative by the audience.* However, there is a fine distinction between acceptance and approbation. Thus, under normal circumstances, a narrator wishes to convince the audience that his or her narrative is *true.* Despite this, there is the possibility that the audience may not welcome or approve of the narrative if it is considered 'bad news'. In this context, social transaction metamorphoses into *social negotiation*, whereby a narrator seeks to justify their actions, and an audience seeks to justify its reactions. Concerning this, evaluation by each party may be both objective and subjective; moreover, judgements may be influenced by beliefs and concepts found at all levels personal, cultural, and structural – within the PCS system as detailed in figure 3.1 above.

Associated with the above criteria, an awareness of possible audience reaction may lead to forethought:

> In this sense, the bulk of the negotiation process is anticipatory or implicit; it takes place with an imaginary audience prior to the moment of action.
>
> **(Gergen and Gergen, ibid)**

Unfortunately, however, the authors do not venture into discussion regarding the degree of introspection involved in the above process. If the term 'implicit' is applied with reference to the implicit self (See Chapter Two) then it follows that much of this internalized negotiation process described is a function of unconscious processes. Similarly, it might be postulated that much of our actions are, indeed, so immediate as to be automatic, thereby fulfilling the criteria of learned social and cultural responses. Integral to these are processes

whereby social negotiation can be implemented to achieve desired responses and/or outcomes, thereby maintaining and supporting social relationships.

3.5.2: Telling my story: reciprocity in social negotiation

Described by Gergen and Gergen (ibid) following their discussion of social negotiation, reciprocity is so important in human relationships that it can be described as fundamental to them. For a person to maintain their narrative constructions (i.e. their memories and understanding of them), they require the *support* of their audience, i.e. their 'significant others'. Similarly, the person is expected to support the narratives of those other persons. It follows, therefore, that reciprocity plays an essential role in maintaining social relationships, particularly close bonds such as those within a family unit. On the other hand, in the event of reciprocity breaking down or being deliberately withheld, consequences can be catastrophic. To show this, the role of reciprocity is best examined in two distinct areas: firstly, within interaction between individuals, and secondly within interaction between an individual and a group.

Between individuals, the concept of reciprocity appears obvious. Used positively, it takes the form of approbation; used negatively, it takes the form of censure. Concerning the latter, Gergen and Gergen (ibid) use the example of an adolescent son berating his mother as 'a very bad mother', so compromising her own view of this aspect of her personal narrative. Thus, at this level, the break-up of reciprocity can be expressed more succinctly and, arguably, more forcibly by the terse summary, 'I reject your narrative'. Thus the person, as narrator, will feel disbelieved, unwanted, or both. However, Novitz (2001) takes a more complex view when referring to the 'politics of narrative identity':

> ....we assert and maintain our own interests not just by advancing a particular view of ourselves, but by undermining the views that others advance of themselves. [...] And in this game of strategy, those who have the last word also have considerable power over those who do not.
>
> **(Novitz, 2001:146)**

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The view of reciprocity as strategy is pursued in relations between individuals in a group by Tajfel's (1978) Social Identity Theory (SIT), which is reviewed by Nezlek and Smith:

> SIT posits that people enhance their social identities by comparing their in-groups with relevant out-groups. In order to boost their positive sense of self, people often highlight the differences between their groups and other groups, focussing on their group's superiority and distinctiveness.
>
> **(Nezlek and Smith, 2005:244)**

It follows, therefore, that the reciprocity involved in maintaining group membership can be used to denigrate another group. Similarly, reciprocity withheld by a group can lead to the stigmatizing and, ultimately, ostracising of an individual or other group. As such, it possesses the potential to be a malign force of unusual potency. At a personal level, this is illustrated by Peter Chadwick (1997) in connection with dysfunctional childhood experiences. Another example concerns my own illness, written by my wife, June, as part of her PhD thesis (Wainwright, 1997, unpublished), which describes an occasion when she called a GP to report a 'florid' episode. Desperate to avoid hospital, I successfully lied about my symptoms to the extent that I convinced him that she was wildly exaggerating. The latter example is extremely important in that it illustrates that social negotiation can often be a deliberate act of manipulation.

I close this section by observing that reciprocity can be internalised, so causing a person to ask potentially difficult questions of himself or herself. We can say 'yes' when we think 'no'; we can act when we feel we should refrain; we can refrain when we feel we should act. In all circumstances, to this construct must be added the forces of agency and communion: as social beings, we see our actions through lenses other than our own as we feel the demands of reciprocity. The perceived interactions of a relationship between two persons, the learned social constructs within a group, the structural and cultural expectations of a society: all can mediate the motivations and pragmatic considerations associated with acting according to a moral principle. As a positive force, it is crucial in enabling cooperation and interaction between persons. As a negative force, it can initiate and maintain forms of rejection, prejudice and hatred. However, it is at a group level that reciprocity within social

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negotiation can be most influential and, potentially, most insidious. At this point, therefore, it is pertinent to cite the stigmatization of persons who experience, or have experienced, phenomena diagnosed as mental illness as an example of negative reciprocity. Accordingly, this topic will be reviewed in the next chapter with reference to societal and cultural overviews of mental illness.

3.5.3: Telling my story: reportability and credibility

At this point, I want to remind you about the ants in my orange juice. I told a nurse that there were ants crawling on my locker. She told me, "Don't be silly" So I deliberately left some juice in my cup so that it would trap some ants. Yes, it is an odd story. Moreover, it happened a long time ago, when I was nine. So you may not believe me.

Personal statement

This short section embellishes the processes of social negotiation and reciprocity, particularly the acceptance of a narrative by an audience. A coherent narrative depends upon basic characterisation (the participants); situation (time, place, etc), details of events; and temporal sequence. Coherence, however, is not the whole of the transaction: the successful telling of narrative involves several additional factors.

The first factor, *authenticity,* is a claim of truth. Therefore it is dependent upon memory: not only that of the narrator, but of the audience. The dynamics of this relationship is described by Ochs and Capps (1997):

> ....acts of remembering are attempts to seize authority with respect to a topic of concern. For the presupposed truths to become recognized as such, these acts require validation by others.
>
> **(Ochs and Capps, 1997:84)**

If the same events have been witnessed by several persons, it follows that such validation can be effected through comparison. Should the recall of a member(s) of an audience differ from that of the narrator, then the veracity of

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the narrative can be challenged. In the event of the narrator being the sole witness, however, validation is altogether a different matter. Instead, it becomes wholly dependent upon the following second and third factors.

Reportability concerns the act of crafting a narrative so that it is interesting to an audience, whilst *credibility* is the degree to which a narrative is believable. Labov 1997) states that the two constructs are related by the *Reportability Paradox:*

> Reportability is inversely correlated with credibility.

(Labov, 1997:8)

In simple terms, Labov's 'theorem' notes that the more interesting and/or exciting a narrative, the more likely it is to strain the credulity of an audience. However, these factors are but part of an extraordinarily complex construct of belief, wherein much depends upon social status of narrator and audience; the linguistic and intellectual acuity of same; plus, as explained above, ebb and flow within reciprocity. Accordingly, despite apparently unassailable truth and reportability, the transaction of a narrative may fail.

3.5.4: Telling my story: 'Failed Narratives'

With reference to the nurse who did not believe me, my complaint concerning the ants in my orange juice was a failed narrative: I was the narrator, she was the audience, my narrative was rejected. And you, the reader: are you exasperated by my persistent use of this trivial tale? If you are, or if you consider that my account is coloured by childhood invention, then it remains a failed narrative.

Personal statement

Using the same 'mathematical' style throughout his 1997 paper, Labov defines a 'failed narrative' as shown below. Importantly, he stresses that failure of a narrative causes the status of the narrator to be diminished:

> A serious narrative which fails to achieve credibility is considered to have failed, and the narrator's claim to reassignment of speakership will then be seen as invalid.
> An "invalid claim to reassignment" is a technical way of stating that the narrator has suffered a loss of status which will affect future claims of this sort as well as other social prerogatives.
>
> (Labov, 1997:9)

Failure of a narrative is synonymous with rejection by an audience. Thus a narrative may fail because it is not believed, or because it is considered unimportant or irrelevant. Moreover, deriving from the definition by Labov, a 'reverse flow' can occur whereby a seemingly viable narrative is rejected due to the low status of the narrator. Thus, in the context of social negotiation, a failed narrative may be an extremely powerful construct: indeed, with reference to my literature search, I believe that this is by far the most potent of all that I have encountered. This is because I immediately applied it on reading to introspection whereby a person is *both narrator and audience* with respect to their own experiences and, particularly, their own role in the course of events. From this initial development it was but a small step to identifying failed narratives in my own life. Perhaps this is because much of my life has been compromised (a word I choose deliberately) by mental illness; the consequences of which have ranged far beyond symptoms and medication. Notably, there is an easy comparison with the term 'failure' as used in some of the questions in the Beck Depression Inventory, which was developed by Aaron Beck et al in 1961 (Williams, 1995) [As part of my on-going treatment, I completed this many times in the 1990's]. Moreover, in the context of social negotiation (see above) there is an obvious link between a failed narrative and loss of self-esteem. Given that social negotiation is also internalized, it is possible that the consequences of prolonged mental illness may be viewed in terms of a failed narrative.

Lastly, it is possible that a failed narrative may be finite. For example, my marriage to my first wife ended in failure: the narrative is over; it cannot be restored. It was this observation that disturbed me most in that it was confrontational: I could not help but acknowledge the past and feel again some

of the hurt, some of the sadness, and yes, much of the guilt. Yet in this bleak overview it is easy to be broadsided by emotion and overlook basic concepts associated with narrative. As stated previously, *all* narratives are subject to constant review and reinterpretation in the light of new experiences and new understanding. This is particularly so if an on-going narrative such as prolonged mental illness is *still active.* Accordingly, to apply the term 'failed' can be unwarranted and pessimistic: instead, if a term is desired to designate a continuing negative narrative, *'unresolved'* is far more appropriate. Obviously, however, to apply this logic to a finite narrative deemed as failed – such as divorce - is more difficult. My considered answer is that unhappy events are nested in all personal narratives. Cautiously, I submit that sometimes they are the source of an essential understanding. More confidently, I would argue that in the context of the on-going personal narrative, even an unhappy nested narrative may contribute to understanding of other nested narratives.

Further development of narrative theory will be examined with particular reference to narrative analysis in the context of methodology (Chapter Seven). This chapter continues with exploration of that which can rightly be viewed as the apex of the self construct. This is the combination of experience, beliefs, and ideals that constitute the personal myth.

3.6: And this is how I want to be known: the personal myth
3.6.1: The 'central monomyth'

Explored in detail by Campbell (1949,1993) as the introduction to his religious/philosophical text *The Hero with a Thousand Faces,* this concept is reviewed by later authors in the context of social identity (Gergen and Gergen 2001; McAdams,1993) and narratives of illness (Frank, 1997). Concerning all possible applications, the most apposite approach is a simple summary. The monomyth describes a journey, wherein a hero overcomes trials and tribulations to achieve a prize. Throughout Campbell's entire text, this is paraphrased with reference to Jungian psychodynamics, including subconscious ideation, and

metaphor concerning human thought and ambition. Thus, often, the prize sought by the hero can be explained in terms of apotheosis leading to a transcendent mental condition.

Essential to the understanding of Campbell's text is the concept of the *hero as exemplar.* Indeed, a hero need not possess any specific powers or ability: the fact that they are the central figure in a narrative is qualification enough. Thus, whilst Campbell's writing may seem somewhat florid and therefore out of context, it is highly relevant by virtue of calling attention to the essentially *personal* nature of a personal narrative. Thus far, it has been described mainly in terms of an interactive vehicle. Not only is it the means by which an individual communicates with other individuals, it is the continuous process by which experience is retained and, possibly, understood. As noted by Barbara Hardy (above) it enables the person to anticipate and plan future actions. Yet, in combination, these constructs are insufficient to form a complete personal narrative. In addition is the dimension of our imagination, wherein lies our capacity to plan future actions and, especially, our fantasies. Thus the hero may become an internalized expression of our self, providing the basis for an iconic image of what is possible. This aspect of the monomyth is explored in research by Sullivan and Venter (2005), which shows that heroes can be more than exemplars in that they become incorporated into the self. In this their influence is similar to that of 'significant others' (above).

3.6.2: The personal myth

Our imagination enables the formation of a *personal myth* within the personal narrative or life story:

> A personal myth delineates an identity, illuminating the values of an individual life. The personal myth is not a legend or a fairy tale, but a sacred story that embodies personal truth.
>
> **(McAdams, 1993:34)**

Due to its religious context, extreme caution is necessary to pinpoint the precise use of the term 'sacred'. Whilst McAdams suggests a conventional meaning, he is not entirely successful in positing an unequivocal alternative to religion. Careful examination of his text, however, suggests that his application is intended to combine the qualities 'of exceeding worth' with 'uniquely personal'.

Thus it follows that the 'personal myth' is a complex expression of personal identity: in this it accords the dimension of reflexivity and learning to the individual as the central character in his or her personal narrative. Whilst it may incorporate imaginative or even fantastical ideas, it is rooted in the other concepts detailed in this chapter. First and foremost, it is a narrative in its own right. Thereafter, in common with all narratives, it is subject to introspective scrutiny and revision as new experience and new understanding is incorporated. Thus the truth is somewhat prosaic: although a personal myth can be associated with quintessential realms, it is, fundamentally, a narrative expression of *who and what we would like to be.* In this context, McAdams (ibid) refers to existentialism; however, his summary of a personal myth could apply equally well to a person who acknowledges a religious figure as exemplar:

> .....we are challenged to create our own meanings, discover our own truths, and fashion the personal myths that will serve to sanctify our lives.
> **(McAdams, ibid)**

This observation leads to areas rife with speculation. Let it be known that I am unwilling to discuss my own personal myth because I wish my most private thoughts to remain my own – in this they are sacred to me. However, I am prepared to acknowledge an ideal of 'hoping to do the right thing at the right time'. Deriving from this, I suggest that most persons wishing to pursue their lives within the laws and culture of their environment follow the same approximate doctrine. Yet, apparently simple, this adage is deceptive. This is due to the gulf between what I can do, what I cannot do but hope to attain, and what I aspire to do but will never achieve.

Where are the boundaries between these three concepts? Undoubtedly there is a degree of overlap, particularly between the first two. As a result, my aspirations become subject to an internalized social transaction: by what means do I measure the worth of my actions? Thus my personal myth is not a constant, rigid concept, but interwoven with uncertainty.

3.6.3: 'Imagoes': the ways in which I perceive myself

'Imago' is the term employed by McAdams (1993) in developing divergent characters within the personal myth:

> An imago is a personified and idealized concept of the self. Each of us consciously and unconsciously fashions main characters for our life stories. [....] Our life stories may have one dominant imago or many.
> **(McAdams, 1993:122)**

In that this term is also used to define the final stage of insect development, it is curiously apt in that it indicates the conclusion of metamorphosis. However, on scrutiny, McAdams' construct is not static but dynamic, being composed of interacting and often conflicting influences. In short, these can be divided into two areas: the first approximating to the PCS system in that it includes cultural and social roles. Thus imagoes in this area include family role, employment status, and so on: for example, the father, the mother, the professor, the banker. In contrast, the second area is more nebulous in that it includes idealized concepts of personal attributes and aspirations, for example, the caregiver, the philosopher, the author.

Imagoes are important to this study in that they pertain not only to who we are but who we would like to be. However, a slight criticism of McAdams' parameters is that he lays little stress on the possibility that a person may not necessarily be the sole architect of their life story. Not only are there the many influences defined by the PCS system, there are the unexpected events that may affect a life story. Insofar as an imago may concern status, it may include an involuntary social role: the 'invalid', the person whose life story is compromised by illness.

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3.7: Conclusion: the gradual onset of uncertainty

Whilst elaborating upon the constructs associated with the personal narrative, this chapter has emphasized the complex interactions between them. In connection with this, I ask, "To what extent are we aware of these?" When I was a child, my understanding was of an orderly world, one of certainty. Central to this was awareness that I was young, therefore I did not know very much about the world in terms of natural phenomena, history of humankind, and so on. However, a function of this awareness was a comfortable conviction that my learning would continue; that as I grew older, so my knowledge and understanding would increase.

Yet, as I acquired the ability for abstract thought so I began to realize that knowledge was not the same as understanding: that I might know of but never know a particular object or construct. Associated with this, I began to question social and cultural constructs and traditions that I had believed inviolate: the rightness of parental decisions and beliefs; the truth of religious thought.
In summary, the tension between agency and communion underwent a fundamental re-adjustment. Erikson (1993) describes this as *identity crisis*: a period in which:

> .....each youth must forge for himself some central perspective and direction,
> some working unity, out of the effective remnants of his childhood and the
> hopes of his anticipated adulthood.
>
> **(Erikson, 1993, 14)**

Suggesting that the identity crisis will be minimal for some people, Erikson notes that for others it will be a 'critical period', marked by 'widespread neuroticisms or by pervasive ideological unrest' (ibid). Although he does not describe them as such, it is probable that these constructs represent opposite ends of a continuum. In reality, there will be many persons who have experienced minimal problems concerning a specific aspect of social interaction whilst encountering difficulties in another area. Also expressed by the author is the opinion that sense of identity 'is not wanting in most adults'. Again, this

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appears somewhat simplistic: it is perfectly possible that many persons experience uncertainty in some areas whilst enjoying absoluteness in others.

Thus, perhaps inevitably, I return to the concept of the subjective self. I know it is within me, I believe it is within other people. Concerning myself, my adult ability to comprehend abstract concepts means that I can visualize the workings of this construct. Thus, although I cannot access it directly, I can perceive it, and thereby I interpret and understand myself. By this process is completion of personal identity fully potentiated. Accordingly, I modify my diagram of the self construct as shown in Figure 2.4 (Chapter 2) to demonstrate this reciprocity.
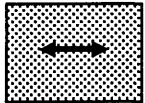
However, the modified diagram (Figure 3.3, overleaf) differs from Figure 2.4 only in that the outer circle depicting the interactive construct of memory and understanding of experiences is larger. Similarly, the double headed arrows indicating interactions of memory and consciousness are also larger, so suggesting increasing application of understanding to the processes of a person's inner environment. However, in reality, this construct will never be complete. As stated previously, by its very nature the subjective sense of self is intangible, a construct deriving from the directing of consciousness towards its own workings. Moreover, throughout the continuing personal narrative there will always be new experiences and new understanding. Thus this chapter concludes by reaffirming that personal identity is in a constant state of flux. Much of it – perhaps the major part – exists in a state of tension between the reality of experience and the idealism of the personal myth. Through narrative we organize the memories of our experience into a coherent form; through narrative we incorporate any understanding gained into appropriate constructs; through narrative we plan our future actions to meet the required outcome. And, through narrative, we may anticipate the consequences of that outcome; be they the rewards of success or the disappointment of failure. Later, when events have passed, reality will, almost certainly, be reviewed in the light of that anticipation. In effect, we judge ourselves and our actions by comparison with our personal myth: what we are compared with what we hope to be or, more poignantly, what we are compared with what we *hoped to be.*

Figure 3.4: Development of the self-system to show reciprocity of subjective sense of self and developing sense of personal identity

The self-system has now fully potentiated the construct of personal identity. This can develop throughout the course of the personal narrative as new experiences contribute to increasing understanding of the self and its relationship with the physical and spiritual environment.

 = interactive construct of memory and understanding of experiences, including capacity for abstract thought
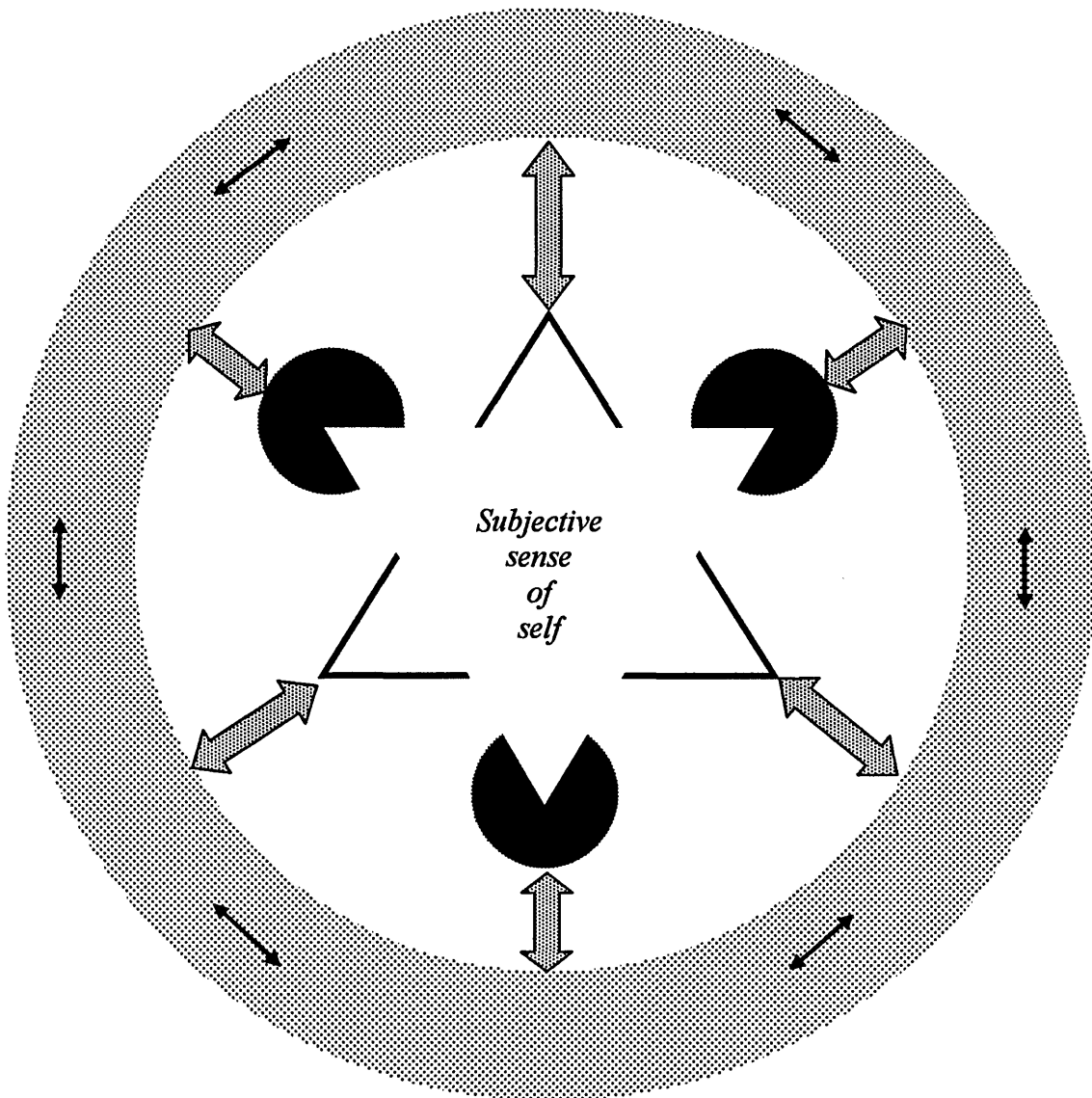
Following from some of the themes indicated in this chapter, the following chapter explores mental illness; both from a medical viewpoint in terms of psychopathology and a phenomenological viewpoint in terms of experience. This chapter ends with my summary of personal identity. Whilst I am obliged to write it in the present tense, the second and final lines acknowledge the future.

Personal identity is my self-image in terms of my perceived role in my experiences:

All that I am, all that I was,

All that I hope to be, all that I do not hope to be.

All of my physical attributes.

All of my mental attributes.

All of my emotional attributes:

all of my likes, my dislikes, my habits, my hobbies, and my motivations.

All of my imaginings, those of the past and those of the present.

All of my experiences:

all that has happened to me,

all that I can remember and all that I cannot remember.

All that I know, and all that I know of,

including all that which I may never know.

Chapter Four: Phenomena diagnosed as mental illness

4.1: Introduction: Where to start?

This chapter proved extremely difficult to write. Having considerable experience of phenomena diagnosed as mental illness, I found that the problem centred on two areas. One was the obvious question of what to include and what to leave out. The other was far more complex: it concerned identifying the point at which awareness of mental illness begins. In this, I often felt I was 'putting the cart before the horse' but, in terms of chronicity, my sequences were logical: like most people, I had suffered from symptoms for some time before I began to learn what they were.

Personal Statement

I open this chapter by taking advantage of Linde's (1993) construct of a 'non-problematic assumption' with respect to *any* experience of illness. That is, on perceiving the symptoms, the person affected will ask, 'What is the matter with me?' Thereafter, this question may prove to be the first of many, for it may not be enough to know what something is called. Rather, the person and/or interested parties may want to know details of aetiology, the implications of phenomena, and, possibly most importantly, the proper responses that are necessary if health is to be restored. This is the full measure of the question, 'What is Mental Illness?' It requires not a single answer, but a nexus of different aspects which, obviously related by a common theme, are nonetheless sufficiently complex to stand as discrete entities. However, such is the vastness of this topic that an exhaustive review is not possible. Therefore, this chapter will concentrate on the understanding and experience of mental illness.

4.2: What is health? What is Illness?

To introduce this section, it is instructive to follow the precise order of events that led to my being diagnosed as suffering with depression in 1967. I decided to visit my G.P. because I felt unwell: that is the all of it. I had no idea what

might be the problem or what it might be called. On reflection, I believe that this is the way of all illness experiences: first, we are aware of a feeling; then we try to find out what it is and what the cause is.

Personal statement

In seeking an overview of mental illness, it is necessary to first examine generalized constructs of health and illness, including questions of agency, plus objective and subjective understanding of human behaviour. Concerning individual attitudes towards illness and understanding of same, both are influenced by and contribute to social and cultural factors. As explained in the previous chapter, normative concepts concerning the behaviour of individuals in a society are mediated by cultural norms, its laws, and, possibly, its religious principles:

> These understandings constitute part of our society's assumptive world, the world that is thought of as normal, decent, and possible.
>
> **(Scheff, 1996:64)**

For the purposes of this chapter, health is therefore viewed as part of the assumptive world detailed above: health is normal, health is decent, and health is possible. Thus; logically, illness is a violation of these qualities: it is 'abnormal', it is not decent, and it should not be possible. Initially, it appears evident that this construct is rather inadequate. Yet, should this summary be explored, then it serves to underline both the essential nature of health and illness, and the attitudes of society towards them. Essentially, all three qualities associated with health – normality, decency, and possibility – are arbitrary measures, upheld by the cultural and social beliefs of a majority. In this context, the World Health Organization has continued to use the same basic definition of health since its inauguration in 1948:

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
>
> **(World Health Organization, 1948, 2010)[Obtained by Internet 3.3.2010]**

Whilst a valid objection to this statement is that it is too vague, it is important to note that it stresses health as a positive entity in its own right. However, use of the concept of 'well-being' can lead to confusion. In the 'New Horizons' document, which is the Department of Health Mental Health policy guidance applicable from December 2009, well-being is defined as:

> *A state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.*
> **'New Horizons' page 18, [italics in original]**

Notably, this document then appears to distinguish between well-being and health:

> Well-being is therefore distinct from mental illness. Someone can have symptoms of mental illness and still experience well-being just as a person with a physical illness or long-term disability can.
> **(ibid)**

To resolve this apparent conundrum, it is necessary to recognize that the WHO definition is intended to be understood as an indivisible whole, that is, health is understood as dependent on all three aspects (physical, mental and social) being positive. In contrast, 'New Horizons' is a policy document focussing on factors associated with early interventions in mental illness and prevention of same. In drawing attention to the fact that mental illness may not affect sense of well-being, it raises issues that are important with reference to identifying illness, as will be discussed later.

4.3: Identifying illness

I've had cuts and bruises, often the result of something stupid such as cracking my fingernail with a hammer, and people have winced in sympathy. I've had a dental abscess and people have expressed concern: after all, most people have had toothache. Yet, when I've had a severe cold, some people have felt that I'm 'overdoing it'; that it is, in truth, not that bad. And, with respect to my experiences of mental illness, some people made it clear that there was no problem, that I should 'pull myself together' or 'get on with my life'.

Personal statement

This section is integral to the narratives of the interviewees in that it pertains to the initial recognition of phenomena diagnosed as mental illness in terms of a discrete event. Importantly, as will be demonstrated in Chapter Nine, 'Overwhelm', such may not have been by the person themselves but by another party or parties. This disparity between persons may lead to complex social interactions that can alleviate or, often, exacerbate illness. As such, therefore, it is necessary to examine these phenomena in more detail.

4.3.1: Signs and symptoms

To identify illness, some sign, or evidence, is needed. Somewhat unhelpfully, Black's Medical Dictionary (MacPherson [ed.] 1992) uses the word 'disease' when stating that this evidence is termed a *symptom.* On examination of specific conditions listed in this text, however, it becomes apparent that this term is applied to all illness, including mental illness. Thus, I consider it reasonable to summarise symptoms in terms of physical and/or verbal evidence:

i)   Symptoms that can be measured and/or felt, e.g. temperature; swelling

ii)   Symptoms that are perceived subjectively, e.g. skin colour

iii) Reports of pain

iv)   Thought processes as expressed verbally

v)   Behaviour, including reaction to physical trauma, such as shivering or torpor

Associated with the above criteria, the following sections will explore how physical illnesses are perceived before proceeding to those problems peculiar to the perception of mental illness.

4.3.2: Primary and secondary qualities of objects

All physical objects possess *primary qualities* and *secondary qualities* (Horner and Westacott, 2000). For the purposes of review these can be summarized thus:

Primary qualities are described as those that 'really do belong to the thing itself'. (2000:41) Including physical qualities, shape, quantity, motion, temperature, etc, these can be measured *objectively.*

Secondary qualities derive from the physical structure of an object and are measured *subjectively.* They include colour, taste and smell. As such, they are 'sense-impressions' that exist in the mind of the person perceiving the object in question.

4.3.3: Attitudes to illness based on perception of primary and secondary qualities.

Concerning the presence and severity of illness, observers may differ in their opinions. Such differences can be illustrated by Venn Diagrams (Johnson and Glenn, 1967; 14 et seq; also 48et seq.) to explore syllogisms, which contain either *universal* or *particular* statements. *A universal* statement contains all the members of a set, whereas a *particular* statement contains some of the members of a set. Thus, with reference to opinions concerning illness, agreement or difference can be shown as follows in Figure 4.1:

Figure 4.1(i): Combination A:

Person A believes that there is illness (Circle A)
Person B believes that there is illness (Circle B)

Therefore, persons A and B are in agreement (Cross-patterned circle: A and B
completely overlap)

A
I believe that
there is illness

B
I believe that
there is illness

AB
We are in complete agreement
that there is illness

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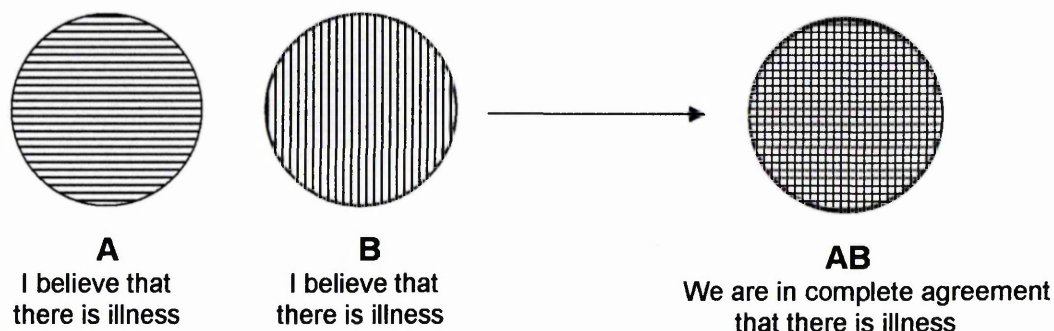
Figure 4.1(ii): Combination B

Person A believes that there is illness (Circle A)

Person B does *not* believe that there is illness (Circle B)

Therefore the circles remain separate (disjoint)

| **A** | **B** | **A** | **B** |
| I believe that there is illness | I believe that that there is no illness whatsoever | We do not agree with one another on any aspect of possible illness | |
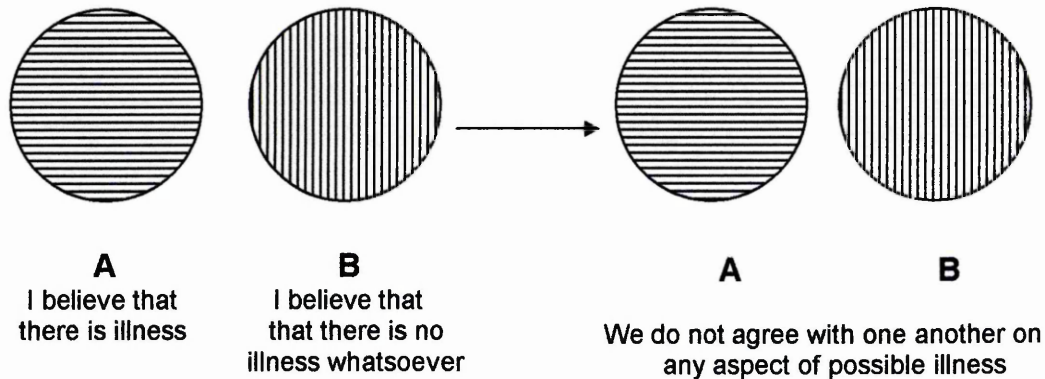
Figure 4.1(iii): Combination C

Person A believes that there is a degree of illness (Circle A)

Person B believes that there is a *different* degree of illness (Circle B)

Therefore the circles overlap

| **A** | **B** | **A** | **B** |
| I believe that there is illness | I believe that some of what you say is correct | We agree on some, but not all, aspects of possible illness | |
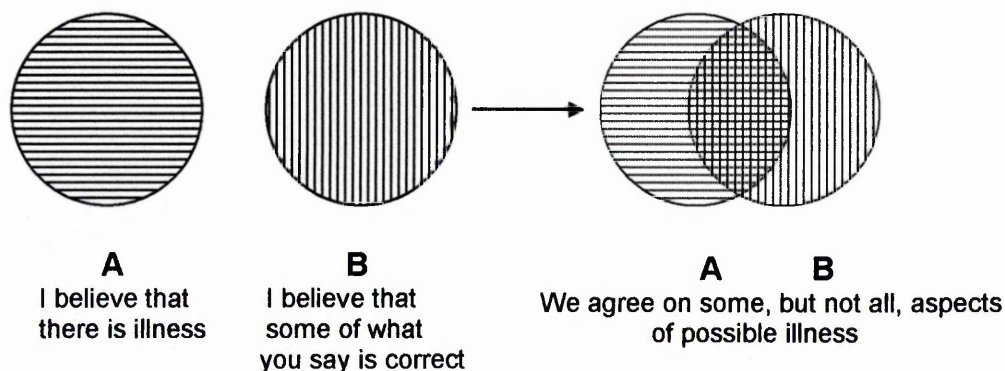
Concerning illness, it is reasonable to aver that, in the vast majority of cases, the combined opinions of different persons will be illustrated by the many possibilities summarised by combination C. Thereafter, by applying observation and some speculation, it is possible to refine this construct. Thus, with reference to *primary qualities,* it can be stated with confidence that such signs are obvious

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in that they can be *felt*. Moreover, it is likely that some can be measured using instrumentation, or detected by biological techniques. Accordingly, whilst some differences in opinion may exist, it is probable that most persons will be in agreement due to the largely objective nature of these signs. As a consequence, the degree of overlap in the resultant diagram will be almost complete:

Figure 4.2: Perception of illness based on primary qualities
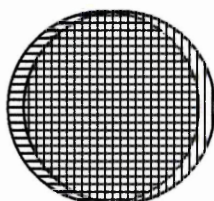
We are largely in agreement that the
physical signs are indicative of illness

With reference to *secondary qualities,* however, there is possibly more scope for differing opinions. This is because of the largely subjective nature of these qualities which, concerning illness, should include those aspects which can be perceived but are difficult to measure; for example, sneezing, shivering, verbal complaints. Accordingly, the resultant Venn Diagram will show less overlap:

Figure 4.3: Perception of Illness via secondary qualities:
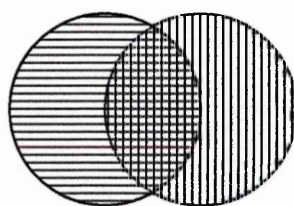
We agree that these signs are indicative of illness
but differ on how severe that illness is

Obviously, many illnesses will cause a combination of symptoms, some of which exhibit primary qualities, and some which exhibit secondary qualities. Thus it is possible – indeed probable – that the primary qualities, those that can

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be measured objectively, will carry the greater weight. However, it is also possible that some illnesses may exhibit *no* symptoms with primary qualities, necessitating a judgement based on subjectivity. Should secondary qualities also be absent, then this will be based on observation of behaviour and verbal report, particularly that of *pain.*

4.4: Pain: a tertiary quality?

How many times have I felt physical pain? Far too many to count: it is a normal and, overall, an unremarkable part of everyday life. The worst pain I have experienced? In truth it is difficult to say – a toenail avulsion; a dental abscess affecting a lower molar; post-operative pain following removal of an epididymal cyst: these are the examples that spring to mind. Yet of greater relevance are childhood experiences: sometimes sympathy was forthcoming, sometimes it wasn't. Very often, the reaction to my pain was, "Oh, stop moaning, it's only a scratch." Such are the trials and tribulations of being a child: sometimes such a judgment was fair, sometimes it wasn't. Sometimes I did make more of it than I should have: this, too, is normal behaviour.

Personal statement

Understanding of the perception of pain is a crucial intermediate stage to the understanding of phenomena diagnosed as mental illness. At its most basic level, pain derives from physical stimulation leading to the activity of specific sensory nerves. In turn, this activity is refined by consciousness to result in a combination of objective and subjective experience. This is acknowledged in the following definition of pain by the International Association for the Study of Pain (ISAP):

> An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.
> **(Merskey and Bogduk [eds], 1994)**

The essentially personal nature of experiencing pain is stressed by Finley (2001):

Self-report is the "gold standard" for pain measurement. The concept that only the patient can really understand what he/she is feeling is embodied in the definition of pain.

<div align="right">

(Finley, 2001:1)

</div>

Since pain is a function of consciousness, *any one person cannot directly experience another person's pain.* Whilst they may recognize that pain is being experienced, whilst they may even know the cause of pain, they cannot accurately assess its degree. For this reason, I believe that pain is properly described as a *tertiary quality.* This is because it may exist in circumstances akin to a perceptual vacuum: although primary and/or secondary qualities may be evident, so providing important evidence of trauma, they may also be absent. In such circumstances, the *only* evidence is through behaviour and verbal report. Moreover, through reciprocity (see previous chapter) the perception by an audience of a narrator's pain may be influenced by personal and cultural prejudices. In this, understanding the perception of pain may be an extremely useful guide in perception of thought processes associated with phenomena diagnosed as mental illness.

4.5: Thought processes: a fourth-degree quality?

Sometimes I have felt myself to be suffering the most terrible psychic pain. This is not a headache or migraine but a numbing heaviness of thought, a nameless dread permeating all mental activity. Thoughts of death, thoughts of sadness: ill-formed ideas that an end will come. Thus have I been rendered helpless, hospitalized because my motivation had become virtually nil. Yet is this pain? Not in the true sense of the word. Distress, yes; pain, no.

Despite this, the comparison is a valid one. Most persons will have experienced a pain so severe that it envelops their entire consciousness. At such times, all they can think of is pain. In the same way, there have been times when all I could think of was my on-going illness. Yet, to a third party, my problems may have seemed minimal.

<div align="right">

Personal statement

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Phenomena diagnosed as mental illness *may include thought processes that cause discomfort to the person.* In this, they are like pain: *felt directly only by that person.* Like pain, thought processes are a function of consciousness. Like pain, a person cannot directly experience another person's thoughts. Like pain, the thought processes of another person can only be inferred by behaviour and, possibly, verbal report. Like pain, a verbal report of thought processes by the person experiencing them may be misinterpreted by a listener. Like pain, vocalization and other forms of behaviour – such as facial expression – are the only ways in which thought processes can be expressed. However, whereas pain is associated with a physical cause, dysfunctional thought processes may not be associated with any physical stimulus whatsoever. Thus, whereas an observer might assess pain by a frame of reference based on medical knowledge concerning the cause and, possibly, mutual experience of same, no similar construct may be applicable to thought processes.

Like pain, in association with the detail of all thought processes is the question of verbal acuity of both describer and listener. Whereas it may be possible to explain one's thoughts with great precision, it is also possible that they cannot be properly described. On the other hand, a detailed and accurate description may not necessarily be understood by an audience. Indeed, it is possible that a particularly difficult concept may be beyond a given person's comprehension. On the other hand, a relatively commonplace event may be beyond a given person should they suffer from a disability of perception. This is easily illustrated by the rather hackneyed problem of describing a rainbow to a person who has been blind from birth.

Unlike pain, *thought processes may require no stimulus other than other thought processes.* As such, they may be beyond verbal description and thereby beyond the perception of any third party. Therefore, to convey this uniquely personal quality, I believe that they should be referred to as *fourth-degree qualities.* As a consequence, belief and unbelief play a major role in the dysfunctional thought processes that, in the main, constitute phenomena diagnosed as mental illness. However, rather than using Venn Diagrams, the

various combinations whereby an individual person and observers may perceive these differently is listed in the following section.

4.6: Belief and unbelief

My father has never regarded my experiences of mental illness as a true illness. In 1994, on learning I was due to see a consultant psychiatrist, his response was, 'Isn't it about time they found out what is wrong with you?'
After consultation, I telephoned him again to the effect that I had been diagnosed as suffering from biological depression (moderate) and obsessive-compulsive disorder. His reaction was to berate me furiously, 'But you've got to get on with your life!'

The truth is that he believed that there was nothing wrong with me and wanted the consultant to tell me so.

Personal statement

Identification of any illness *begins with a decision by someone that something is wrong.* The subjective nature of phenomena diagnosed as mental illness being *wholly associated* with thought processes increases the possibility that an individual may disagree with 'significant others', as to whether or not they are experiencing illness. As explained in section 3.2.3., 'significant others' may include family members and health care professionals such as the person's G.P. Whilst the following list of possible combinations can, strictly speaking, be applied to any illness, it can be used with particular reference to mental illness:

i) The individual is the only person who believes that they are experiencing illness: *I feel ill but no-one agrees with me.*

ii) This differs from combination (i) in degree: the individual person believes they are ill but family members, *actively* oppose this: *I feel ill but people insist that there is nothing wrong with me and tell me to pull myself together.*

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iii) The individual person and a family member(s) believe that they are ill but the person's doctor disagrees: *I feel ill, and my family thinks I am ill, but my doctor thinks there is nothing to worry about.*

iv) The individual person believes that they are ill and are supported by an unrelated third party (usually, but not necessarily, a health care professional such as the person's doctor). However, their family does *not* agree with them: *I feel ill, and my doctor agrees with me, but my family think that nothing is wrong with me.*

v) The individual person believes that they are ill and are supported by their family and an unrelated third party. *I feel ill and both my family and my doctor agree with me.*

vi) As explained in the 'New Horizons' document (see above), experience of mental illness may not affect a sense of well-being. Thus an individual may believe that they are *not ill* despite the disagreement of family members and/or a third party. *I feel fine: there is nothing wrong with me, but other people are saying that I am ill.*

Concerning all of these combinations, it is extremely important to recognize that they are unlikely to be absolutes: rather they are representations of possible prevailing opinion at any one time. Deriving from this, it is possible that these combinations may be fluid and interchangeable: unbelief may become belief as symptoms seem to worsen; belief may give way to rejection as tolerance and sympathy wear thin. Inherent in these processes is reciprocity, whereby actions and reactions influence one another. However, this is complex and unpredictable – rejection by a third party may cause a person to deny their symptoms, to believe that they are not as severe as thought; alternatively, the same rejection may cause a person to know despair. Yet, specific to mental illness, no combination is more loaded with doubt and uncertainty than combination (vi), whereby a person believes they are not ill despite the opinions of family members and third parties. This is because experience of phenomena designated as mental illness *may not be unpleasant.* A person may experience

ecstasy, or believe that they are privy to a great truth; they may speak of their feelings but attempt no physical harm to another person. Nevertheless, *with respect to concepts of normality and abnormality,* a person may be adjudged to be in need of medical treatment. In such cases, if treatment is refused to be accepted voluntarily, it can – and may – be enforced by legal powers. Thus may an individual believe themselves to be a victim of society, of which medicine is an integral part. Thus an individual may willingly enter the medical system, only to change their mind as phenomena persist and/or treatment proves unpleasant, ineffective, or both. Yet, in fairness, it may be that a person responds to treatment – despite any misgivings to the contrary – resulting in recovery.

In the Western world, the probable consequence of any of the above combinations is that a person will enter the medical system. Thereafter, the course of any treatment will depend upon medical opinion in response to present and subsequent symptoms. As explained in the previous paragraph, this may be associated with the legal process.

4.7: This is being done for the safety of yourself and the safety of those around you: legal understanding of mental illness

In 1994, whilst in hospital, I became verbally aggressive and began to bang my head against a wall. I am told (to this day, I have no memory of these incidents) that I threatened to leave the ward and go home: by a first-floor window if necessary. At this point my wife was advised that 'We have to section him, we have no choice.' Accordingly, I was detained under Section III of the 1983 Mental Health Act.

Personal Statement

For the purposes of this study, it is sufficient to state that, in the United Kingdom, the 1983 Mental Health Act ,amended in 2007 (Jones, 2009), allows for persons deemed as suffering from 'mental disorder' to be admitted to hospital against their wishes. Initially, the purpose of involuntary admission is assessment; thereafter, if treatment is believed necessary, the person may be

further detained under Section III of this Act. Although this is highly controversial, I do not consider that prolonged discussion will be particularly instructive. Instead, experience of detention will be scrutinized in connection with experiences described in the interview data.

4.8: Sometimes you become a part of the system: experience of mental health services

This exploration has reached the point at which the possibility of illness has been recognised and deemed sufficient to necessitate medical attention. However, this is such a vast topic that it is not possible to attempt a comprehensive review. Therefore, this chapter continues by focussing on areas of controversy within mental health. These are important in that the interviewees contributing to the study will almost be aware of some if not all of these. Associated with this, their viewpoints and understanding of their own experiences may be influenced thereby. This is, therefore, an appropriate point to draw attention to the term 'user': a ubiquitous description given to any person who uses, or has used, mental health services. Associated with this term is 'carer': the term applied to a family member or friend who assists in the welfare of a user.

As stated previously, the remainder of this chapter explores some of the more controversial areas within understanding of mental illness. In particular, it will draw attention to the paradox associated with medical generalization of what many hold to be wholly personal.

4.9: To see through a glass darkly: personal experience of mental illness

> For now we see through a glass, darkly; but then face to face: now I know in part; but then shall I know even as also I am known.
> **The First Epistle of St. Paul to the Corinthians, 13:12**

When searching through literature for accounts detailing experience of mental illness, I was constantly aware of the problem of reflexivity. Some words, some

phrases, and some stories carried descriptions that had a particular resonance. When I read them I immediately thought, "Yes, I can relate to that." As to exactly why this should be I am at a loss to explain. In this my feelings are truly personal: they are mine and mine alone. Yet the fact that I can identify with another person's experience means that there is some common ground. Mental illness may be difficult to describe and even more difficult to understand, but it is not unknowable.

Personal Statement

To facilitate exploration, I must begin with a massive generalization. Using my own experiences in tandem with background reading, I submit that *all* phenomena diagnosed as mental illness lie on a continuum between extreme sadness and extreme elation. Additionally, they *may* be associated with perceptions and thoughts deemed to be abnormal. Thus it is possible that a person may exhibit neither misery nor joy whilst experiencing unusual thoughts. Moreover, as a consequence of the continuum, *phenomena are not necessarily unpleasant.* Throughout over thirty years of experiencing mental illness, there have been many times when I have believed myself to have plumbed the depths of misery and, albeit, far less often, times that I was excitable and garrulous, not at all aware that I was ill.

In tandem with this overview is a wish to avoid other than a brief use of medical terminology at this juncture. Many words describing extremes of emotions or mood are a part of everyday language: indeed, they are frequently used to describe our response to various life events. Thus, at this point, terms such as 'depression' or 'elation' are unhelpful. Instead, I begin by noting I that terms such as 'schizophrenia' may be well-known but imprecisely so; similarly words such as 'madness' and 'loony' are still used as colloquial descriptions of mental illness. For example, the former term is employed by Corry and Tubridy (2001) as an overview of several criteria, including the following:

- being constantly afraid that something harmful is about to happen to you, about which you can do nothing

- thinking thoughts and feeling compelled to behave in ways you don't wish to, and being unable to stop them

(Corry and Tubridy, 2001: ix)

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A similar theme is pursued by Breggin (1993). Coining the term 'psychospiritual' with reference to human ideals, he applies the term 'psychological overwhelm' to describe mental illness:

> This combination of psychospiritual passion and overwhelming helplessness is characteristic of almost all the people we tend to label mad, crazy, or insane [...] Each is an example of *psychological overwhelm* or, at the least, hazardous stumbling along life's path.

> (Breggin 1993: 33)

An objection to Breggin's view is that he applies the term 'psychospiritual' exclusively to persons who experience schizophrenia. However, it is reasonable to suggest that complex philosophical thoughts may be pursued by all persons. This undue emphasis is a pity, for his essential construct is both sound and apposite. In conjunction with his own explorations, he cites the example of Boisen (1971) in emotional research. Possibly overlooked because of its strong religious overtones, this partly autobiographical work predominantly concerns the influences of environment and cultural beliefs. Many of the author's writings detail difficulty or failure to cope with the demands of life. Indeed, in a sample of 173 hospital patients in 1931, he reports that:

> There are hardly any who have not some manifest maladjustments in the field of self-expression. [...] We may therefore conclude that in this group we have individuals who are thwarted in their effort to attain their major objectives in life in terms of their own picture of themselves. [...] But it cannot be too strongly emphasized that there is no objective measure of such maladjustments. The individual himself is the judge.

> (Boisen, 1971, 27)

These observations are peculiarly potent in noting that individuals may judge their own actions and thereby condemn themselves. The consequence of this is an internal struggle whereby a person attempts to achieve the necessary understandings in achieving equilibrium with his or her environment. This leads to a satisfyingly clear construct:

> Analogous to fever or inflammation of the body

> (Boisen, ibid 29)

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Of all the possible descriptions of mental illness, Boisen's brief summary is supreme in that it conveys the possible seriousness of phenomena. Thus severe manifestation of phenomena can be likened to severe fever in that it represents extreme necessity. Moreover, it serves to establish a construct of a part of the person – in this case, the mind – under attack in the same way that the body may be affected, leading to:

> ...some eruption of the subconscious which is interpreted as a manifestation of the supernatural. The impact of such an experience is apt to be terrific. It may destroy the foundations of the mental organization and upset the structure upon which the judgments and reasoning procedures are based.
>
> **(Boisen, ibid, 33)**

On first inspection, this description may seem unduly lurid. Yet, the detail in his text can be applied surprisingly well to relatively modern autobiographical description. For example, Chadwick (1997: 24 - 35) gives a detailed account of the gradual disintegration of his thought processes during his illness in his text *Schizophrenia; The Modern Perspective.* This is extremely instructive in that the author experienced a gamut of emotions before entering a period of persecutory delusion culminating in a suicide attempt. Similarly, highly traumatic experiences are often described in the 'grey' (i.e. unattributed) literature that can be found on the Internet, (e.g. 'Jordan' (1995); 'Louise' (1998); Chovil (2003)). Central to many texts are themes of continuing condemnation that only serve to magnify distress, whether from the opinions of oneself, relatives, and/or other quarters.

Associated with this is the fact that despite seeking knowledge of the possible biological and environmental causes of mental illness, any subsequent understanding may not confer resistance. This is because it requires extreme discipline to maintain complete objectivity in the face of constant subjective input from phenomena. Doubt constantly undermines logic. The consequence is a paradox: a person may know that they are ill, possess understanding regarding medical viewpoints, yet not believe that they are ill.

Admittedly, my own experiences were mild, even trivial compared to some of those detailed above. Yet there was a sense of strangeness, that something

was wrong; eventually I felt forced to visit my G.P. For me, like so many persons, this is how it all began. To become a user of mental health services involved a series of diagnoses, various regimes of medication, three courses of E.C.T. and what seemed to be innumerable consultations. However, I deem further discussion on these topics unnecessary on the grounds that they are well known; also that they might pre-empt exploration of interview data.

4.10: Maybe I deserve condemnation: the reciprocity of stigma

Many people believe that mental illness is not a 'proper illness'. Nevertheless, when I was told to 'Snap out of it" or 'Pull yourself together' I rarely retaliated. Instead my hurt was internal: did people believe that I wanted to be ill, that I was deriving some vicarious satisfaction from all that was happening? Then there was another, more subtle, source of doubt. Were some of my actions really beyond my control? Or could I have made a real effort, could I have forced myself to deny the clattering of my thoughts? I was convinced that I could have done so if I had tried hard enough. The truth was otherwise: sometimes I had lost control to the extent of not being aware of my behaviour. Yet, to this day, the doubt remains. I could have tried harder. I was weak when I could have been strong.

Personal Statement

Although wary of exploring this topic for the same reasons mentioned at the end of the previous section, it is helpful to explain the various interactions involved. Ideally, the structure of society is founded on enlightened concepts that recognize the integrity of the person. However, embedded in these is an uneasy balance between that which is *normal,* or usual, and that which is *normative*, or designated to be normal. Whereas the former is, essentially, value neutral, the latter may be founded upon arbitrary social and cultural beliefs, acceptable to a majority of persons but marginalizing a minority. Inherent in this approach is what is best described as a socio-cultural anomaly: that is the tendency of humans to extend the range of a name to label an individual. Thus, with direct reference to illness, a person suffering from a named illness may be described – or labelled – thereby. For example, a person suffering from *diabetes mellitus*

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may be referred to as a 'diabetic'; a person suffering from schizophrenia (a named mental illness) may be referred to as a schizophrenic. Such over-emphasis on symptoms may suppress the identity of the person experiencing them, as explained by Repper and Perkins (2004):

> Even if the 'illness' goes away, the label of mental illness does not. And when the 'illness' continues, roles and responsibilities are suspended indefinitely and it is all too easy to become nothing but your 'illness'
>
> **(Repper and Perkins, 2004; 24 – 25)**

When describing attitudes towards mental illness, Scheff (1996) attacks the 'ideology of the white middle class of Western Societies':

> The concept of illness and its associated vocabulary – symptoms, therapies, patients, and physicians – reify and legitimate the prevailing public order at the expense of other possible worlds.
>
> **(Scheff, 1996; 65)**

The author maintains that the medical model of mental illness in Western medicine, as briefly described above, is explained by the labelling theory of deviance, developed by Becker in 1963. In essence, this details the factors whereby phenomena are labelled as mental illness and suggests that this process causes what might be a transitory episode to be viewed as a chronic one, with associated stigma. Accordingly, if labelling is resisted, it may be possible to channel the course of the illness and prevent this outcome. In making this assertion, he (ibid) makes brief mention of the role of shaman in Indian tribes, so implying that other societies and cultures take a more tolerant and enlightened attitude to mental illness. This may or may not be the case: Warner (1996) details both positive and negative attitudes to mental illness in other cultures, concluding with a five point summary. In the main, this is highly optimistic, noting but one possible exception:

> Although some psychotics in non-industrial societies may be brutally treated, in the majority of cases vigorous and optimistic efforts are made to achieve a cure.
>
> **(Warner, 1996: 61 – 62)**

In the Western world, many user-campaign groups (e.g. MIND, SANE) and other organizations, including the NHS, insist that active methods are needed to

combat negative personal and/or cultural attitudes to mental illness. Walker and Beckett (2003) note that:

> The term social inclusion has gained rapid acceptance within the social work lexicon at the beginning of the 21st century.
>
> **(Walker and Beckett, 2003:92)**

One aspect of challenging stigma is straightforward in that it draws attention to the ingrained social and cultural attitudes mentioned above. Another is, potentially, more controversial in that it attacks the motives of institutionalized psychiatry and pharmaceutical companies. In turn, this leads to the movement broadly known as 'anti-psychiatry'.

4.11: What you are experiencing is not illness: 'Anti-psychiatry'

I have already explained how I have often doubted myself. So, should you accuse me of malingering, exhibitionism, histrionics, or any other lack of self-control, I am obliged to resort to the claim that my illness has eroded my willpower. On balance, despite the ever-persistent gnawing of doubt, I believe this to be the truth: I have suffered, and continue to suffer, from a genuine illness. Nevertheless, you may decide otherwise.

Personal Statement

This brief discussion centres on an overview that the term 'mental illness' is misapplied, being an invention of society to medicalize abnormal and/or deviant behaviour. In this context, it is essential to recognize that Scheff's development of labelling theory (noted above) is a *sociological theory* as opposed to a medical one. Similarly, Szasz (1970, 1997) views deviancy in terms of departure from socially understood norms before applying this concept to psychiatry:

> Social deviancy is thus a term naming a vast category. Which kinds of social deviance are regarded as mental illness? The answer is, those that entail conduct not conforming to psychiatrically defined and enforced rules of mental health.
>
> **(Szasz, 1997, xxx)**

Notably, the author denies the concept of mental illness on the grounds that it does not exhibit physical symptoms (e.g. 1997:25). However, it is essential to acknowledge that he does not deny that the phenomena exist, only that they should be treated outside institutional psychiatry. This view is expressed in highly provocative terms:

> The inquisitors who opposed and persecuted the heretics acted in accordance with their sincere beliefs, just as the psychiatrists who oppose and persecute the insane act in accordance with theirs.

(Szasz, 1997:26)

The unequivocal nature of this viewpoint means that much care must be taken in examining opposing arguments. One avenue is a straightforward, even casual denial, as exemplified by Chadwick (1997b) concerning 'general gossip' between recovering patients:

> We all recognized that we were where we were because things had gone 'seriously wrong in our lives and in our heads' but *no one* attempted to market the Szaszian style position (Szasz, 1971, 1976) that we were 'never ill and it was all a political game' [.....] I never heard a single spontaneous remark in 10 years from anybody to that effect!

(Chadwick, 1997b, 581)[italics in original]

However, a basic problem with this stance is that it is not automatically applicable to all patients. For example, I know of at least one person who, despite regular admission to hospital and on-going treatment, is adamant that he is not suffering from mental illness. Therefore, it is probably better to note that, unsurprisingly, some exponents within psychiatry defend themselves vigorously. For example, Gelder, Gath and Mayou (1992) describe Szasz and his peers as 'extremists' and state that their argument:

> .....can be sustained only by taking an extremely narrow view of pathology, and it is incompatible with the available evidence.

(Gelder, Gath and Mayou, 1992:77)

Similarly, Clare, in a polemical rebuff of Szasz's arguments, fights fire with fire by describing them as 'deceptive and meretricious' (1989; 3). In doing so, he draws attention to psychiatry as understood by 'the public':

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The public, bewildered by the apparent ideological chaos within psychiatry, is ready prey indeed for any spokesman who peddles a simple answer to the difficult philosophical and practical questions facing psychiatry in its present poorly developed state.

(Clare, 1989, 3)

Important issues are highlighted by the above statement. It is to Clare's credit that he acknowledges that psychiatry requires much development. Therefore, although psychopathology is the dominant paradigm within medicine, it is reasonable to believe that it is fallible. Moreover, practitioners of psychiatry, like their patients, are human – it is always possible that mistakes can be made. As described throughout this chapter, the essentially personal nature of symptoms means that the various parties may disagree: illness may be denied, or seen to exist contrary to the belief of the user and/or carer. In such circumstances, the advice and activities of psychiatry (possibly supported by the legal system) may indeed seem threatening. Therefore, although the views of Szasz and other 'anti-psychiatrists' are indeed controversial, I close by noting that many users and carers turn to them as a viable alternative.

4.12: Conclusion: Then shall I know even as also I am known: what is mental Illness?

Now that I draw near to completing this chapter, my overall feeling is akin to exasperation. The topic is vast: the exploration has been overlong but there is still much that I could have included. There will be opportunity to do so later, in relation to data gathered through interviews. In this context, throughout my discussion I have been aware of the need not to pre-empt this, that I should prepare the ground but plant as few seeds as possible. As stated earlier, my approach has been deliberately orientated towards theories and constructs. Although the result may appear somewhat soulless, it is an essential stage in the overall purpose of this study: the equivalent of the pencil drawing preceding the painting. By illustrating a clear concept of an overall construct of which phenomena diagnosed as mental illness are an integral part, it will be possible to investigate the research question.

Personal statement

A direct answer to the question 'What is mental illness?' can be discerned in a surprisingly short summary: *phenomena diagnosable as mental illness are thought processes leading to personal dysfunction according to the prevailing cultural and social climates of which the person experiencing those processes is a part.*

However, this discussion has shown that a *complete* answer necessitates looking beyond the symptoms of illness to the person directly affected: the user. In entirety, mental illness is an interactive construct incorporating phenomena diagnosed as symptoms and the consequences of those symptoms. The latter include direct consequences for the individual, and those arising from the response of culture and society. Pertaining to the individual, experience of mental illness may be represented as areas of a continuum between appalling unhappiness – or even terror – and feelings akin to ecstasy. Pertaining to the responses of society and culture, I feel that it is useful to differentiate between 'formal', 'informal' and 'semi-formal' responses whilst noting that much depends upon the behaviour of the individual user. Formal responses are those which are provided and regulated by governmental bodies. Ideally, these should be uninfluenced by personal prejudices; they include medical treatment, legal response (if any) and the provision of care after treatment, including financial assistance. In contrast, informal responses include the voluntary activities of carers and the opinions of other persons concerning *all* aspects of the user's life. I apply the term 'semi-formal' to the activities of national charities and local support groups concerned with the welfare of both users and carers. This group may draw on persons from both the formal and informal groups.

This chapter completes exploration of personal identity, narrative, and mental illness with reference to constructs and related fields described in academic literature. The following chapter explores methodological issues related to steps towards generation of narratives about personal experiences of phenomena described as mental illness.

Chapter Five: Methodology and data generation

5.1: Introduction: research protocols

This chapter is concerned with the means of collecting original data and the associated protocols. It will discuss the various procedures and issues associated with:

- Refinement of the research question
- Obtaining approval for the research from a Research Ethics Committee
- Recruitment of volunteers
- Interview theory and techniques
- Transcribing of original data

5.2: Preparation for the research

5.2.1: Title of the research

At a very early stage I decided that the somewhat unwieldy epithet 'phenomena diagnosed as mental illness' would be used throughout, thereby acknowledging differences in opinion concerning the nature of specific thought processes. As stated above, the original research question was a statement: 'The impact of phenomena diagnosed as mental illness upon sense of personal identity.' The decision to rephrase it as a *question* was at the behest of the adjudication panel (see above), who felt that a statement was pre-emptive. Accordingly, the working title of the study was amended to become as neutral as possible: *'How do phenomena diagnosed as mental illness impact upon sense of personal identity?'*

Wengraf (2006) uses the terms 'Central Research Question' to refer to the main question and 'Theory Question' or 'Research Question' to refer to subsidiary questions. Concerning the latter, he suggests between three and seven research questions (p64); however, I feel that this is somewhat prescriptive. Therefore, I decided to adopt a 'broad' outlook by specifying only two secondary research questions prior to undertaking interviews. Described in full in section

5.2.4., these served to define the parameters of the Central Research Question. In this way, my main criterion was whether or not a particular issue appeared to be important *to the interviewee*. If so, it was identified according to the basics of Wengraf's system. By following this protocol, I believe that my mind was far more 'open', i.e. receptive to issues that I might not have thought of if I had prepared a set list of research questions.

5.2.2: Literature search

My concept of a literature search is that it is akin to finding oases in a desert: the journey may be long, wearisome, and often unrewarded. The beginnings of my journey were easy in that, by virtue of my wife's career, we already possessed many references on mental illness and mental health practice. Thereafter, once my gleaning began in earnest, it focused on two separate avenues:

- My supervisors, Julie Repper and Gordon Grant, encouraged me to search the Internet for personal stories in the 'grey literature'. This would provide me with awareness and insights into common concepts and concerns.

- Due to my lack of experience in sociological research methods, Julie and Gordon provided me with *'New Horizons: GMH 6010 Research Methods: A Distance Learning Package'* (Fox et al, 2001). In tandem with texts already in our possession, plus recommendations for further reading, this enabled me to acquire the necessary knowledge.

By now, my vis-à-vis contact with my supervisors was approximately six-weekly. In connection with this, my usual practice was to write a summary of learning areas suggested at a previous meeting. In this way, we were able to discuss my ideas, drawing attention both to progress made and to constructs or concepts that needed 'firming up' and/or further investigation. Unfortunately, it was at this time that I was unable to gain access to Sheffield University library facilities, despite the input of library staff and an experienced technician. Given that our

home is 2½ hours from Sheffield, this was a considerable inconvenience. However, to a large extent this was offset by the 'Google' search engine, forays into websites such as 'Amazon', frequent suggestions from my supervisors (including e-mails and telephone conversations), plus using the reference lists of academic texts. In addition, I must stress serendipity: my wife and I were ever alert for newspaper articles and/or recommendations, relevant magazine articles (e.g. 'Open Mind) and second-hand books in charity shops. In particular, the latter source was fruitful in that since books were relatively inexpensive, I could afford to buy in hope as well as expectation.

Thus, by the time of my upgrade presentation, I had accumulated sufficient references to craft a full 10, 000 proposal. On re-reading this, I was aware that it concentrated heavily on:

- The possible aetiology and medical models of mental illness

- Philosophical constructs including interactionism

- Research methods including grounded theory

The upgrade meeting and the following months marked a turning point for two reasons. Firstly, I was advised to abandon grounded theory in favour of narrative analysis. Secondly, on transferring to Sheffield Hallam University, I was able to access their library facilities, including their 'Find your reference' search engine and 'LitSearch' database. By using the time-honoured method of single word of short phrase searching, this was invaluable in obtaining such journals as 'Self and Identity'. Nevertheless, I also continued to use my earlier methods by virtue of the fact that they were tried and tested. This was especially so concerning the references cited by academic texts, which gave details not only of specific texts but also of authors. For example, since Elliott (2005) frequently mentions Hinchman and Hinchman (2001), I purchased same. Similarly, Elliott (ibid) cites Labov and Waletzky (1967): in obtaining their paper from the Internet, I learned of a special edition of Narrative and Life History (1997), which I obtained through the local library. Like Hinchman and Hinchman (ibid), this proved a valuable source of articles and further references.

Throughout my research I had maintained a determination to emphasize the uniqueness of personal identity. Initially, I had sought to explore this with reference to mind-body philosophy, including neurophysiological constructs. Gradually, the direction of my research turned away from biological models to phenomenology. Whilst this decision was influenced by my supervisors, it was also an inevitable consequence of research into narrative models of identity. Additionally, as the interviews were conducted and the data processed, it became evident that biological concepts were rarely discussed, save for the 'fact' of illness. Sometimes, as will be shown by the data, a subject area would be discussed that required checking and/or further search (e.g. cognitive-behavioural therapies, the role of support workers). Similarly, but to a far greater extent, the combined data often necessitated re-reading of references and/or a search for relevant new material.

This entire strategy continued until the final draft of this thesis. In summary, it was a process of triangulation involving many and sometimes disparate sources. At this point, I wish to thank my supervisors: despite my best efforts, their knowledge often provided that extra and vital reference that I would otherwise have missed. Thus I conclude as I began, with the analogy of oases in a desert. As a traveller, a researcher is often thirsty. And when they have drunk from an oasis, there is a sense of relief but also of frustration. There is always more water that might be drunk; there are always more references that might prove useful.

5.2.3: Obtaining a sponsor

Since I was a distance learning student, it was not practicable to conduct interviews in premises owned by Sheffield Hallam University. Therefore I obtained an honorary contract as an unpaid researcher with the Tees, Wear and Esk Valleys NHS Trust. This was arranged by the Trust's User and Carer Involvement Co-ordinator.

5.2.4: Obtaining ethical approval

All research involving humans requires the approval of an NHS Research Ethics Committee, which determines that all ethical concerns have been properly acknowledged. Explored in detail by Foster (2001), these can be summarised as a complex relationship between three approaches:

i)   *Goal-based:* are the goals of the intended research appropriate?

ii)   *Duty-based:* the way the research is conducted.

iii) *Right-based:* concerning the consent of participants and subsequent confidentiality.

The first stage in obtaining ethical approval for this research was the completion of an on-line form (NHS REC 5.0). This application was vetted on 11th April, 2006 by the County Durham and Tees Valley 2 Research Ethics Committee, who then asked me *in vivo* questions concerning my application. During this meeting, recommendations were made for small alterations to be made, following which approval was granted.

5.2.5: Central research question

Although the principal research question might be viewed as synonymous with the title of the research (above), in practice it was more specific. It was paraphrased to specify the viewpoints of intended respondents:

> To explore, within the narratives of service users, the question, 'How does personal experience of phenomena diagnosed as mental illness impact upon sense of personal identity?'

Later, this was amended, in keeping with the requirements of Sheffield Hallam University Graduate Studies Team to eleven words:

> 'How do phenomena diagnosed as mental illness impact upon personal identity?'

5.2.6: Secondary research questions

The secondary research questions served to define the parameters of the study:

i)   To explore how service users make sense of their diagnoses with respect to their mental health.

ii)   To explore how service users construct their identities and the place of mental illness in these constructions.

5.2.7: What is the scientific justification for the research?

Of all the questions in the form, I considered this to be the most searching. My immediate impression was that an answer to these questions could, unchecked, develop into a small essay. After wrestling with possibilities, I realised that it is, essentially, one question requesting specific aspects within a single answer. Although the issues cited have been explored in depth in Chapters One and Two, it is important to recognize that the Ethics Committee base their judgements on the completed form alone. Therefore, in illustration, I provide my full answer, which is written in italics. When formulating this, I felt that the most difficult issue was the tension between providing an accurate summary of the intended study whilst avoiding pre-empting any findings:

The primary objective of the study is to build on the literature which explores the effects of the experience of mental illness on the lives of service users. In particular the study will seek to examine the impact of mental illness on the user's sense of self and/or personal identity.

For the purposes of this research, 'identity' refers to a person's self-image in relation to personal expectations and understanding of an individual's role in the society and culture that they live in.

Work by writers such as Peter Chadwick (1997) and Anton Boisen (1936) acknowledge the profound impact that symptoms of mental illness have on a person's life. This is particularly apparent during their early adult life, when they are seeking to secure a firm psychological foundation on which to build relationships with themselves, others, and the world at large. Similarly, 'grey' literature, i.e. unattributed and academically non-validated stories on the Internet, stress the feelings of isolation and many other problems associated with mental illness.

The overwhelming impression is that mental illness causes great distress by disrupting the client's life. In particular, the person's sense of self-worth and role in society may be challenged by incapacity which may, in turn, lead to hospitalisation or long-term sickness. Associated with this may be stigma due to relatives or friends holding negative views of mental illness.

However, authors such as Chadwick and Boisen (above) plus Peter Breggin (1991) and Ronald Laing (1967) imply that mental illness may be a way of resolving or attempting to resolve life trauma. As a result there is a question as to the extent to which personal identity, as defined above, and some of the symptoms of mental illness overlap. Alternatively, this question could be described as to asking to what extent, if any, some of the symptoms of mental illness are, in fact, an integral part of a person's mind.

This area has not been fully explored, especially through the vehicle of narrative analysis, which will allow users' own voices to be heard. Of particular interest will be the ways in which users can incorporate and assimilate symptoms yet successfully maintain a positive sense of worth.

The study will contribute to and deepen present understanding of experience of mental illness.

5.3: Arrangements for the obtaining of original data

5.3.1: Quantitative or qualitative?

To explore the research question, I would require the stories and views of persons who had, or continued to have, experience of phenomena diagnosed as mental illness. Some psychiatric assessments (e.g. Beck's Depression Index; PSYRATS; PRIME-MD PHQ-9) attempt to make quantitative measurement of phenomena diagnosed as mental illness. This is achieved by devising set questions, to which the multiple choice answers are allotted arbitrary values. By adding the answers, a final score is achieved, which serves to gauge the severity of an illness. Also, and perhaps more importantly, successive questionnaires serve as indicators of progress in recovery. By recording a measurement or 'score' over a period of time, the course of an illness can be plotted. However, in terms of assessing illness at any one time, the value of such devices can only be regarded as superficial. This is because the standardized set of value-rated questions upon which they are based can take no account of any aspects of illness that are not included. Moreover, it

must be stressed that the according of any value to a phenomenon or mood is highly artificial, being largely subjective.

Given these disadvantages, I did not consider any form of quantitative assessment. Instead, I deemed qualitative data, the description of the quality of experience, as the most appropriate vehicle for gaining the required data to meet the research question. Whilst such data could have been obtained by requesting written responses to questions, I considered that the best method would be face-to-face interview.

5.3.2: Choice of interview type

After some deliberation, I decided that the data would be best obtained by interviewing individuals as opposed to organizing focus groups. My reasoning was based on experience of small conversation groups at user involvement events, including social functions. Inevitably, a group would be dominated by some individuals whilst others contributed very little. Therefore, I felt that the only way to ensure an uninhibited exchange was to speak person-to-person.

The next question concerned the type of interview that I would use. There are three basic types of interview (Bowling, 2002; Fox et al, 2001; May, 1997; Parahoo, 1997; Wengraf; 2006):

    i)   Structured Interview: Questionnaire
    ii)   Semi-structured interview
    iii)   Unstructured or In-depth interview

Questionnaires invite short answers to specific questions.

Semi-structured interviews invite open-ended answers to prescribed questions.

Unstructured or In-depth interviews invite detailed answers to questions based on a central theme.

I rejected the first two options on the grounds that they would prove too prescriptive. Thereafter, to term an in-depth interview as unstructured is, possibly, misleading: although it is extremely fluid, the underlying intent is, ideally, wholly focussed on achieving the aim of obtaining, and exploring, original data pertinent to a research question. Much depends, therefore, upon whether or not a researcher believes that a selected interview technique will maximise the exploration of the research question. For example, the conversationalist methods of Studs Terkel were based on the concept that from all persons could be evoked a wealth of information providing that the right questions were asked. Terkel's own description of this technique was '....idiomatic rather than academic' (Terkel, 2004; xx). Noting that Terkel was a 'consummate journalist and interviewer', Holstein and Gubrium (2004) suggest that his technique 'permeates the social sciences'. However, this is intended as a warning against naivety:

> ....we typically believe that we merely have to ask the right questions and the other's reality will be ours.
>
> **(Holstein and Gubrium, 2004:143)**

In querying as to whether the concept of the respondent as a 'passive vessel of answers' is wholly desirable, the authors make a valid objection. As noted in Chapter Three with reference to Linde (1997), an individual may constantly review and re-evaluate some of their experiences. Therefore, if an interviewer accepts a 'passive' view with little or no questioning, any re-evaluation will not be attempted. In contrast, Holstein and Gubrium (ibid) propose an 'active' approach, whereby an interviewer invites mutual exploration of a respondent's experience that may lead to fresh (and important) insights. Against this, however, is the possibility that a researcher may, albeit inadvertently, 'give directions' to the interviewee, so potentially straying into a form of therapy (Wengraf, 2006:129). By virtue of my own knowledge and experience, I realised that the very subject matter of my interviews would involve reminiscences and self-exploration similar to those used in cognitive therapy. Accordingly, I deemed this to be a significant risk.

Most of my objections can be countered by scientific protocol. Firstly, Hammersley and Atkinson (1990) making a telling argument that the descriptions of interviews above are, strictly speaking, inaccurate. With reference to social interaction, *all interviews* are structured by both researcher and respondent (pp 112 – 113). Instead, the authors distinguish between *standardized* and *reflexive* interviewing. As implied in their titles, the former depends upon set questions, whereas the latter is more open, directed by issues that the researcher wishes to explore. My own interviews were of the second type: given that I hoped to explore an interviewee's concept of personal identity, I wished to obtain a narrative that concerned their own ideas in their own words. To meet this requirement, I decided to try to model my approach on that of Studs Terkel, by using Single-Questions-Inducing-Narrative (SQUINs) as described by Wengraf (2006). A SQUIN may be formulated by a researcher prior to an interview, or arise in the course of an answer to another SQUIN.

Thus the interview proper can be said to begin with the first SQUIN. Thereafter, the interview is 'unstructured' in the sense that a respondent may pursue a narrative course unanticipated by a researcher. In such an event, the researcher is faced with the undeniably problematic issue of whether to allow the respondent free rein or to steer the interview back to the research question. The first choice risks a lengthy excursion into irrelevance; the second could mean the loss of valuable insight.

Although the interviews would be conducted in a 'conversationalist mode', I intended that my approach would be in a 'narrative mode' whereby my questions maintained focus of the purpose of the interview. Associated with this, my proposed method would be motivated by one wish alone: to intervene as little as possible. However, in stating this, I stress that my ideas were not instinctive but informed: during my experience as a Samaritan and, later, as an Advocate, I had learned what I consider to be two vital lessons:

i)   To listen intently to the other person. Whilst it is reasonable to allow possible responses a fleeting attention, your thoughts should not be given to what you intend to say next.

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ii)   To maintain the focus of the conversation upon what the other person is saying. Unless absolutely relevant, details of one's own life experiences should not be disclosed.

With reference to the second issue, the Research Ethics Committee was concerned about the possible degree of self-disclosure. For clarity I reproduce their entire comments:

> *On the guide to interview for participants, it was acknowledged that although self-disclosure was a useful tool to make people feel at ease, members felt it would not be appropriate for the researcher to go into so much detail about his personal details, as this may lead to comparison of experiences rather than focussing on the research question.*

I make further observations concerning the conducting of my interviews in Section 5.4 later in this chapter. For the purposes of the NHS REC form, it was noted that the overall interview procedure would be as described by Elliott (2005). This deploys an iterative process wherein data from a first interview is used to format questions concentrating on specific aspects in a second interview. Seidman (1998) is quoted by the author in suggesting that three interviews with each respondent should be sufficient to obtain the required data.

5.3.3: Saturation

In simple terms, 'saturation' is self-explanatory: describing the complete extraction of data. However, it is used in two ways in research: the first, *'saturation'* is applied by Morse (1995) and Elliott (2005) with reference to *collection of data.* The second, *'theoretical saturation',* is used by Strauss and Corbin (1998) with reference to identification of 'properties, dimensions and relationships'. With reference to interview strategy, it is the former – 'saturation' – that is the primary concern. Accordingly, I suspect that I was like all researchers in hoping and intending that my interviews would yield the maximum possible data, thus comprehensively exhausting all possible avenues of discovery. However, as explained by Morse (ibid), 'there are no published guidelines or tests of adequacy for estimating the sample size required to reach saturation (p147). Therefore, it becomes evident that saturation can only be

assessed retrospectively: if a researcher finds sufficient material in transcripts to effect convincing analysis, then saturation has been achieved. If however, concepts remain indistinct, then it is obvious that saturation has not been achieved and more data is required.

5.3.4: Identification and recruitment of respondents

I made an early decision that I would not attempt to interview any person who was undergoing in-patient treatment in a hospital. My reasoning was that I felt unqualified to judge whether or not a person would be well enough to participate in prolonged conversations. Similarly, because of the possibility that they might be unwell at the time of interview, I felt that it would be unwise to interview any persons detained under Section III of the 1983 Mental Health Act. Thereafter, the salient question was whether or not a person undergoing out-patient treatment and/or receiving medication could be interviewed without suffering undue distress. Thus it was agreed that prospective participants should, ideally, be service users who were actively involved in Service User interest groups within one particular NHS Trust; and that an initial approach should be made by the User and Carer Involvement Co-ordinator at the Trust. Alternatively, should I contact any party(ies) directly, then I was to appraise her that I had done so and provide pertinent background information. If interest was shown, then she would provide them with a Study Information Sheet (see above and Appendix) plus accompanying letter from me as principal researcher. The purpose of the Information Sheet was to summarize the purpose of my study; explain the need for details of personal experience of phenomena diagnosed as mental illness; and, in inviting the reader to participate, detail any risks involved. Associated with this last aspect is the need for 'informed consent' (see below).

5.3.5: Number of interviewees recruited

Given that in-depth interviewing is a lengthy process, it is usual to limit the number of respondents. After discussion with my supervisors, I decided that six respondents would provide sufficient data for analysis but that more could be recruited if required (i.e. if subsequent analysis suggested that saturation had

yet to be reached). This number was queried by the Ethics Committee on the grounds that it might prove insufficient but it was accepted after discussion regarding the potential scope of in-depth interviews. Subsequently, I interviewed nine respondents. The pseudonyms used by these were:

Mr. CBA

Dorothy

Mr. K.

Eddie Hooper-Smith

Mr. P.

Anita

Anne

Sandra

Mr. Gwent

Mr.CBA is a single man in his fifties. After successfully completing a degree course he was employed in a professional capacity before becoming ill in his twenties due to symptoms diagnosed as schizophrenia. Since then he has been unable to work due to persistence of some phenomena; however, his financial security is safeguarded by an occupational pension.

Dorothy is a single woman in her thirties. In the second year of a university course she became ill for the first time due to phenomena subsequently diagnosed as bipolar disorder and, possibly, personality disorder. Despite this and later episodes , she managed to complete her university course. Since then she has pursued varied careers, both vocational and professional; however, continuing episodes have restricted her capacity to work full-time. At present, she is in receipt of benefits and occasionally works in a voluntary capacity.

Mr. K. is a single Asian man in his early twenties. In his teenage years he developed schizophrenia, which eventually led to four periods of hospitalization. Since stabilization due to medication he has been an active participant in the user movement. At the time of the interview, he had obtained his first employment as a user support worker.

Shortly after obtaining employment in a professional capacity following a successful university career, *Eddie Hooper-Smith* developed schizophrenia necessitating prolonged hospitalization. Following this, he lived at home to facilitate a gradual recovery. In his late thirties at the time of interview, he has progressed sufficiently to be able to move into his own flat.

Mr. P. is a single gay man in his thirties. Following a series of adverse life events in his twenties, he succumbed to depression, leading to a suicide attempt. Following this, he lived in sheltered accommodation and attended a day centre, at which he received counselling. This led to a sustained recovery and voluntary involvement in user activities which, in turn, led to paid employment in this field.

Describing abuse during childhood, *Anita* explained that she was placed in care at the age of ten, from which she later ran away. In adulthood she has been involved in several partnerships including marriage, from which she has had several children. Despite her problems, she is proud of having bought a house and kept her family together. However, persistent symptoms of illness, particularly bipolar disorder and depression, have prevented her returning to employment. At present, in her mid-forties, she is undergoing further tests in an effort to stabilise her illness.

Anne is in her late twenties. Following a successful university course, her career prospered for a short period. However, during a holiday to the Far East, she developed symptoms of schizophrenia. At the same time, she separated from her long term partner: a combination of events that led to two suicide attempts. Since periods of hospitalization, she has lived in supported accommodation. Unable to work, she lives on social security benefits and attends local user support groups.

Sandra is also in her late twenties. Although suffering from depressive symptoms for many years, she successfully completed a university course. However, shortly afterwards, she was sectioned under the Mental Health Act due to experience of paranoia and bizarre delusions. Subsequently involved in user activities, she has suffered a further episode before recovering sufficiently, at the time of interview, to initiate a return to her intended career.

Mr. Gwent is a married man in his fifties. Having pursued a successful professional career for many years, he suffered a sudden episode of depression necessitating a prolonged absence from work. Thereafter, although encouraged to consider early retirement, he has recovered sufficiently to resume his responsibilities at their former level.

5.3.6: Informed consent

In accordance with usual practice, a Study Information Sheet was to be forwarded to a prospective respondent as soon as possible after interest had been shown. Subsequently, prior to interviewing, an interviewee would be asked if they had any questions. If the interviewee appeared to fully understand what was required of them, they were deemed capable of giving *informed consent;* that is their agreement to be interviewed. To document this, two copies of a consent form were to be given for signing by the interviewee and countersigning by me as Principal Researcher. This was compiled using the guidelines associated with the Internet NHS Ethics Form. (Nevertheless, as one of the first stages of the interview process, the reading and signing of the Consent Form seemed somewhat unwieldy. As a result, I quickly learned that the best – i.e. most relaxed – method of fulfilling this obligation was to read the form aloud.)

Copies of the Study Information Sheet and Consent Form, plus a specimen letter to an interviewee's GP are provided in Appendix II.

5.3.7: Reflections (i): How informed is informed consent?

Amid currents of reflexivity arose a crisis that led to the temporary halt of this study. This experience is detailed in the first of my reflections, which, in part, is a précis of an article authored by me that was published in 2007 as part of an exploration of narratives of mental health service user researchers (Shields, Wainwright, and Grant; 2007).

In the year following my upgrade meeting, my studies were, essentially, suspended for two reasons. The first was two separate episodes of severe exfoliate dermatitis requiring hospitalization. The second was that, for reasons that remain unknown to me, my CRB clearance was delayed for almost twelve months. Of these issues, the second far outweighed the first. Although suffering greatly from soreness and lack of sleep, my mind was active whilst in hospital: I even managed to read a text on research methods. The lack of CRB clearance, however, was an imponderable factor, a frustrating obstacle that was beyond my efforts to solve. All that I could do was to continue with appropriate background reading. Thus momentum was lost, so allowing the pervasion of doubt. I suspect that many studies fail in this way: a researcher may become daunted by the size of the task ahead or disillusioned by a lack of progress. In my case, I focussed upon the probable course of my interviews and began to question the morality of what I intended to do. Not only would I invite persons to talk of their experiences of phenomena diagnosed as mental illness. I also intended to ask them to reflect upon those experiences, and the life events preceding and following them; in short, their hopes and their disappointments, their triumphs and their failures, their opinions and their beliefs. As indicated by its title, my study would call for them to reveal their own understanding of their personal identity so that I could ascertain any possible impact of their experience of mental illness.

I was, perhaps, fortunate in that the major source of my dilemma was both readily identifiable and irrefutable. In 1999, I had participated in research organised by the Royal Victoria Infirmary (RVI), Newcastle, into the possible application of Cognitive Behavioural Therapy (CBT) in the treatment of psychotic illness. My role was as a client/respondent: I was interviewed for approximately one hour at fortnightly intervals. These interviews consisted of exploring my past and my present; my interests, my motives, and my beliefs. From the outset, I was wary: during our first interview I said to the therapist, "I fear that you will let the genie out of the bottle and not be able to get it back in again."

In some ways I enjoyed the sessions that followed. In particular, I found the concept of core beliefs exciting. Nevertheless, my fears were realised: I found that whilst I could mount an intellectual challenge to the strangeness within, I could not withstand the emotional efforts involved. Increasingly, as the sessions continued, the car journey home with my wife became a debriefing session during which I unloaded my burden. The end was inevitable: I wrote to the therapist requesting that our meetings did not continue. Her response was to thank me for my participation, at the same time enclosing a self-help booklet. At the time, that hurt: I felt that she had no insight into the reason why I had written to her. I saw her shortly afterwards – a coincidental meeting at the RVI – and she exhorted me to try harder with the therapy: that hurt also. Later, I learned that that I was not alone in my reaction to cognitive therapy. In 2006, the RVI published its findings: they showed that CBT is effective in the early stages of an illness. However, in the case of prolonged illness, it is not as effective as medication and can even be counter-productive (Scott et al; 2006)

I did not imagine that my proposed interviews would be a form of cognitive therapy. However, due to the degree of introspection that they would involve, I considered that there would be marked similarities. As a result, the problem seemed insurmountable: I could not, in clear conscience, invite persons to undergo an experience that I would refuse. Accordingly, I notified my supervisors of my intention to abandon the study and, later, destroyed my files and my computer discs on a garden bonfire. Looking back, I believe I needed that act of finality to break the mindset into which I had become entrapped. For, after a short period, I began to look at the wider picture of informed consent and realised its true extent. That is, by providing a person with detailed information and discussion leading to an invitation to make an informed choice, I was respecting their *integrity* and their *right* to choose whether or not to participate in my study. Obviously, it was essential that I retained awareness of the potential sensitivity of their contribution, alert to the possibility of the interview morphing into a form of cognitive therapy. However, these were issues associated with interpersonal reaction and interview protocol, which is discussed in the second of my reflections. This reflection closes by noting that the bulk of my material

was recovered by means of my wife's arcane computer skills and files held by my supervisors.

5.4: Arrangements for the conducting of interviews
5.4.1: Welfare of interviewees

Associated with the obtaining of informed consent, it follows that the welfare of all participants is the responsibility of the researcher. This issue is addressed both directly and indirectly by several questions in the NHS REC Form. Concerning direct questions, I opined that an interviewee might find the interviewee process upsetting. Therefore I instituted the following arrangements, details of which were included in the Information Sheet given to prospective interviewees:

i) That the interviewee could terminate the interview at any time should they wish to do so.

ii) That the User and Carer Co-ordinator of the participating NHS Trust, would be appraised of the outcome of all interviews.

iii) That additional support could be arranged if the interviewee wished, including that of their G.P. and/or Care Co-ordinator.

Associated with this are the obvious problems involved in interviewing female respondents. To satisfy the needs of the NHS REC Form, I noted that I should be accompanied by a female volunteer. In this I was extremely fortunate, for my wife is both an Approved Social Worker and a researcher in her own right, having obtained a PhD in 1997. After some discussion concerning advantages and disadvantages, we decided that she should accompany me in *all* interviews. There were three reasons for this; firstly, that the research personnel would be the same in all of the interviews; secondly, that her experience as a social worker could prove important should support for an interviewee be required (see above); and lastly, that she would be able to monitor my own health (see immediately below).

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5.4.2: Welfare of the researcher

This issue is specifically raised by the NHS REC Form. By virtue of my own illness, my answer was almost a 'mirror image' of that pertaining to prospective interviewees. For clarity, I reproduce this:

> *It is possible that the researcher could be distressed during revelations by the participants. If this occurred the researcher would seek the advice of:*
>
> i) *The User and Carer Involvement Co-ordinator of the participating N.H.S. Trust. This person will act as the researcher's clinical supervisor throughout the research.*
>
> ii) *The Research and Development Manager of the above Trust, and his academic supervisor.*

5.3.3: Place of interviewing

The venue for conducting interviews was to be made by mutual agreement based on the most convenient arrangements for the respondent. Four interviews were conducted in a designated room at an NHS Trust site, being the main meeting place for users regularly attending meetings organised by the NHS Trust. Three interviews were conducted in the interviewee's homes at their request, whilst two were conducted in my own home.

5.4.4: Recording data

Provided that an interviewee gave permission, I used a cassette tape recorder to record an interview. (On the other hand, should permission have been withheld, the interview would have been written during the interview and counter-signed by the interviewee as a true record.) All nine respondents agreed readily to the use of the tape recorder. Not only did this enable full transcription of each interview, it enabled study of the ebb and flow of conversation: in short, a 'living' document'. Following interviews, the tapes were transcribed as soon as possible and a copy of the transcript given to each interviewee for checking. Concerning this, it is important to emphasize that this was a 'raw version' in that I appended no remarks whatsoever. This was for two

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reasons. The first was that I wished to avoid any possibility that a respondent would believe my interpretations to be judgemental as opposed to academic. Secondly, the main purpose of this exercise was not analysis but internal validation: it was important that an interviewee agreed that a transcript constituted a true and proper record of the interview. Associated with this, some of the experiences described might be referred to or further explored in a second interview. If so, although I never had need to make use of same, a transcript would be available to remind either an interview or myself of the fine detail of a narrative.

5.4.5: Beginning an interview

Although I was interviewing each person concerning specific experience of phenomena diagnosed as mental illness, the research question meant that, inevitably, I was inviting them to reflect upon the course of their lives. Initially, I found the interview process awkward due to preliminary procedures. Nevertheless, I tried to maintain a relaxed atmosphere by talking through the Consent Form and explaining the need for this protocol: to facilitate this, I read questions aloud. Following this, the tape recorder was tested to make sure that *all* parties could be heard clearly from *where they were going to sit throughout the interview.*

As explained above, included in these protocols was the choice of a pseudonym. After my first interview, in which I suggested 'Mr.CBA', I realised that the interviewee should be given autonomy. In doing so, I was sometimes surprised by the responses.

Dorothy hesitated before deciding on the name of a distant relative.

Mr. K. was quite happy to use his real name: Mr. K.' was, in effect, an after-thought.

Eddie Hooper-Smith answered me immediately, explaining that this was his chosen epithet when participating in any research.

Mr. P. suggested 'Porky Pie' because 'he was feeling mischievous at the moment'. Together, amid some amusement, we agreed that such an alias might not be appropriate for academic research. Thus, like 'Mr. K.', 'Mr. P.' was an afterthought.

Anita seemed genuinely pleased to be asked for her choice of name. I felt that this assisted in establishing a rapport very quickly.

Anne was used to research etiquette: accordingly her choice was matter-of-fact.

Although *Sandra* was also used to research etiquette, she was rather amused by the question. After suggesting 'Sandra', she laughed, adding 'It's the first name that comes into my head for some reason.'

Like Mr. K., *Mr. Gwent* was perfectly happy to use his real name.
In keeping with the conversationalist style as advocated by Studs Terkel (2004), I felt that much depended on maintaining an informal relationship. Therefore, I began every interview with words to the effect, "This is Ray Wainwright interviewing N——. Thank you for agreeing to be interviewed. (Pause) How are you?" Often, this question was sufficient to begin the interview process proper. If, however, this was not the case, then my next question was intended to hand the initiative to the interviewee:

"Do you have any ideas of the sort of questions I might ask you?"

My purpose in this was two-fold. Firstly, as explained above, I wished to establish an informal atmosphere. Secondly, I wished to allow the interviewee choice of initial direction with respect to experiences within the personal narrative. In the event, the first question sometimes led to an overview of an interviewee's present circumstances (e.g. Mr. CBA; Dorothy) whilst others (e.g. Mr. K.) would give a generalized answer. Concerning the bulk of the interview, some of the interviewees (e.g. Mr. CBA; Eddie Hooper-Smith) would give short answers then pause, obviously awaiting another question. On the other hand, some interviewees (Dorothy, Mr. K.) would range far and wide in their responses. Rather than interrupt, I would listen intently, trusting that they would return to the subject matter. In the event, this nearly always proved the case. Indeed, I feel that much valuable data was gained by allowing such free rein.

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5.4.6: Reflections (ii): Listening skills and the processes of interviewing

My intention was that an interviewee would remain relaxed, as though in conversation, but enter 'narrative mode' concerning their experiences, to be guided by my questions when appropriate. In contrast, I was in 'interview mode' as opposed to 'conversation mode' with respect to my listening skills and technique. In making this statement, I realise that it is difficult to avoid homilies whilst pinpointing crucial differences between the two modes. For example, it is obvious that one should pay attention to the interviewee, show encouragement by non-verbal cues when appropriate, and not interrupt too much (Wengraf, 2006). Notably, whereas in conversation one might respond verbally, interjections may alter the focus of an interview, therefore they should be withheld if possible. However, associated with this is the rather more difficult aspect of concentrating upon what is being said whilst making a mental note of important issues that might require elaboration.

I appreciate that this procedure may appear idealistic, even pompous; nevertheless, it can be followed *providing a researcher accepts that they can relinquish control of an interview so that the interviewee can speak unhindered.* In practice, I found this aspect of interviewing tiring; akin to a mental pinball machine wherein I wondered where a flow of narrative was going. More than often, I felt that an interviewee had wandered far into areas of total irrelevance and that I would have to subtly intervene. Yet, gradually, and almost always, they would return to the central focus of the study. Thus, with hindsight, I realise that all of the interviewees, without exception, were in 'recall' or 'reminiscence' mode which could be described as a combination of narrative and conversation. By being allowed free rein, interviewees often appeared as relaxed as they might be in a casual exchange. The benefits to the study were two-fold. Firstly, gaps in narrative flow were usually entirely natural, so allowing the next question, which was either pre-planned or engendered by earlier narrative. Secondly, with respect to the amount of data gathered, all of the interviews were extremely productive.

5.4.7: Ending an interview

In the first of my reflections (above) I queried the extent of informed consent and opined that the interview process might be upsetting. Therefore, it was agreed beforehand that, on ending the interview, all participants would remain together for comments and, most importantly, 'small talk'. Whilst I recognize the value of making notes immediately after an interview (Wengraf, 2006:42) I feel that the welfare of the interviewee should take precedence. In this, my motives were not entirely altruistic: for my own peace of mind, I *wanted* to know that an interviewee had returned to conversational mode. In the event, all interviewees said *at the time* that they had enjoyed the interview. Intermingled with such feedback were the types of inconsequential questions that make up much of everyday exchange: plans for later, who is seeing who and so on.

Approximately mid-way through my interviewing of respondents, the NHS Trust's Research and Development Co-ordinator advised me that, although the interviews had been unusually long, people had, overall, felt empowered by them. However, concerning his second interview, one respondent (Mr. CBA.) sent an e-mail to me that encapsulated my fears concerning inadvertent therapy. In short, whilst giving me permission to use both interviews in my study, he explained that although 'June and I might be able to analyse our feelings, I cannot – it just leads to me having bad thoughts'. Associated with this, he included two vituperative messages that he had forwarded to a family member. Although full analysis of the relevant transcripts will be detailed later, it is pertinent to note that Mr. CBA.'s reminiscing had led to exploration of highly sensitive subjects. At the time, I appended a note to the relevant data to the effect that I remained convinced that I had properly complied with informed consent. Thereafter, I expressed the private hope that Mr. CBA would come to realise that his revelations had not diminished him in my eyes. Yet, this sombre experience is instructive: despite all my precautions and determination to exercise sympathy and empathy, an interview had proven painful for the interviewee.

5.4.8: Confidentiality of personal data

Prospective interviewees were to be advised that every attempt would be made to ensure confidentiality by altering or withholding personal details. However, my opinion is that this applies to an 'ideal world' where all is possible and straightforward. Whilst the proposed safeguards should be rigorously applied, it is likely that to do so in all cases would render a transcript difficult to understand. Moreover, given that most persons are well-known to at least one other person, it is probable that an informed third party make an 'educated guess' as to the identity of a respondent. The following text is my answer given on the NHS REC form:

i) *Personal details will be altered so that participants will not be recognisable via description in the research report.*

ii) *Any details of personal addresses will not be referred to in the research.*

iii) *All access to research material will be via a password known only to the principal researcher.*

iv) *Tapes of interviews will be destroyed after the research has been completed.*

In addition, the Local Ethics Committee recommended that I stored data on a removable data stick as opposed to the hard drive of my home computer.

5.4.9: Personal qualifications

One of the main functions of the NHS REC Form is to draw attention to all issues associated with the welfare of the participants in the research. In this context, question A13 requested details of proposed interviews and the training received by the persons undertaking it. Whilst experience of interviewing is not a mandatory requirement, I noted my training as a Samaritan, also that as an Advocate for mentally ill persons. However, it is stressed that this question concerned *training;* therefore I did not consider my own experiences of phenomena diagnosed as mental illness to be relevant. However, by virtue of

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my intermittent participation in events organised by user activity groups (e.g. 'Develop', a group that met regularly in Hartlepool), I was known by almost all of my prospective interviewees to be a user of mental health services. This fact had, potentially, extremely important issues concerning this study.

5.4.10: Reflections (iii): Can only a user understand another user?

The purpose of this reflection is to explore not only the truth of these words but their implications concerning this study. My starting-point is my own role as a user of mental health services which, in recent years, I have not attempted to disguise or deny. Consequently, although they did not know the details, all of the interviewees in this study knew of my mental illness. That this created 'common ground' upon which we could tread is undeniable. Nevertheless, this claim requires clarification: by virtue of the fact that I was known to be a user of mental health services, an interviewee was likely to assume that we possessed mutual experiences. Although I could cite many probable examples of these, caution decrees that I mention but four, of which three are medical and one is social:

- Consultation with a G.P.

- Treatment with medication

- Consultation with a psychiatrist and associated personnel

- Stigma

The significance of this 'common-ground' shared between me and my prospective interviewees can be summarised by two aspects:

- the confidence that I would believe their narrative

- the confidence that I would not judge their worth as individuals through the lens of their experience of mental illness

Yet, prior to the conducting of interviews, my own experience of common ground is that it has become extended and distorted into a wholesale assumption of knowledge. *Why have other users told me that my illness can't have been as bad as it was; that I didn't need to be sectioned? Why, when I told them that my thoughts had become dangerous, did they respond by telling me they were sure that I would not have done anything bad? Why did so many tell me that I didn't need ECT, that ECT should never be used, that 'they' could have given me something else which would have been just as good? Why did many insist that cognitive therapy is the answer to all my ills and pooh-pooh my misgivings? Why is it that a good friend could not understand that lithium carbonate had no effect on me despite it being her salvation? Why do so many users declare that, 'Only a user can understand another user,' despite having no knowledge of me save that I am another user?*

I appreciate that my exasperation could lead to this review becoming an intemperate rant. Instead, I wish to draw attention to the fact that insight and understanding are widely separated points on a continuum. Thereafter, I believe it is reasonable to make comparisons to explain the difference between the two. For example, familiarity with the works of popular classical composers does not constitute a deep understanding of all classical music. Similarly, appreciation of well-known paintings is but the beginnings of knowledge of the many movements within art.

As explained in Chapter Four, the range of phenomena diagnosed as mental illness is vast. In tandem with this, the ranges of personality traits and other experiences pertaining to humans is also vast. Thus it follows that any one user's experience of phenomena diagnosed as mental illness can only be described in terms of an entire illness-experience construct. Although focussing essentially on the phenomena diagnosed as illness and their treatment, it necessarily incorporates all other aspects of a person's life, including ancillary social, cultural, and political issues. Thus any one user of mental health services is more than a user: they are a person in their own right. Accordingly, to fully explore the ramifications of this issue could be an entire thesis in itself. It would have been easy to prove how difficult it is for one person to understand

another by references to the philosophical constructs of reality as discussed in Chapter One, plus exploration of linguistic acuity. In this context, Stern (1984) examines in great detail the meaning of words, even to the extent of whether or not they are wholly understood by their author. Associated with this, I call attention to my personal identity as an aspect of my consciousness, which cannot be directly accessed by you, the reader, or anyone else. To claim understanding, even of oneself, is a massive statement. Insight yes, but the depth of knowledge required to achieve understanding is much greater.

To explain why users claim understanding, I am forced to speculate that the issues cited above, particularly stigma, engender an understandable defensiveness. As a result, the concept of common ground becomes magnified into a stronghold, a sanctum wherein users are known to one another. Yet the consequences of this, if unchecked, are extremely worrying, both within and without research. The terrible irony of believing that only a user can understand another user is that stigma is perpetuated by those very persons who are its victims. To claim that only a user can understand another user is to dismiss without qualification the opinions of any person who has not used mental health services. It negates the sympathy and empathy of any person who has not had experience of phenomena diagnosed as mental illness. And worse, it reifies the label: by emphasizing their differences, users invite others – the non-users – to overlook the similarities between them.

With particular reference to this research, to believe that I, as a user of mental health services, can automatically understand another user would be catastrophic. Interviews would be seriously jeopardised for the basic reason that I would fail to listen. By virtue of believing to know most of the answers already, I would fail (sometimes, not always) to ask the right questions: although the narrative would be recorded faithfully by tape, its flow would be lost. 'Truth' would be broadsided by prejudice: analysis of transcripts would be carried out through the lens of foreknowledge, serving only to confirm what I believed to know already. Yet not all would be enthusiastic self-approbation, for I would be constrained by pessimism. If only a user can understand another user then it follows that anyone who does not use mental health services will not

understand this study. So might I falter, ultimately to fail, in resentment that few academics could see the rightness that is undoubtedly mine. Obviously, I unreservedly reject this possibility. However, it underlines the necessity to craft as complete a picture as possible of an interviewee's personal identity. Only then can the possible impact of phenomena diagnosed as mental illness be properly explored.

I close this reflection by observing that I have often felt a terrible loneliness because of my illness. Often this has been because of the phenomena themselves, often because of the condemnation of other persons, and often because of those people who insisted they knew me when, in truth, they knew only that I suffered from a mental illness. Thus I say to all persons, irrespective of whether or not they are 'users': *First and foremost, a user is a person, a person whose many experiences include the use of mental health services. So, by all means, refer to me as a user; but never forget that I am a person. So can you understand me? A part of me, yes; but not enough to assume that you understand all of me.*

5.5: Transcribing of data

Transcription of interviews was to begin as soon as possible. This was to be carried out by me manually typing on a lap-top computer, an exercise that would necessitate constant playing and rewinding of the tape to be sure that I had transcribed the data correctly. In addition to words, I recognized that it would be essential to convey the flow of the interview by means of accurate notation. Elliott (2005) and Wengraf (2006) both refer to a procedure derived from conventions devised by Gail Jefferson. However, Wengraf (ibid: 216) also quotes Scheff (1997) in stressing that notation is intrinsic and does not necessarily have to be formal. In practice, by far the most important aspect of any system of notation is its applicability.

The following system was adopted for all nine interviews:

i) Apart from my wife's contribution as assistant researcher, the transcript is typed in Arial, Font 12

ii) My own questions, remarks and/or interjections are aligned **left**

iii) My wife's (research assistant) questions and/or interjections are in Times New Roman Script, Font 12, aligned **left**, and preceded by her name in brackets [June]

iv) The respondent's answers, remarks and interjections are aligned **right**

v) Personal details and other details that might enable the respondent and associated persons to be identified are italicised and bracketed.

vi) Significant pauses are indicated by rows of dots

vii) Stressed words or phrases are indicated by <u>underlining</u>

viii) Word whispers are indicated phonetically or as aspirant (sigh)

ix) Instances of emotion are indicated in italics and brackets

x) A hyphen at the end of a sentence indicates interruption

5.6: Initial analysis of transcripts

An integral part of transcription was a preliminary analysis. Although this will be discussed in detail in the next chapter, it should be noted that a first interview was fully transcribed before a second interview. In this way, data from the former could be used to inform questions in the latter.

5.7: Further correspondence with interviewees

Although it was mandatory that interviewees received a copy of the transcript, some pre-empted me by requesting a copy. As stated earlier (page 137), I returned the 'raw' data only, i.e. omitting any analyses. Generally speaking, the reaction to the transcripts was pleasure, sometimes accompanied by disbelief that one 'could say so much'.

Additionally, some respondents asked if they could have a copy of the completed study. In answer, I had stressed in my Information Sheet that, on completion, the completed study would be available to all participants.

5.8: Conclusion: research and identity

This chapter has described the crafting of the means that I hoped would achieve my desired end: the analysis of raw data provided by persons describing, in their own words, their experiences of phenomena diagnosed as mental illness. Essentially, this process is impersonal: it is, ideally, a carefully managed process wherein each stage is designed to facilitate the next. Yet, in research like this, I feel it is incumbent to be aware of when an impersonal approach should give way to a personal one. Obviously, as explained above, this was most evident in the conducting of interviews. On reflection, this was much easier that might be imagined: I like to believe that through a combination of good judgement and good fortune a productive atmosphere was engendered.

Given the main aim of my study, I feel it is supremely important that I do not lose sight of the person, and thereby personal identity, within the data. This possibility applies to a greater degree concerning further analysis, where aspects of data will be 'isolated' from an original transcript. The following chapters explain the application of narrative analysis in deconstruction and reconstruction of the data.

Chapter Six: Analysis of Transcripts

6.1: Introduction: the purpose of analysis

A transcript is a glimpse into a respondent's personal narrative; it contains biographical details pertinent to the Central Research Question. This chapter will describe the intended analytic process, the close examination of the transcripts obtained from the taped interviews. In doing so, it will inevitably create an overview involving both anticipation and retrospection. The reason for this is straightforward: long before gathering of data was initiated, I had researched the many and varied methods of analysing same. Accordingly, whilst I was confident that I had selected a method or combination of methods suitable for analysis, it proved necessary to modify these in response to the narrative form of the transcripts. Initially, therefore, this chapter will define the precise purpose of analysis by exploring the overall research question. Different methods of analysis will then be compared with a view to deciding which, whether singly or in combination, will be used. Finally, there will be a critical discussion of my own viewpoint as researcher with reference to the gathered data.

6.2: Narrative analysis

Broadly speaking, narrative analysis can be divided into two approaches that are very different despite the fact that each can contribute to the other. These are:

i) Differentiation of a narrative into biographical elements and linguistic structure

ii) Differentiation of a narrative into separate nested narratives

As detailed in Chapter Three, the first approach was pioneered by William Labov and Joshua Waletzky in the paper 'Narrative Analysis: Oral Versions of Personal Experience' [1967, reprinted 1997]. This study formalised narrative structure into five features, which can be summarized thus:

Orientation:	concerns *person, place, time and behavioural situation.*
Complicating Action:	The events described by the narrative; what actually happened
Evaluation:	This emphasizes the relative importance of the events to one another. Importantly, this may be both subjective and objective, so indicating the attitude of the narrator to the narrative.
Resolution:	How the narrative ended. Resolution may coincide with evaluation. Thus, in the event of a narrative which is on-going, evaluation and resolution are constantly formed and reformed.
Coda:	An element which relates the verbal perspective of a past narrative to the present day.

To this list is added-

Abstract	This term is not included in the elements cited in the 1967/1997 paper by Labov and Waletzky. However, Labov (1997:5) refers to an *abstract clause* as reporting 'the entire sequence of events in a narrative.

Labov and Waletzky's system remains highly influential. Since its inception, it has been elaborated upon, both by the original authors, and by many other researchers. This has led to development of other systems, including Bruner's (1997) application of Burke's 'Dramatic Pentad' (1945); the 'Recount, Anecdote and Exemplum' system of Martin and Plum (1997); and the approach of Rosenthal and Fischer-Rosenthal referred to as the Biographical-Narrative-Interpretive Method (BNIM) by Wengraf (2006). Concerning all methods, it is crucial to recognize they represent but the *first stage* of narrative analysis. Following differentiation, an element requires further deconstruction in order to identify its role and potential significance. This is particularly true of the Complicating Action and the Evaluation: without the fine detail of these elements, it is not possible to determine exactly what happened or its meanings and implications.

This observation leads to scrutiny of the second approach, namely differentiation into nested narratives. As explained in Chapter Three, the personal narrative that describes a life story can be regarded as being comprised of a multitude of interlinked narratives, each pertaining to a life experience. With reference to this construct, the general term applied to a narrative within a larger narrative is a *nested narrative* (Gergen and Gergen, 2001). For the purposes of analysis, nested narratives can be identified and categorized according to 'theme', i.e. in terms of the event described.

Comparison of the two approaches shows that linkages can easily be made. If it is to make sense, a nested narrative requires some, but not all, of Labov and Waletzky's five elements. The main difference concerns applicability to a complex narrative containing a large number of nested narratives. If Labov and Waletzky's system is applied to the entire narrative, then there arises a necessity to sub-group each category (e.g. Complicating Action would need to be CA1; CA2; CA3 and so on). If however, a narrative is first differentiated into nested narratives, this cumbersome and potentially confusing procedure can be avoided. Thereafter, once identified, nested narratives can be subjected to further analysis, either by Labov and Waletzky's system, or by different means, as will be discussed in the following sections.

6.3: Coding of data
6.3.1: Definition and function of coding

Miles and Huberman (1994:56) summarize coding in three words: 'Coding is analysis'. Rather more helpfully, they define a code as 'a tag or label for assigning units of meaning to the descriptive or inferential information compiled during a study' (ibid). Thus codes can be applied to data of any size, from a single word to a paragraph. However, with regard to the latter, some care must be taken to ensure that it can either be described according to a single code or, if necessary, more than one code. Concerning the creation of codes, they describe three methods:

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i) A provisional 'start-list' which is clarified as the data are processed.

ii) Development by induction of codes from the data

iii) A combination the first two approaches by creating general 'accounting schemes' in which codes can be developed.

In discussing these, the authors (ibid, 61) state a preference for the first method but do not say why. Thereafter, whilst no opinion is expressed concerning the second method, a slight wariness is noted concerning the third. This is because although it offers greater flexibility, the accounting frame may become 'little more than a catalogue unless the categories are meaningfully developed.

These different approaches serve to highlight the tension that permeates all analysis. Essentially, the aim is straightforward: it is to deconstruct and interpret the data from as many viewpoints as possible until no further differentiation is possible. In practice, however, such is not possible: instead, it is governed by pragmatism. As explained by Strauss and Corbin (1998:186) the process of data-collecting could become endless if limitations are not applied. Thus, there will always be room for speculation or a new question: in this sense, coding is an infinite process. Additionally, as will be explained later, the analytical process may be subject to the prejudices and expectation of the researcher, albeit unwittingly. However, before elaborating upon these, it is logical to proceed to examination of the system used in this study.

6.3.2: Level of coding

Miles and Huberman (1994) state that codes should be recognizable as applying to the concept they describe and not be over-elaborate. Although this advice might appear obvious, it is, in fact, important: not only does a researcher need to be able to analyze data without having to check their own system; the results need to be accessible to a reader. Accordingly, the authors suggest that a code of two or three facets is acceptable for manual analysis. Concerning this, it is not my intention to use software such as NUD.IST (Non-numerical Unstructured Data. Indexing, Searching and Theorizing) in the final analysis of data. Although there are undoubted advantages in using this programme

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(Kendall, PhD Thesis, unpublished), I preferred the manual approach to analysis throughout. This is because it inevitably involves many re-readings of the data, so providing opportunity to revise analysis and also check for instances of personal bias (see section 6.4.2.2.Reflexivity).

6.3.3: Initiating coding

Wengraf (2006) explains that the act of transcription should be the first part of the analytical process:

> You could argue – almost – that the only point of doing the slow work of transcription is to force the delivery to your conscious mind of as many thoughts and memories as you can, forced as you are to *work slowly* [...] *while your mind has time to think fast and widely about the material and the event* in which the material was gathered.
>
> **(Wengraf, 2006:209 [italics in original text])**

Concerning this research, transcription proved a labour-intensive exercise. Of the nine respondents, four were interviewed twice; of the thirteen transcripts, the shortest was 8,787 words plus provided attachments, whilst the longest was 22,882 words. One of the most difficult aspects of transcription was keeping up with the pace of a respondent's speech: in one case, although the tape recorder had been correctly positioned, the respondent often spoke so quickly that they were inaudible. As a result, I was obliged to replay sequences several times until I fully understood what had been said (rather perversely in the context of this discussion, I interviewed this respondent twice). Occasionally I would interview a respondent for a first time before I interviewed another respondent for the second time. However, in the interests of maintaining a reasonable workload, I avoided arranging another interview before completing analysis of interviews already conducted. In other words, as stressed below, 'I did not have a backlog' of tapes awaiting transcription.

In an ideal world it would be possible to interview a respondent, transcribe the interview, subject the data to an exhaustive coding procedure, then use the initial findings to inform later interview questions and analysis (Miles and Huberman, 1994; Strauss and Corbin, 1998). However, I considered that the following preliminary stages were adequate in this regard:

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i) *First level coding:* The transcription of the tape into prose form, this level was probably the most important in that it included casual observations and methodological notes, plus recommendations for follow-up questions. With reference to the respondent, this would include notes on tone of voice, expressed emotions, and so on. With regard to myself, I would include *reflexive comments,* i.e. those relating to my own knowledge, emotions, and biases *both at the time of interview and at the time of transcription.* These will be discussed in greater detail later in this chapter.

ii) *Second level coding:* This would be a summary of the first level coding. Strictly speaking, this level did not represent a further process of analysis. Instead it was an overview of the transcript, including my speculations, comments on procedure, and recommendations for a second interview (if possible and/or desired).

6.3.4: Completing coding

First level and second level coding *were always completed before a second interview.* Thereafter, all transcripts were subjected to two further levels:

iii) *Third-level coding:* This would be the detailed analysis of the transcript. I hoped that I would be able to undertake this in time for a second interview with a respondent (as stated, this was not always possible). However, I stress that although this was *instructive*, it was not *exhaustive.* Instead, I viewed this operation as the prequel to successive coding until saturation was reached, that is no new categories emerged (Strauss and Corbin, 1998; Miles and Huberman, 1994).

iv) *Fourth-level coding: Division of narrative into 'idea units'.* Both Elliott (2005: 54 *et seq.*) and Riessman (1993: 44 *et seq.*) discuss the work of James Gee (1985, 1986, 1991) who viewed the smallest unit of discourse as 'a line'. In this context, Elliott (ibid) uses the extremely useful concept of an 'idea unit'. Somewhat contentious, however, is the fact, as stressed by Riessman, that this results in a poetic structure.

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Indeed, the main application of this method is with reference to structure, particularly the rhythm of a narrative and emphasis of constituent events. As such, this aspect undoubtedly contributes to understanding of content. However, as stressed by Elliott, it is time-consuming and therefore unlikely to be used where content is the main criterion. Accordingly, it is usual to apply it to a portion of data as opposed to the entire transcript. Therefore, my expectation was that this device would prove useful if a portion of data contains more than one category or theme. Where appropriate, I appended short notes, some of which included a question mark to indicate speculation. This level differed from the first and the third in that scrutiny was repeated until I believed that saturation had been reached.

An obvious and valid criticism that can be asked of me is, 'Why did you conduct your interviews in a relatively short space of time instead of waiting until you were fully ready?" In answer, I found that I had entered an 'interview mode', wherein my thoughts were directed towards the interactions of my interviews. Perhaps most importantly, the fact that I had interviewed other respondents recently meant that *their narratives were fresh in my mind.* Therefore, comparisons came easily at this time, facilitating both my interview technique and analysis *at the time of transcription.* As an integral part of the interview and eventual coding, I regarded this as a crucial aspect of the research. Thus my overview of this procedure was that it would be sufficiently rigorous to meet the advice of Miles and Huberman (above) whilst acknowledging practical limitations. With regard to subsequent interviews, I anticipated that the preliminary analyses would be particularly useful in identifying areas for subsequent questioning.

6.3.5: Choice of codes for this research

After consideration, I decided that *a priori* codes would be pre-emptive. Nevertheless, it is obvious that I was influenced by the Central Research Question: therefore it was self-evident that I would be particularly alert to details of mental illness, plus any mention of self-image. Given that these are extremely broad areas, I anticipated that differentiation by categorisation would

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be required for clarification. Therefore, I intended that my overall approach would be inductive in that I would allocate categories to portions of data according to the content described.

6.3.6. Reflection (i): Maintaining interest in the research

It is often said that 'one cannot see the wood for the trees.' After what seemed an interminable exercise in concentration when transcribing, I found myself confronted (I use this word deliberately) by an unruly and only partially tamed mass of data. Whilst my first-level coding had proved successful in identifying many important themes, there was also a feeling that much of the narratives contained in the transcripts remained incoherent. Much of this depended upon the interactions between me and the interviewee: whilst some told a story in an approximate chronological order, others ranged far and wide, mixing past and present in a tangled weave of comment and reflection. The obvious answer, to re-examine each transcript, was only partially successful. Although first-level coding could be challenged and qualified by additional observations, I felt that the overall product was lifeless, giving little insight into identity or experience of illness.

It was at this point that I felt more than a little frustration. My attempts at elucidation were compromised by the fact that I was unhappy with the overall concept of specific codes or themes. In reality, a personal narrative – which is what each transcript was – consists of hundreds, if not thousands, of nested narratives which *are linked to other nested narratives*. In consequence, I felt that to isolate and label any single narrative contributed little to the coding process. For example, to draw attention to 'low self esteem' in the context of past events meant little unless the import of same was speculated upon through deduction. However, to do so was not necessarily helpful, especially if accompanying detail in the transcript was not specific. Yes, the possible impact of low self-esteem at a particular time in a person's narrative appeared obvious, but this was not always stated as such. Given that this scenario recurred concerning other events or concepts throughout the transcripts, my overall feeling was an intuitive conviction that they contained a wide variety of reactions to mental illness.

From an academic point of view, such is dangerous ground. It would be easy to transgress the tenets of analysis by looking *for* codes in the data as opposed to looking *at* the data. Yet, perhaps oddly, this led to a return to basics: in citing the linkage of nested narratives, I was repeating the question, 'What all is going on here?" Thereafter, the means of obtaining answers – though not necessarily the completed answers – lay in the data itself. It is the interview itself that informs the answer; it is the respondent telling their narrative. When, despite misgivings, I experimented with division of portions of transcript into 'idea units' (see page 117) the results of this were immediately apparent. The act of division was in itself a form of coding by drawing attention to a single aspect of narrative: an event, a place, a person, a thought and so on. Sometimes, the wording of an idea unit surpassed any analysis in conveying meaning. For example, 'Mr. P.'s' description of playground bullying, 'It was like a stone in my heart', encapsulates emotional pain and rejection in eight short words. Naturally, not all phrases were so eloquent: many were 'link units' providing details of time, persons and places, so meeting the requirements of orientation with respect to complicating actions. In this context, most lines were self-explanatory; however, I was able to append brief interpretive labels to others. In particular, I could make an important distinction between a definite and a speculative item. For instance, when 'Mr. P.' told of losing his job, this was a fact, a statement of truth. Thereafter, it was reasonable to speculate by deduction that this would have impacted upon his self-esteem.

From a practical point of view, reduction into idea units was both exhaustive and exhausting. Although I discarded irrelevant sections of the transcripts, even this process was sometimes exasperating due to the afore-mentioned linkages between nested narratives. Moreover, the reduction of the selected passages was indeed time-consuming; particularly if it transpired that I needed to refer to the original transcript to check on the location of a chosen extract. However, a crucial aspect of this exercise was that it forced me to *constantly look at the data.* In its unadulterated form, a reduced transcript (i.e. one free of appended comments and codes) is virtually guaranteed to be true to the original data. Perhaps the only objections are that the act of reduction is somewhat arbitrary, also that it may accord an undue emphasis on a mundane idea or comment.

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Once completed, the reduced transcript was re-read several times in assigning codes if appropriate. Often, a code was merely 'self-explanatory'; at other times, it would be interpretive, e.g. 'stressor'. The end-product of these codes was summarized in my 'fourth level coding': this followed the relevant extract in all cases.

In truth, I had not anticipated the sheer volume of work or that 'idea units' would prove to be the most effective means of analysis. Despite this, the last transcript was finally reduced to my satisfaction. Following this, the closing exercise of cross-case analysis was greatly facilitated by the accessibility of the processed data. However, it should be stressed that, on occasion, I felt it necessary to refer to an original transcript in order to be certain that I was expressing a concept in its proper context.

6.4: Cross-case analysis

Described as 'cross-case analysis by Miles and Huberman (1994) and 'comparative analysis' by Strauss and Corbin (1998), this is the final refinement of categorization. Whilst the former text notes that it 'enhances generalizability' (p172), both stress that it will increase understanding of the data. My own view of cross-case analysis is that it is synonymous with the instruction, 'Compare and Contrast' with reference to units of data. This can be pursued by two related but distinct avenues:

   i)   To compare and contrast the course of single nested narratives as identified by named categories with reference to the nine respondents.

   ii)   To compare and contrast the entire personal narrative of each respondent. This would be reconstructed from the nested narratives categorized as above.

Associated with both schemes, it was necessary to arrange the personal narrative was arranged in chronological order. This was achieved by manually sorting a printed copy of the data after it had been subjected to fourth-level coding. If a respondent had been interviewed twice, it was at this point that data

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from the two interviews could be intermingled. Thereafter, I decided that it would be instructive to divide the chronology of the personal narrative into three stages determined by the course of mental illness:

The first stage covers a respondent's life before the onset of mental illness. In some cases this is very detailed by virtue of description of childhood experiences, including family life. For example, Dorothy, Anita, Mr. P., and Sandra covered much of their entire personal narratives in the course of the interviews. In contrast, the other five respondents (Mr. CBA, Mr. K., Eddie Hooper-Smith, Anne and Mr. Gwent) made much less reference to the early stages of their lives. Nevertheless, all nine respondents provided sufficient detail to enable me to gain some insight into their personal narratives before the onset of mental illness. Accordingly, I have termed this stage *prologue.*

The second stage is accounts of significant experience of mental illness whether this concerns a single, relatively short-lived episode that is now resolved with or without the aid of medication (Mr. K., Mr. P., Mr. Gwent); a longer episode leading to on-going symptoms (Mr. CBA, Eddie Hooper-Smith, Anne), or recurring episodes associated with on-going symptoms requiring medication (Dorothy, Anita, Sandra). Concerning all respondents, each experienced a *first* significant episode, that is phenomena sufficient to cause severe problems. Although a range of feelings associated with this (e.g. fear, bewilderment) is described by Corry and Tubridy (2001), I prefer a phenomenological description by Boisen (1971) of 'acute disturbances'. Although this is written with reference to schizophrenia, I believe it applies equally well to the onset of all severe phenomena:

> The impact of such an experience is apt to be terrific. It may destroy the foundations of the mental organization and upset the structure upon which the judgements and reasoning processes are based.
>
> **(Boisen, 1971:30)**

In keeping with the above and with an overview used by Breggin (1993), I have termed this stage *overwhelm.*

The third stage is an accounting of experiences following overwhelm. In that the interviewees have recovered sufficiently to tell me their story, I term this stage *recovery.* However, it is essential to recognize that the degree of recovery may vary and may not be 'complete' by virtue of continuing experience of mental illness (for example, both Dorothy and Eddie-Hooper-Smith continue to require the input of a support worker, whilst Anita continues to experience problems with medication). Also, in the event of recurrent episodes, the path of recovery may not have been 'smooth', but may have been interrupted by subsequent periods of overwhelm.

(Important note: In the event of an interviewee's health worsening during this research, I had not pursued any further interviews.)

In making these distinctions, I stress that they are arbitrary: in real life, they are not separate and distinct but overlap with one another. Nevertheless, they are useful in that they enable a detailed personal narrative of each interviewee to be fashioned. In particular, I believe that they facilitate understanding of the interviewee *as a person*, the man or woman of whose personal experiences mental illness is but a part.

6.5: Neutrality in research
6.5.1: Is coding a neutral process?

Whilst every effort can – and should – be made to ensure neutrality in research, it is inevitable that understanding, and therefore coding, of data is modified by the sense-perception and pre-conceptions of the researcher. The following section explains how this came be moderated by awareness of the processes involved.

6.5.2: Bias of respondent and researcher

In a section called 'Waving the Red Flag', Strauss and Corbin (1998) state that it is important to:

> ....recognize when either our own or the respondents' biases, assumptions, or beliefs **are intruding into the analysis.**
> **(Strauss and Corbin, 1998:97)[Bold type in original text]**

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Given that the Central Research Question concerns personal identity, I maintain that a respondent's personal beliefs concerning *any* topic should be regarded as an integral part of the data. Far from eschewing it, a particular belief should be investigated if deemed to be of importance to an interviewee. However, my own biases are a different matter entirely. In the main, these are of two types. The first is straightforward: it is possible to be lazy, careless, and/or make genuine mistakes: to attribute causation where none exists, to ignore categories, to claim that data supports a particular stance despite evidence to the contrary, and so on. The second is much more complex in that it concerns my personal beliefs and understandings, both those pertaining to my personal narrative and those pertaining to my reading of the literature in the context of this research.

6.5.3: Relativism and reflexivity

Concerning the epistemology of research, these terms are regarded as separate and distinct despite an apparent overlap between them. This is probably because, unlike reflexivity, relativism is a named philosophical construct. Accordingly, these will be discussed as separate topics before review in the context of this research.

6.5.3.1: Relativism

Epistemologically, relativism can be described as *non-realism* (Horner and Westacott, 2000) in that it denies the realist concept of an independent reality. With reference to 'cognitive realism' the authors provide a useful summary, explaining that relativists believe that....'the truth or falsity of a statement is relative to some particular standpoint' (p55). Later in their discussion, they apply the *coherence theory of truth* (that the truth of a statement consists in its coherence with other statements) in combination with a non-realist view of the relation between the mind and reality. Concerning this, it becomes evident that relativism can be viewed as deriving from the tension between the rather simpler concepts of *direct realism* (that reality is independent of our cognition of it) and *representative realism* (that some qualities of objects exist only in the mind of the observer (Horner and Westacott, ibid).

Much care must be taken in application of relativism. Pursuing a convoluted course of discussion, Horner and Westacott (ibid) note critiques that centre on areas of inconsistency. Similarly Hammersley (1992) notes ambiguity concerning declaration of certainty. In summary, to adjudge the veracity of a particular stance, it is necessary to declare that a referential point is true; however, this may not be justifiable. However, Horner and Westacott (ibid) suggest a solution that is satisfactorily clear. If the referential standpoint includes a relativist view of the relationship between the mind and reality (i.e. incorporating representational reality) then it is possible to acknowledge uncertainty without contradiction. This approximates to Hammersley's (ibid, 50 - 54) construct of *subtle realism,* whereby recognition of our own assumptions and beliefs is applied to ethnographic research.

6.5.3.2: Reflexivity

In some texts, especially Woolgar (ed) [1988], discussion of reflexivity is extremely elaborate. Therefore, rather ironically, it is best to apply relativism by beginning with a text that takes a definite standpoint. Denscombe (1998) defines reflexivity as..... 'concerns the relationship between the researcher and the social world' (p240). Thereafter, he explains that since a researcher is a part of the social world, they can never be entirely objective. Thus his definition of reflexivity is very close to Horner and Westacott's closing remarks concerning relativism (above). However, whereas this observation is echoed by other authors (e.g. Hammersley and Atkinson (1990), Woolgar (1988) uses the ambiguity inherent in relativism to challenge this stance. Accordingly, it is necessary to explore further the nature of the relationship between 'the researcher' and the 'social world'

Again, Denscombe (ibid) is helpful when discussing reflexivity in the context of ethnography. Broadly speaking, his observations can be divided into two linked groups. The first concerns our observations of events and our interpretations of them, being the product of our own experiences. The second, the writing up of same, is also affected in that an author is never entirely objective concerning the presentation of text. Undoubtedly important with regard to any research, this

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concept is explained in much greater detail by Atkinson (1991). However, this discussion concentrates on the first concept, namely the role of our experiences in interpretation. In particular, what are those experiences and interpretations? In short, the answer is 'all'. All that happened to a person, all that they have remembered, and all that they have understood, including constant re-interpretation of memories as new understandings are gained through new experience. As suggested in previous chapters, experience can be both direct, whereby the person participates in events, and indirect, through the narratives of others.

In this context, reflexivity becomes explicable in terms of an active process within the larger construct of relativism. Included in this is a self-referential aspect, namely that awareness of relativism and reflexivity is in itself a part of both processes. Whilst this observation risks over-elaboration, I believe that it enables an overview of reflexivity. To achieve this, I take a diversion into biology by viewing reflexivity as pertaining to a *a reflex* in terms of a *reaction to a stimulus.* Fundamentally important to this viewpoint is that a reflex can be *involuntary,* involving no conscious processes. In physiological terms, the pathway of a reflex is termed a *reflex arc,* of which a simple type involves three neurons (Bennett, 1990):

Figure 6.1: Reflex Arc

sensory receptor: **(feeling of stimulus)**

Interneuron in spinal cord

Motor end plate makes muscle contract: **(reflex)**
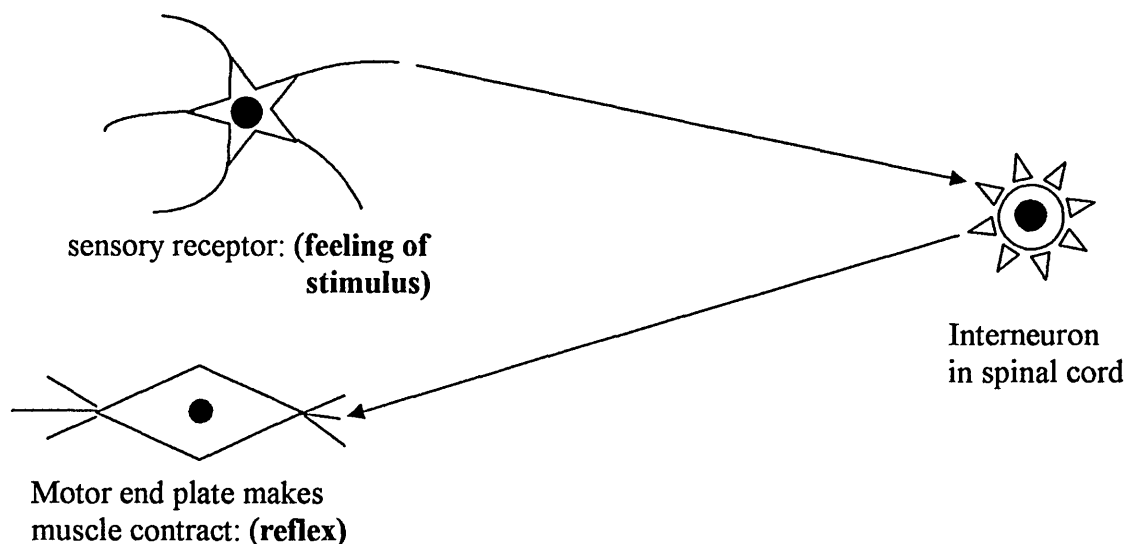
The crucial aspect of this comparison is that almost immediately after the reflex has been effected, *the conscious mind becomes aware of it.* For example, if you touch something very hot, (e.g. a ring on an electric cooker) you jerk your hand away before realising why. Therefore, the reflex process consists of two parts: the reflex itself and the subsequent appraisals of what happened, why, whose fault it was, and so on. Arising from this appraisal, future behaviour will probably differ from previous behaviour: since you know that the cooker ring may be hot, you will avoid touching it. Moreover, this act will become automatic, involving nonconscious processes (Edelman, 2005).

Applying this process to a research setting, the vast majority of researchers are in the position of 'knowing that the cooker ring may be hot'. However, application of reflexivity demands that *we are aware of that knowledge and that we may react to it.* That is, we undertake research with the aid (or burden) of foreknowledge gained either from previous research, or background reading, or personal experience: original data are gathered and, *initially*, interpreted amid a welter of *involuntary or unconscious experiences.* Try as we might, we cannot altogether avoid the possibility that an event will remind us of something we have seen, heard, or read. However, we can try to be aware of a possible reaction prior to data collection and plan accordingly. In my own case, the NHS Local Ethics Committee raised the possibility that mutual disclosure of experiences during interview could lead to a loss of focus. Also, we can try to be aware of our reactions when transcribing data: providing that these are recorded, they can be acknowledged as part of the eventual analysis. Concerning this study, my own technique was to detail my responses during transcription and first level coding, i.e. my reaction to statements – and the way in which they were said – made by the respondents as I heard them again on the tape. Occasionally, but much less often, I was fortunate enough to be able to remember my reaction at the time of the interview.

In conclusion, whilst there are similarities between bias and reflexivity, there is an important difference between them. Both are associated with the knowledge and experiences of the researcher plus the understanding of same. Both can derive from a non-conscious influence of these through reaction of memory to

on-going collection of data. Both may be subsequently recognized to exist. However, recognition of bias does not necessarily lead to a remedy: indeed, it may continue to be exercised in the crafting of the research. Reflexivity, on the other hand, includes the acts of *reflection* and *appraisal* in determining the influencing of the researcher upon the research. In short, if properly applied, reflexivity acknowledges that although we can forget something we have learned, we cannot unlearn it. Therefore, a researcher needs to be aware of their pre-conceptions and assumptions when planning the research, collecting original data, analysis of same, and presentation of the findings. If this can be achieved, then the rigour of the research will be maximised. That said, the very nature of reflexivity means that an ever-present criterion in research will be imperfection. Despite the levels to which research is scrutinized for objectivity and neutrality, no-one is immune from subjectivity and the vagaries of understanding. The key question for the researcher, therefore, is not 'what is the perfect methodology and analytic scheme' but, rather, 'what methodology and analytic scheme is fit for purpose?'

6.6: Reflection (ii): My personal experience of mental illness

As emphasized throughout this thesis, I have experienced phenomena diagnosed as mental illness for over forty years. Colloquially speaking, my experiences are innumerable. Concerning the phenomena – the symptoms – themselves, my diagnoses have been many and varied: depression, endogenous depression, psychotic depression, 'don't know', bipolar disorder, obsessive-compulsive disorder, schizo-affective disorder, schizophrenia, and, latterly, ultra-rapid cycling mixed affective bipolar disorder. Concerning the medical personnel whom I have seen, there have been those I have liked, there have been those I disliked, even those I have feared. There have been those I have admired, those whom I thought had made their minds up before I walked through the door; those whom I felt tried to help me, those whom I thought couldn't be bothered. Concerning medication, there has been a succession of tablets, either in isolation or as part of a regime: Tryptozol, Imipamine, Stelazine, Droperidol, Prozac, Clopromazine, Risperdal, Sodium valproate, Zispin, Efexor, Lamotrigine, Gabapentin, Citalopram, and Quetiapine.

Concerning other treatments, I have received Cognitive Behavioural Therapy (CBT) and Electro-Convulsive Therapy (ECT). Concerning the effects of the combinations of symptoms and treatment...... This is the mass of my personal experience, *my own* memories and understandings.

From an epistemological viewpoint, I recognize that my status could present a reflexive nightmare. Perhaps curiously, however, I found that I was able to set aside the bulk of my experiences when interviewing and transcribing. Instead, my style was (as detailed in the last chapter with reference to Studs Terkel) that of an interested observer occasionally prompting the main speaker in a guided conversation. Occasionally, and inevitably, there would be mention of my own experience if the context was relevant, particularly from my wife, June, in her capacity as Assistant Researcher. Whether these were in keeping with the overall spirit of neutrality is a moot point. Although it is probable that some of our remarks were unnecessary, I maintain that they contributed to the often convivial nature of the interviews. Moreover, though I am less sure of this, I suggest that the exchanges assisted both the interviewee and myself to retain a person-to-person relationship. In truth, despite being constantly aware of my role as researcher, I never felt that I conveyed an academic detachment.

This attitude persisted during transcription: when playing and replaying the tape I could often see a mind's eye image of the interviewee as I heard their words and the way they were said. As stated earlier, there were also the demands of sheer concentration in listening to the tape: sometimes my whole attention was devoted to successive replays in order to capture a quiet word or statement. Therefore, whilst acknowledging the risk of hubris, I was, and remain, confident that the interviews were conducted and transcribed without the undue influence of my own experiences. Against this, I was alone when transcribing, more able to give myself to my thoughts as opposed to ensuring the smooth flow of the interview. Accordingly, the person within worked alongside the academic: ideas formed and reformed as existing knowledge was recalled.

6.7. Conclusion

In this chapter, I have explained how the raw data of a transcript is deconstructed through a series of four levels into 'idea units', that is, a form suitable for scrutiny and cross-case analysis with other transcripts. In doing so, I have discussed at length the various sources of personal bias that can, potentially, affect all research. Additionally, in this context, I have explored the possible impact of my own experiences of mental illness upon my interpretations.

The following chapter will explore narrative theory before applying this to the four levels of coding. In particular, it will discuss evaluation of narrative trajectory and named narratives of illness described in academic literature. This will lead to the development of narrative diagrams to illustrate the three stages of illness named by me on pages 166 – 7, namely *prologue*, *overwhelm*, and *recovery*.

Chapter Seven: Significant narratives

7.1: Introduction: interpretation of data: words and pictures

The purpose of this chapter is to describe the application of narrative analysis to the data and how this can be used in the creation of visual interpretation of the relevant aspects of personal narratives. In discussing the importance of visual displays, Wengraf (2006) invites controversy by averring that '....most social scientists under-use such displays'. This accusation is then compounded by the statement that:

> It is a mistake – a mistake that qualitative researchers *not* trained in quantitative display devices are most likely to make......
> **(Wengraf, 2006, 359) [italics in original text]**

Associated with *vraisemblance* (Atkinson, 1991) this charge highlights a vexed issue. The presentation of research is not a neutral exercise, but is crafted to meet the needs of scientific rigour and, perhaps of equal importance, the expectation of the reader. Described by Atkinson (ibid) as 'intertextuality', a text is persuasive by obedience to linguistic and academic conventions. If follows, therefore, that reflexivity plays an important role in the manner in which this text is received. Not only is the methodology and findings of a research project under scrutiny, but also the way in which these are described. In this context, if Wengraf's generalizations are correct then sociologists not only under-use 'visual displays', they are also suspicious of them when reading.

To explore this issue, it is necessary to view it as a problem of accessibility. An important lead is provided by Atkinson (ibid) in noting that 'arcane jargon' need not be a prerequisite in textual construction. In simple terms, easily understood words will not devalue or diminish important findings. However, it is also true that clumsy syntax and ill-chosen words will have that precise effect. Consequently, the ideal path is a 'middle road' whereby research is presented in a format of acceptable academic standard. *Nevertheless, the problem of prejudice through reflexivity remains.* In practice, it is virtually impossible to

produce a piece of work that does not contain a few jarring notes. A sentence that is too long for some readers, the frequent use of a particular adjective or conjunction, a word considered obscure by some persons despite its everyday use by an author, all can evoke a negative reaction.

To concentrate overmuch on these aspects of access and accessibility would be unproductive. Instead, it is better to focus on a common-sense approach to presentation of findings. Thus written reports should be lucid: clearly written, unencumbered by obscure words or phrases. Concerning diagrams, my belief is that they are indispensable providing that they are clear and easy to understand, particularly in the case of flow diagrams. However, such idealism is not necessarily easily applied. With reference to generating a life-story in interviewing, Keady, Williams, Hughes-Roberts and Quinn (2007) make use of a Venn Diagram to summarize respondent-interviewer interaction. Later in the same text, a 'personal theory' of experience of living with Alzheimer's disease is summarized using a flow diagram. On the other hand, whilst many of the diagrams found in Miles and Huberman (1994) are excellent in their clarity, others are difficult to follow due to the number of factors illustrated. Thus one is faced with a dilemma: whilst the desired aim is clarity through simplicity, it is essential to include all relevant data concerning a construct. It was this consideration that led me to devise a visual means of depicting narratives, the entire process of which will form much of the discussion in this chapter. Firstly, it is necessary to finalize exploration of narrative constructs.

7.2: Narrative coherence

An important aspect of coding is that, despite deconstruction, the document – the narrative – can still be viewed as a unified whole. This quality, the continuity and overall meaning of a narrative, is termed *coherence* (Linde, 1993; Elliott, 2005). However, a detailed exploration of this construct leads to realms of apparent artificiality. For example, when quoting Baerger and McAdams (1999), Elliott (ibid) itemizes four qualities of coherence:

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i) Temporal, social and personal context.
ii) Structural elements of an episode system.
iii) Evaluation to give emotional significance
iv) Meaning of experiences within context of larger life story.

Similarly, using generalized views of science and history as examples of narrative, Landau (2001:116) identifies three linked 'premises', which can be can be summarized as follows:

i) the *beginning-middle-end* template of all narratives
ii) *evaluation* to designate certain events as being of especial significance
iii) *causality:* the possibility that one event leads to another

Basic narrative structure has already been discussed in Chapters Three and Five. The specific purpose of this chapter is to review those elements which, more than any, convey coherence, namely *causality:* the possible linkage between events; and *plot:* the essential meaning of a narrative. Thereafter, it will develop the concept of nested narratives with references to constructs cited in academic literature. In particular, it will explain how nested narratives can be designated as significant or even dominant within the entire personal narrative. This understanding will then be discussed with reference to future analysis and interpretation of the data obtained from the interviews.

7.3: Narrative structure: causality

An essential part of narrative coherence is a logical temporal sequence of events. Within this, as explained above, *causality* is the concept that one event can lead to another. Concerning this linkage, Elliott (2005:8 – 9) stresses the difference between a *causal link* and a *causal law*. The former describes an events or events leading to a subsequent events or events, whereas the latter states that an event will inevitably lead to a specific later event. However, in the context of these explanations, she draws attention to an obvious but fundamental fact: that causality does not always exist. Associated with this is a common human error, whereby causality is *assumed* to exist, even if it is not stressed (ibid). In this context, Horner and Westacott (2000: 2 – 3) explain that

the concept of everything having a cause is known as *determinism*; and that the idea that every event has a cause is termed the *causal principle.* In contrast is the concept of *free will*, leading to the following observation by the authors:

> ...if determinism is true, then human decisions and action must, like all other events be the necessary effects of prior causes. Yet most of us believe that at least some of the time we are responsible for our actions...
>
> **(Horner and Westacott, 2000:5)**

Concerning this research, the possibility that causality might be assumed to exist, despite a lack of evidence, must be examined from two viewpoints, those of narrator and audience. In an interview setting, the *interviewee* is the *narrator* and I, *the researcher,* am the *audience.* If, within their narrative, an interviewee speaks of causal links between events, then *these are part of the data despite whether or not they appear to be valid.* As such, it is incumbent upon me to include them in analysis of the narrative. However, when conducting that analysis, I must exercise extreme caution if looking for causal links *not identified by the respondent.* In particular is the risk of a subjective assumption that causality must exist and awaits discovery:

> And even if two events seem not obviously interrelated, we infer that they may be, on some larger principle that we will discover later
>
> **(Elliott, 2005:8 quoting Chapman [1978:46])**

In combination with other narrative components, causality contributes to the meaning of the entire narrative. This, the coherent sequence of events, is termed *plot.*

7.4: Narrative structure: plot and genre

As a device for enhancing the flow and cohesion of a narrative, *plot* applies the various elements of a narrative to enable an overall understanding of events:

> ...the main device that we use in trying to make sense of our lives.
>
> **(Hinchman and Hinchman, 2001:1)**

Similarly, Riessman (1993) quotes Cronon (1992) in explaining that plot enables individuals to make sense of experience:

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Narrators create plots from disordered experience, give reality "a unity that neither nature nor the past possesses so clearly. In so doing, we move well beyond nature into the intensely human realm of value".

(Riessman, 1993:4, quoting Cronon, [1992:1349])

Incorporating all aspects of causality including the potential for error, plot presents probably the greatest problem in narrative analysis. Riessman's text is crucial in highlighting the fact that plot is an artificial device, a human construct involving subjectivity as well as objectivity. Moreover, underlying any narrative is the possible incompleteness of memories plus reinterpretation of same. In this context, Hinchman and Hinchman (2001) ask:

Is the past something that can be *re*constructed, on the basis of memories, or can it only be *con*structed? [...] Can there be any true stories about the past, or do interpretations as such inherently falsify experience?

(Hinchman and Hinchman, 2001:1-2)[Italic script in original text]

Intentionally or unintentionally, a narrator may alter the plot of a narrative by emphasizing, diminishing, or even omitting specific details. Notably, such alteration may be wholly due to the influence of memory, whereby some events are rendered more vivid whilst others are forgotten. As Carr (1986) explains, a storyteller can make a 'selection of all the events and actions the characters may engage in'. However, in the context of an interview, as cited above, a narrator's concept of plot *may be of fundamental importance.* Narrative analysis may be concerned not only with the 'raw facts' of the data, but also in the way the narrator perceives his or her own experiences. Therefore, study of this process, an integral part of personal identity, will be one of the central tenets of this thesis. However, in keeping with the observations on causality, there is a significant risk that a researcher will believe plot to exist where it is, in fact, absent. In consequence, they may pore through data in search of same; moreover, there is a possibility that even the most tenuous of links between events will be over-exaggerated.

According to its central theme and course as determined by '...the persistence of certain conversational elements', plot can be classified into categories termed *genre* (Riessman, 1993, 18). With reference to this study genre is crucial in that can be applied to experiences of illness.

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7.5: The role of genre in describing the course of a narrative

Also discussing the application of genre by describing commonalities of plot, Gergen and Gergen (2001) begin by identifying three simple forms which are 'rudimentary bases for more complex variants' (ibid, 166). Expressed in terms of good – bad dimensions, these are:

i)   *Stability Narrative* – the course of experiences remains the same. Experiences may remain good, bad, or neutral.

ii) *Progressive Narrative*– the course of experience improves from bad to good.

iii) *Regressive Narrative*– the course of experience worsens from good to bad.

Reproduced in figures 7.1, 7.2. and 7.3, these forms are fundamental in describing change or evaluation over time. Covering all options for evaluative movement, they form the basis for development of more complex variants.

Figure 7.1: Stability Narratives

With reference to trajectory, this model represents three stable states:

Positive stability narrative

Neutral stability narrative

Negative stability narrative

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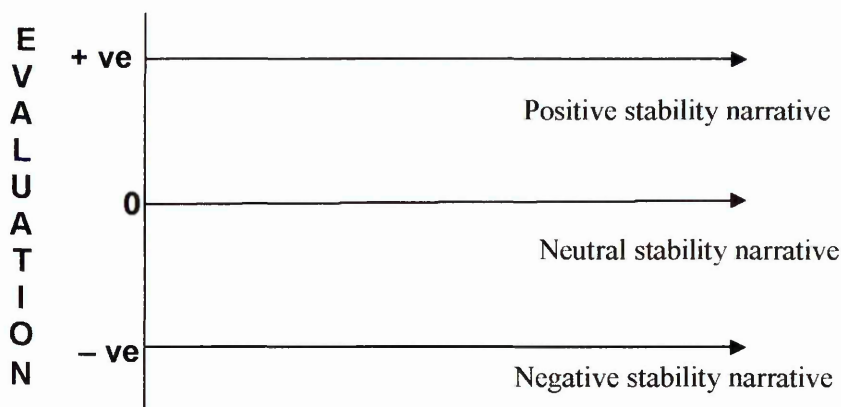
Figure 7.2: Progressive Narrative: improvement
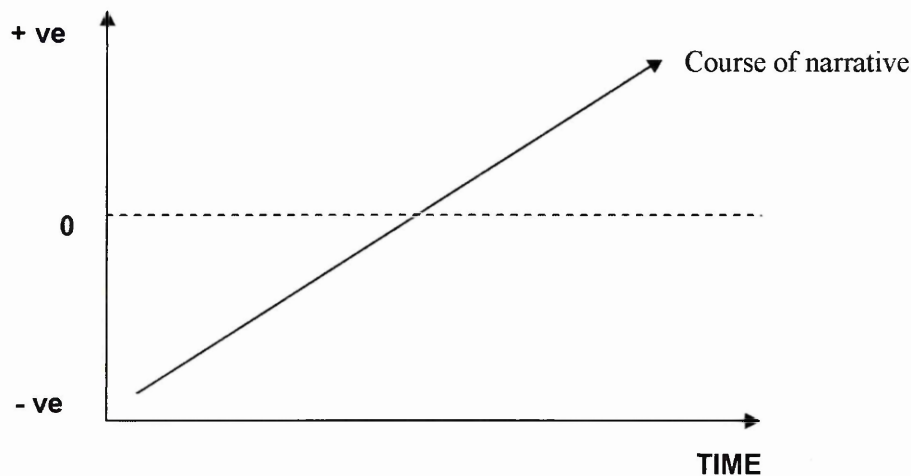
Figure 7.3: Regressive Narrative: worsening
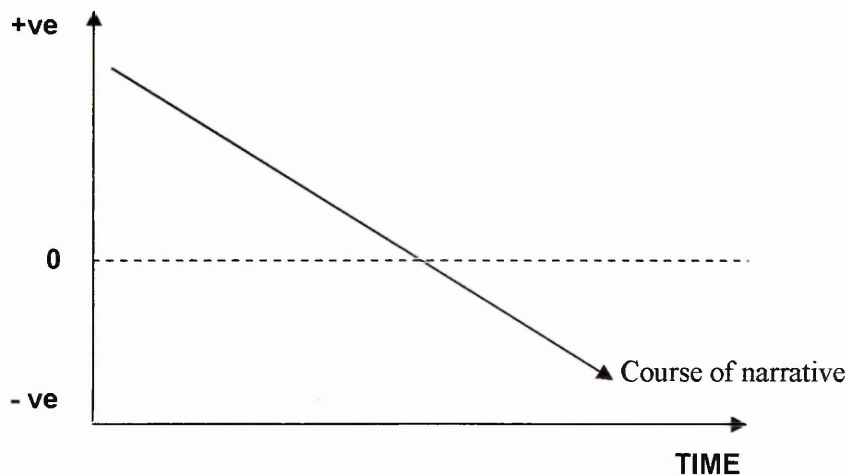
Although the potential variety of combinations is, theoretically, infinite, genre is reduced to four dramatic types with reference to plot (Gergen and Gergen, ibid; Riessman (1993). These are: *comedy/melodrama* (triumph over adversity); *romantic saga* (a series of triumphs and setbacks; *tragedy* (fall into adversity); and *irony/satire* (unexpected outcomes). However, far more relevant to this study are named narrative types that describe the trajectory of illness, for example Frank (1997) and Charmaz (1997). Also associated, by virtue of being nested narratives contributing to plot, are descriptive terms such as psycho-spiritual overwhelm (Breggin, 1993); 'phoenix' and 'epiphany' (Frank, 1993); 'failed narratives' (Labov, 1997); 'aspiration and victory' (Kleinman, 1988); 'disruption' and fragmentation' (Rimmon-Kenan, (2002); and 'broken narratives'

(Hydén and Brockmeier, 2008; Frank, 2008). These are sufficiently important to merit examination later in this chapter.

7.6: Application of named types of narrative in analysis

With reference to the four genre forms noted by Gergen and Gergen, also Riessman (above), it is stressed that these are archetypical, therefore they have little use other than in basic description. Nevertheless, the basic concept of genre; that of naming narrative types, proved extremely important in developing my own interpretations of narrative trajectory. To begin, I felt that I needed to develop a generalized system wherein important nested narratives could be scrutinized. In this context, and deriving from the terminology employed by Linde (1997, 283), I decided that I would name a complex nested narrative detailing a series of events a *'significant narrative'* to indicate its importance within the personal narrative. Thereafter, I preferred not to speculate overmuch. Instead, in order to gauge the possibility of impact on personal identity, I looked for a means of retaining an awareness of a significant narrative as *an integral part of the personal narrative.*

7.7: Development of narrative constructs to show influence of significant nested narratives

7.7.1: Imagoes

As noted in Chapter Three, 'imago' is the term applied by McAdams (1993) to describe 'the characters that dominate our life stories'. Whilst obviously influenced by Jungian psychology, the author is at pains to explain that imagoes are *not* archetypes (ibid, 133). Instead, suggesting that they are formed in early adult years, he explains that imagoes are an interaction of social roles with divergent aspects of the self. Thus it follows that they are aspects of the subjective self, that reflexive part of our awareness that acknowledges our role in the on-going events of the personal narrative. Under normal circumstances, imagoes co-exist in interactive flux as explained in the following extract:

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> With maturity, we work to create harmony, balance, and reconciliation between the often conflicting imagoes in our myth.
>
> **(McAdams, 1993,123)**

Thus it follows that, in narrative terms, an imago is a *significant narrative* within the personal narrative. Within a personal narrative an individual may possess many imagoes, each an internalized concept of their self relating to an aspect of their life. McAdams (ibid) explains that, although imagoes can be classified according to agentic and communal types, they are unique and personalized with reference to and aspect of identity. To illustrate this, I use myself as an example:

> Ray – as – husband (lover)
>
> Ray – as – father (care-giver/teacher)
>
> Ray – as – eldest son
>
> Ray – as- friend/member of the local community (humanist)
>
> Ray – as – PhD student (academic)
>
> Ray – as – house-owner/country-lover
>
> Ray – as – user of health services

At certain times, one particular imago may become dominant. For example, as I write and rewrite these words, the Ray – as – PhD student is most active. Later, when work is finished for the day, another imago (though not necessarily) may become dominant. In this context, McAdams (ibid) notes that:

> Our life stories may have one dominant imago or many. The appearance of two central and conflicting imagoes in personal myth appears to be relatively common.
>
> **(McAdams, 1993, 122)**

The relevance of imagoes to this study is obvious. In keeping with the nature of the personal narrative, they are in a state of constant flux and reinterpretation. Moreover, new imagoes may be generated as a consequence of significant events. Such an imago could be positive or negative: for example, positive imagoes might be a result of graduation or marriage; negative imagoes could result from prolonged unemployment or divorce. This observation leads to a

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vexed question of the precise limits of an imago, especially whether or not a narrative is sufficiently significant to be considered as such, and whether or not a narrative is sufficiently distinct from other narratives.

The latter problem can be partially resolved by applying the agentic and communal categories named by McAdams, for example, 'counsellor' and 'caregiver'. The former problem is much more arbitrary; being dependent on both an objective and a subjective assessment of content and duration. To explain this, it is necessary to provide examples. If I enjoy a fortnight's holiday in a foreign country, then although I would view this event as a significant narrative, I would not consider myself to have generated a 'tourist imago'. Similarly, if I am ill for a month due to influenza, then I would not consider this event to have generated an 'illness' imago despite it being a significant narrative. On the other hand, if I travelled the world for one year or more, then I would view my identity as including a temporarily dominant 'backpacker' imago. Similarly, as indicated above, I view my on-going illness, which has persisted for years, to have generated a 'user-of-services' imago.

Thus, in summary, a personal narrative includes one or more imagoes, each of which is a significant narrative. In keeping with previous detail, it follows that an imago will likely contain many nested narratives. In addition to imagoes are other significant narratives which are lesser due to insufficient content and/or duration. However, under normal circumstances, *all narratives,* including imagoes and these lesser significant narratives, interact to create balance.

7.7.2: The 'balanced narrative'

In the to and fro of daily life, we encounter many trivial events. Examples of these are designated arbitrary values in the 'Hassles and Uplifts Index' developed and revised by Kanner, Lazarus et al in the 1980's (Cooper and Dewe, 2004). 'Hassles' were described as 'experiences and conditions of daily living that have been appraised as salient and harmful to the endorser's well being'. 'Uplifts' were defined as the exact opposite – 'experiences and conditions of daily living that have been appraised as salient and positive or

favourable to the endorser's well-being' (ibid, 46 – 47). In all, 117 hassles and 135 uplifts were used to make up the Index in 1981. Thus this is peculiarly instructive in two ways. Firstly, it indicates the sheer number of nested narratives that may exist at any one time, whether important and trivial. Firstly, it appeals to a common-sense view of personal narrative in that alongside a significant nested narrative, such as severe illness, minor events can still occur (a simple example is a visit from relatives). Secondly, it indicates the sheer number of nested narratives that may exist in a personal narrative at any one time.

If one extends this construct to cover a long period of time, it follows that the number of nested narratives and interactions between them can be huge. Therefore, I submit that to portray the personal narrative as a straight line against time is inadequate. Instead, I use a band spanning positive and negative values either side of a central axis on shown in Figure 6:1 below. This diagram enables an assumption that the *overall value or rating* of the personal narrative is *neutral*. Accordingly, I term this type of narrative a *balanced narrative*:

Figure 7:4. **Personal Narrative drawn as a band containing positive and negative values: a *Balanced Narrative***
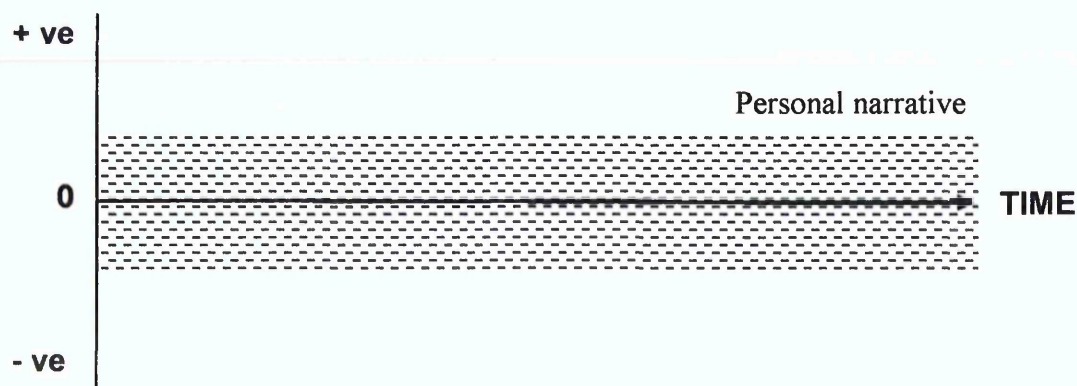
The personal narrative is shown as a band spanning an axis of neutral value. Each short line in the banded narrative represents a short-lived nested narrative pertaining to a minor positive or negative event, such as those detailed in the Hassles-Uplift Index.

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The balanced narrative is the most important of my constructs in that it enables the activity of *any chosen variable* to be shown in terms of *a nested narrative* with respect to *the personal narrative.* To illustrate this, I choose two trivial examples: one pleasant and the other unpleasant (or, better, stressful), namely a visit to a cinema and a dental appointment to have a molar filled. Both events can be shown as a short, discrete nested narrative as shown in Figure 7.5:

Figure 7.5: **Balanced Personal Narrative showing specific positive and negative nested narratives**
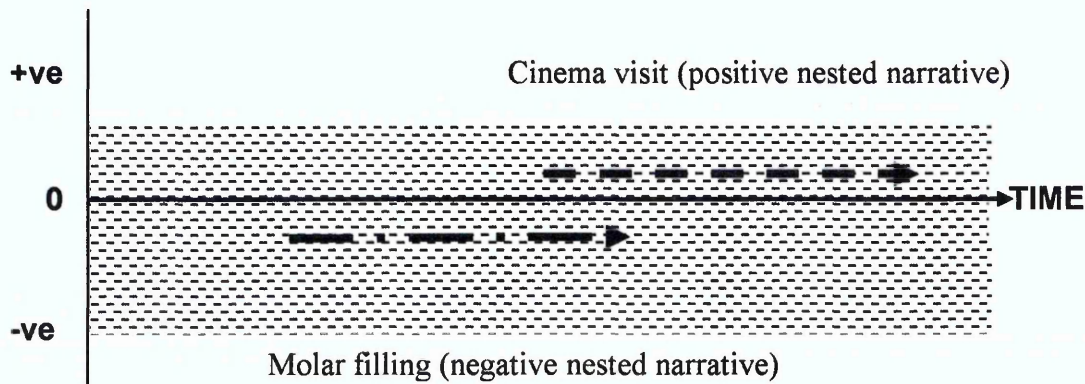
For the purposes of development this series of diagrams, the balanced narrative remains neutral. In this context, it is important to recognize that less significant nested narratives, as shown by the short lines, continue to occur.

Up to this point, my development has been straightforward. The next stage explores the possible impact of a *significant narrative.*

7.7.3: Impact of significant narratives upon the personal narrative

In contrast to the 'Hassles- Uplifts' Index is the *Holmes-Rahé Social Readjustment Scale,* devised by Thomas Holmes and Richard Rahé in 1967. Based on data from 5,000 patients, the authors attempted to qualify and quantify 43 *major* life events (e.g. divorce; loss of job; serious personal injury or illness) in terms of stress value. However, as reported by Cooper and Dewe

(ibid, 45) this has largely fallen in disrepute because of various perceived failings related to over-generalizability. Most prominent of these was the unanswered question of:

> ...whether it is the objective presence of life events that should be the focus of interest or the person's appraisal of them as being stressful.
> **(Jones and Kinman, 2001:24 [quoted by Cooper and Dewe, 2004:45)**

Although the Holmes-Rahé may not be useful for analysis, it serves as an indicator of significant narratives. Also, the objections above are highly pertinent in that they stress that any narrative pertaining to an event is dependent not only on the nature of the event itself, but on the person's reaction to same. That is, a person's reaction may be directly proportional to an event; or that may over-react, or that they may under-react. Thus significance of a narrative may depend more on personal reaction than the event itself. In turn, this leads to the question of dominance: that is whether or not a narrative can become sufficiently significant to dominate other narratives within the personal narrative. This possibility has already been established in principle concerning the interactions between imagoes (see above). It follows, therefore, that reactions between significant narratives can follow a similar pattern if the combination of content and reaction is of sufficient import. To illustrate this, I choose an example from the Holmes-Rahé Scale, namely 'Fired at work'. The reason for choosing this example is simple: in that it is not directly related to the research question, I will avoid any charge of prejudice. Moreover, it illustrates a narrative that, if long-term, will gradually affect the entire personal narrative, even generate new significant narratives. For instance, it is logical to believe that long-term loss of employment will cause financial problems, loss of self-esteem, possible relationship problems, and so on. In this way, it is possible that a significant narrative may become both more substantial and more complex. The overall effect is to *displace* the personal narrative in a negative direction as shown in Figure 7.6:

Figure 7.6: **Personal Narrative drawn to show persistent dominant narrative e.g. loss of employment.**
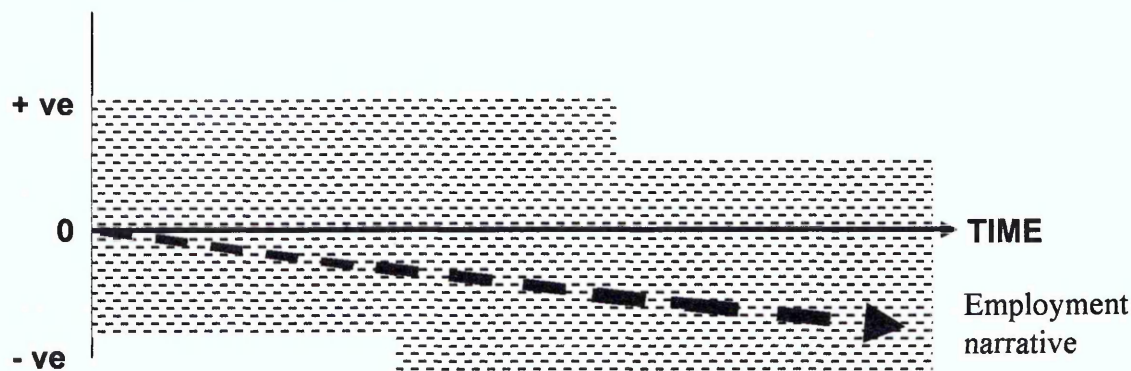
The humdrum events of daily life, as shown by the short lines, continue. Gradually, the employment narrative becomes dominant and displaces the balanced narrative in a negative direction

Once the concepts of significance and dominance are established, they can be realistically applied to all narratives. In doing so, it can be shown that dominance *may be almost entirely due to the reaction of the person as opposed to the objective content of the narrative.* For example, concerning the visit to the cinema as cited above, I assume that the film is of sufficient quality to hold the viewer's attention *and concentration.* Similarly, concerning the visit to the dentist to have a molar filled, I assume (and compare with my own experience) that *virtually my entire concentration* will be given to the process. Moreover, it is reasonable to assume that both experiences will include a degree of anticipation and, probably, continue afterwards: imagery of the film will remain fresh in iconic memory, whilst the filling may remain painful. Therefore, the impact of *both* examples within the personal narrative will, in the main, be as follows:

Objectively: all nested narratives within the personal narrative continue their course unaffected by the course of the temporary pursuit.

Subjectively: all other nested narratives are *virtually forgotten:* evaluation is suspended during the course of the temporary narrative.

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Thus, *objectively,* the temporary nested narratives have little impact on the balanced personal narrative. However, *subjectively,* the same narratives detailed *dominate* the personal narrative during their course whilst all other aspects of the personal narrative are *subordinate.* Accordingly, I designate a cinema visit as a *positive dominant narrative* and a visit to the dentist as a *negative dominant narrative* as shown in figures 7.7 and 7.8:

Figure 7:7. **Personal Narrative drawn to show positive dominant subjective narrative e.g. cinema visit**

The visit to the cinema is a short-lived *positive dominant narrative.* During this experience, other nested narratives may remain active but they will be temporarily forgotten by the person
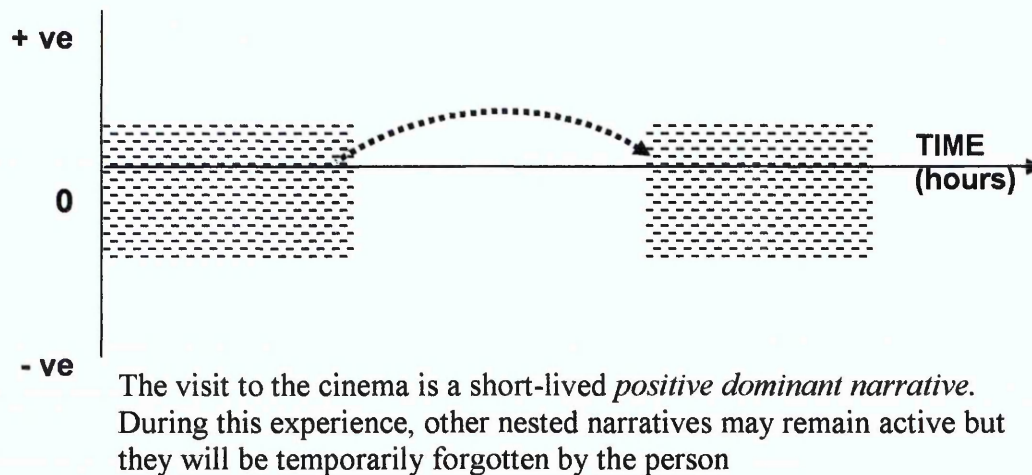
Figure 7:8. **Personal Narrative drawn to show *negative* dominant subjective narrative e.g. molar filling**

The visit to the dentist is a short-lived *negative dominant narrative.* During this experience, other nested narratives may remain active but they will be forgotten by the person. N.B. Although I have shown the course of this narrative as a curve, it may continue as a significant negative nested narrative if discomfort persists

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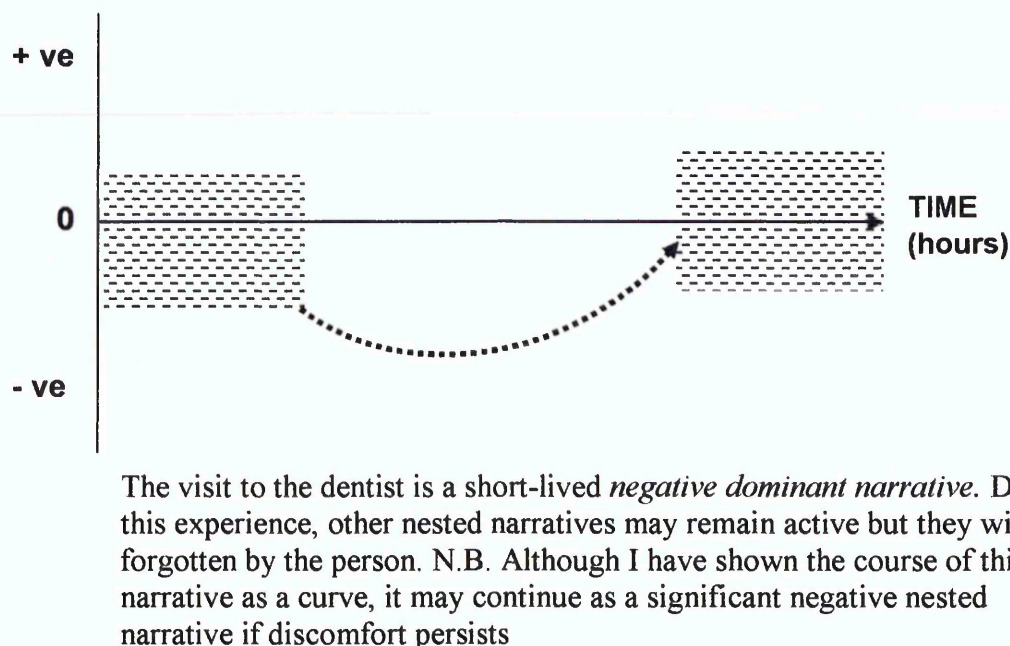
7.7.4: Named genres of illness

In his text *The Wounded Storyteller* Frank (1997) uses the central monomyth of Joseph Campbell (1949) as described in Chapter Three. To reprise, the monomyth describes the person as a hero, the central character engaged on a journey to discover an ultimate truth. Applying the experience of illness to this construct, Frank develops three types of narrative:

i) *Restitution:* This is based on the concept that illness is curable, that a person can regain health.

ii) *Chaos:* This is the opposite of restitution in that illness is acknowledged as incurable.

iii) *Quest:* Of the three types, this is closest to the central monomyth in that it approximates to transcendence, whereby the experience of severe or terminal illness leads to the discovery of knowledge and understanding.

The approach of Charmaz (1997) differs from that of Frank in that she uses narrative types with specific reference to chronic illness:

i) *Interruption:* the sufferer expects that they will eventually recover. This level differs from the others. Thus this can be compared with a restitution narrative.

ii) *Intrusion:* persons accommodate symptoms and treatment, and learn to plan their lives accordingly. Thus it is possible that the degree of intrusion will be mediated.

iii) *Immersion:* the severity of the illness is sufficient to necessitate prioritization. Of the three types, this is the closest to a chaos narrative. Associated with immersion, Charmaz describes *transcendence:* a process of re-invention, of discovering new feelings, and re-interpreting the illness experience. As such, this echoes Frank's quest narrative.

The first type, the *interruption narrative*, differs from the other two types in terms of duration by virtue of being finite. Therefore, strictly speaking, it should be applied to an *acute illness* as opposed to a *chronic illness*. Types (ii) and (iii), the *intrusion narrative* and the *immersion narrative* are both chronic, i.e. recovery is not expected. The difference between them is in terms of severity: it follows, therefore, that the boundary between the two types will be indistinct.

7.7.5: Named genres of illness as significant narratives

Whilst the narrative types named by Frank and Charmaz are highly informative as devices for discussing general narratives of illness, they are far too restrictive for extensive use in analysis. The reason for this is simple: following coding and reconstruction, there would be an attempt to 'fit' a respondent's narrative into one of the named types. However, it is obvious that the principle of illness narratives is far too useful to discard. First and foremost, *they are significant narratives in their own right*: as such, they possess the potential to become dominant within the personal narrative. Thus, discussion returns to the issue of imagoes; specifically, whether or not a significant narrative can become of sufficient import to be considered an imago. To meet this, it is helpful to consider the possibility of illness as a dominant narrative.

7.7.6: Illness as a dominant narrative

To illustrate this possibility, I use a generalized example based on combining Charmaz's (1997) constructs of illness as interruption, intrusion and immersion with Frank's (1997) restitution narrative. As explained earlier, the degree to which a narrative is significant depends upon a combination of content with duration. Thus it follows that the most potent of Charmaz's constructs is *immersion*: that state of illness requiring prioritization. Associated with this, it follows that the longer the duration of immersion, the more likely the possibility of the illness narrative becoming dominant. Thereafter, the question of whether or not the narrative becomes an imago is, to some extent, dependent upon a combination of personal persuasion and social conventions. As explained in Chapter Four, 'labelling theory' is a process whereby narratives deemed to be

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abnormal are identified by labels, often pejoratively so. Thus, by these means, the creation of complex process. In theory, I can reject the label of 'mentally-ill person' in favour of 'user-of-mental-health services'; nevertheless, I find myself unable to do so. Therefore, in an attempt at compromise, I use both: the imago can have two names without contradiction.

Finally, in this section, I return to the strength and duration of imagoes as discussed above. In the event of recovery from illness, it follows that the illness narrative will become less significant. Accordingly, the imago will also come to a logical end, to persist only in memory. In such instances, the overall trajectory of illness would be shown as *interruption* despite including a period of *intrusion,* followed by *immersion* (Figure 7.9).

Figure 7.9: To show interruption of the personal narrative by a dominant illness narrative

INTRUSION   IMMERSION   INTRUSION/RECOVERY
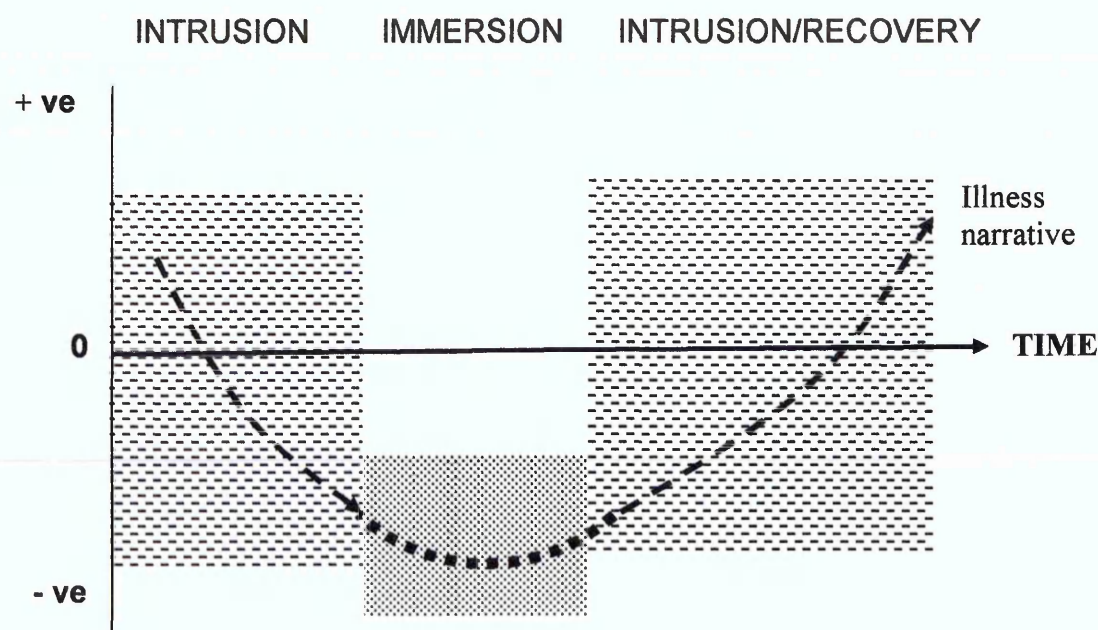
As the symptoms of illness worsen, so the associated nested narrative becomes dominant until it is sufficient to severely displace the entire personal narrative as shown by the position of the patterned areas. This complies with Charmaz's (1997) construct of *illness as interruption*: initially the illness *intrudes*

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into the person's life then, as symptoms become severe, the personal narrative is *immersed*. Notably, minor events continue to be a part of the personal narrative (as shown by the short lines); however, the frequency and import of these will be reduced when the illness narrative is most dominant, i.e. immersion. Later, as the symptoms of illness lessen and the person recovers, immersion ends as dominance decreases. The person then enters another period of intrusion before final recovery. This entire process is in accord with Franks' (1997) construct of a *restitution narrative*.

7.8: Identifying significant narratives in analysis

The four levels of coding represent a deconstruction of the data into significant narratives. After consideration, I have decided not to append titles to these on the grounds that the first three levels are intermediate, their purpose being the identification of relevant passages for differentiation into 'idea units'. Concerning these, I feel that the subject matter of each, being a discrete narrative, is sufficiently self-explanatory without the need for a title.

7.9: Application of narrative diagrams

The following three chapters will explore, in order, the prologue, overwhelm, and recovery stages of the narratives of the nine respondents. Within each chapter, the concepts of significant narratives will be applied to inform and summarize their experiences. Concerning these, I found after experimentation that the best results were obtained by using one diagram for each respondent. The reason for this was simple: if I attempted to show more than one narrative then the resulting diagram was too cluttered. Also, I wish to stress at this juncture that the diagrams are intended to be a *representation* of narrative trajectory as opposed to a *wholly accurate reproduction*. In particular, it is obvious that a narrative does not proceed in straight lines: instead, it will show minor fluctuations in response to positive or negative events. Lastly, the narrative diagram is not intended to be the whole of the final product, but to enhance understanding and appreciation of the particular stage under review.

7.10: Conclusion: perception and coherence

Central to the discussion in this chapter is the concept of narrative in terms of a coherent structure. Integral to this are concepts of causation associated with evaluation of events. However, it should be stressed that unstructured interviews, such as those conducted in the course of this research, are comparatively undisciplined. Instead of an ordered catalogue of events in chronological order, a typical interview contains asides, repetitions, abrupt change as something overlooked is suddenly remembered, and so on. Rather than mediate these trends, my role as interviewer often exacerbated them: this was due to a perceived need to ask a question, or request clarity. Therefore, to obtain a viable personal narrative of a respondent, it was often necessary to 'cut and paste' sections of data. This exercise was mandatory in the event of a second interview, wherein data would often, at my request, reprise an event in greater detail.

Nevertheless, this procedure did not alter the data or its context in any way. Instead, I termed the end product as 'Final transcript' or, in instances where a respondent was interviewed twice, 'Final combined transcript'. With reference to the latter, portions of text were labelled (1) or (2) according to the transcript from which they were taken. For the purposes of cross-case analysis, these were then reduced by removing data deemed irrelevant and/or superfluous to the research questions. In this way, 'Reduced transcripts' suitable for division into the three stages of illness – prologue, overwhelm, and recovery – were produced. These form the subject matter of the next three chapters, following which there will be discussion on the integrated findings.

Chapter Eight: Before it all began: prologue

8.1: Introduction: before experience of mental illness

This chapter explores the prologue: that part of the interviewees' personal narratives before the first onset of phenomena diagnosed as mental illness sufficient to cause overwhelm. Appearing in the order that they were interviewed, the narratives are presented in the format of 'idea units' as described in Chapter Six. Concerning this, it is important to stress that this form of reduction is *not* intended to represent the inflections and pauses made by the speakers: these are indicated as detailed on page 149. Instead, it enables emphasis of important events within a narrative. Thus, for the purposes of demonstration, the concept of idea units can be explained thus:

> The purpose of idea units
> is to separate and emphasize
> important events
> within a section of narrative.

Thus all data have been analyzed through the four levels of coding detailed in this chapter. Concerning these, I stress that an integral part of fourth level coding was to append notes alongside individual idea units. However, in the interests of space, and to avoid possible confusion, these are not included in the examples of text provided. Similarly, it is not possible to include long extracts of coded data. Instead, the process of coding data is shown in full in Appendix III.

For reference purposes an introductory comparison of the nine prologues is shown in Table 8.1 on the following page. The main purpose of this table is to

summarize the entire personal narratives of each of the interviewees up until the time when *overwhelm was imminent*. However, an essential part of this procedure is that *it avoids the wisdom of hindsight.* Although it is possible to speculate that some of the interviewees knew unhappiness and even a sense of strangeness, it is *certain* that they were not aware of the coming onset of overwhelm. As will be shown in the next chapter, this is because the very nature of overwhelm is that it is, once initiated, unstoppable. Accordingly a prologue, no matter how compromised by negative dominant narratives, should be viewed as continuing until the mental health narrative becomes dominant.

In the course of analysis and discussion, I produced a narrative diagram for each of the nine prologues. However, in the interests of continuity and space, these are not included in this chapter. Instead, examples are included in Appendix IV.

Table 8.1: Comparison of prologues: personal narratives

Name	Sex	Age at onset of overwhelm	Employment Status	Possible Complicating Factors	Personal Narrative
Mr. CBA	M	20 – 29	Professional	i) Loneliness ii) Drug use (Cannabis) ii) Pressure from family re employment iii) Immaturity (*stated)*	Slightly negative
Dorothy	F	20 – 29	Student	i) Social difficulties esp. with 'boys' ii) Overworking (?)	Slightly negative; more so than Mr. CBA
Mr. K.	M	Late Teens	School leaver	None apparent	Even, Balanced
Eddie Hooper-Smith	M	20 – 29	Professional	University life (+ve) Drug use (Cannabis)	Even, Balanced
Mr. P.	M	30 – 39	Various unskilled	i) Childhood infirmity ii) Low status in family iii) Withholding of emotions iv) Bullying due to speech impediment v) Relationship (+ve)	Childhood negative then even in adulthood due to relationship
Anita	F	Late Teens	Various skilled	i) Sexual abuse by father ii) Rejection by mother iii) Repressive early childhood iv) Taken into Care (age 10) v) Sexually abused in Care v) 'Living rough'(Age 15)	Childhood strong negative; improving in adulthood but dominant narratives persist by virtue of memory
Anne	F	20 – 29	Professional	i) Career (stressed +ve) ii) Relationship (ve+) iii) Drug Use ('skunk')	Positive due to work and relationship
Sandra	F	20 – 29	Student	i) Dysfunctional family background due to father (bipolar disorder) mother (depression) ii) Death of friend iii) Death of close friend's mother iv) Social difficulties at university v) Drug use (Cannabis, LSD)	Negative due to stated problems with family; also social isolation
Mr. Gwent	M	50 – 59	Professional	None apparent	Even, balanced

8.2.1: Mr. CBA: isolation and black periods

Mr. CBA has known both June and myself as friends for many years. After speaking concerning the present, Mr. CBA spoke of his years at university. By far the most significant theme of these was an inertia bordering on loneliness. He found coursework difficult and coped as opposed to prospered. Thus the social pursuits associated with university life were of great importance.

> I didn't like it.
> I didn't like it.
> I just scraped through
> with the minimum amount of work.
> You know, I just had a great time at University
> and the work was sort of a...
> sort of ... Nuisance.
> I had probably the best time of my life
> but I didn't do any work.

In the second year of his course, Mr. CBA lived alone. In that he describes feeling 'isolated', I speculate that he may have felt lonely. The following passage is a summary of all three years of his course: notably, he describes his happiness with his girlfriend in the third year:

> Um...There were black periods to be honest.
> [....]
> The crowning glory was the last year
> where I had a steady girlfriend,
> I'd found my feet,
> and I knew
> I was going to get some sort of degree,
> that was great,
> but the first year I realised
> I wasn't going to make an honours degree
> and ...The second year I felt-
> I lived out,
> which was a stupid thing to do,
> and I felt very isolated.
> So it wasn't three years of fun
> but the last year was glorious.

In my *fourth level coding* I made the following observations:

i) An overview of Mr. CBA's university career suggests that he was often lonely and unhappy ('Black periods'). With reference to his putting in a minimal amount of course work, the impression gained is that this was due to the difficulty of same as opposed to an active choice. Accordingly, course work should be regarded as a source of stress, a constant reminder of a difficult target.

ii) Although living alone was a choice, it was obviously a mistake.

iii) The reference to a single long-standing relationship, (i.e. steady girlfriend in the final year) is instructive from two points of view. Firstly, Mr. CBA's final year was a happy one in which he gained self-esteem and a sense of direction. Secondly, he may have felt his solitude in the first two years acutely.

Mr. CBA became engaged but, unfortunately, this was short-lived. Thus, in terms of an unhappy conclusion to the above extract, this will probably have impacted considerably on his self-esteem. Thereafter, his life seemed to 'drift' into a career amid a stated need to prove himself to his family:

You've got to do something with-
I mean, I had to earn a living
and get on, you know, that's-
I really didn't want to live at home,
so big, big impetus to retain my independence, yes...

(Ray:) So how did you see yourself at that time?

(Sigh)..........I felt there wasn't-
I didn't have very much emotionally or anything.

In addition to being lonely, Mr. CBA was compared unfavourably with his brother concerning academic and post-university achievement. Also, as detailed below, he was obviously unhappy in his work: thus it is probable that his self-esteem remained very low at this time.

I was too young and too immature.
I should never have been in the job.
I'm not being modest,
I shouldn't have been in it.

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This detail led to the following observation in my *fourth level coding*:

> Despite an apparent desire for a quiet life, Mr. CBA seems to have been beset by stressors. He was obviously unhappy in his work, he was lonely, plus he was compared unfavourably with his brother.

This extract is the last in Mr CBA's prologue. After an unhappy spell in his first post, he changed careers and, gradually, became withdrawn. This was the beginnings of illness that would lead to overwhelm. After some consideration, I view his personal narrative at this stage as slightly negative due to a complex of negative significant narratives of loneliness coupled with low self-esteem. Concerning the factors involved in Mr. CBA's narrative, it is essential to recognize that loneliness, low self-esteem or, indeed, any stressor is *not necessarily an indication of on-coming phenomena diagnosable as mental illness.* Instead, they should be regarded as phenomena in their own right, an aspect of his personal identity.

8.2.2: Dorothy: feeling left out and different

Dorothy has known my wife, June, as a colleague in mental health user activity groups for many years and also as a personal friend. She has known me for about the same time but not nearly as well. The interviews took place at Dorothy's home. Initially, the first interview was traumatic for Dorothy as she spoke of the hurt and frustrations associated with her on-going illness. Then, as she warmed to the overall subject, she spoke quickly and at length, reminiscing upon many periods in her life. From my own point of view, interviewing was difficult due to trying to keep up with this flow whilst formulating possible questions that emerged. In two interviews, Dorothy did not always maintain a linear narrative, instead making reminiscences that had recurrent themes. However, unlike Mr. CBA., the prologue contains many references to childhood:

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........what Dad used to say.
[....]
'You've got to learn in this life
that you don't get pats on the back
every time you do things right.'
So obviously I sought reassurance back then –
I think if somebody is born
with a natural sensitive disposition
then events that follow on from that
impact a lot harder.
It's the meaning you attach to events.

In my *fourth level coding* I noted that:

This extract is of supreme importance in that it sets the tone for Dorothy's
personal narrative, i.e. she feels driven to prove herself. This is complicated by
her stated impression of 'feeling different' as detailed in the following extract
from **Interview 2:**

I think I felt different
even in High School.
And that even though
we had a good laugh at my school –
and that was a *girls' school   (Dorothy's stressing)*
and I had a solid group of friends
that I'm friends with now
all these years later.

Yet Dorothy stresses that although she was friends with others, she was less
certain that they were friends with her:

So all through school,
I didn't have one particular best friend.
[....]
I would generally be able to socialise,
because I was a quite sociable... person...
with the naughty kids, the naughty group.
And the shy group, and the shy thick group-
[.....]
I think I put more weight into the times
I spent being a best friend to somebody than they did.

Also important is an overall impression gained during the interview that Dorothy
was a sensitive child who disliked change. However, in childhood and
schooldays, change is inevitable:

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there was a few boys *[sic]*
from the local Boys' School up the road
who came to the Art Department for a taster class-
[.....]
Well, I couldn't handle it-
It was horrible,
having those boys in the Art class.

Guardedly, I submit that the above extract describes a pivotal event in Dorothy's personal narrative in that it represented a disruption of her environment. Although she spoke at length about subsequent events and her associated emotions, I feel that the following passage provides the best summary of these. Given her stated comments about writing a journal, it is possible to speculate that she was often suffering greatly.

I think I wrote it if I was distressed
and something had affected me.
That's what it seems to be-
more than just a reflection on the day.
Like one of them starts-
This is about feeling like my friends
and feeling left out
and feeling different-
[.......]
And it's all about me
feeling completely emotionally and mentally left behind

Although Mr CBA did not speak of his schooldays, I felt that there was a similarity between Dorothy's expressed unhappiness and his description of 'black periods'. Moreover, it is incumbent that I declare similar feelings of isolation and 'difference' prior to my first illness at the age of 17. Thus it is was probably fortunate that university life marked the possibility of resurgence, a new dawning of opportunities for Dorothy:

I was so nervous about going,
that far away from my family,
I thought, 'Right, I can be whoever I want to be
and I'm not going to be shy
or nervous any more.
I'm going to be..... sociable.'
[.....]
and we formed a close-knit group straightaway.
There was only four girls on the course
out of all men because it was an [----] course *(details given)*

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so there was very few women
and we shared a bedroom
so we formed a close-knit group right from the word 'off'.

As noted above, I felt that Dorothy prospered because the close-knit group would be, in the sense of same-sex friendship, reminiscent of her schooldays. In the summer, she decided to remain on the university campus. However, old problems began to resurface:

And... I had quite an enjoyable first year
but then in the <u>summer</u> a few of us decided
that we were going to stay down on the campus-
we were allowed to stay there
and <u>work</u> during the summer holidays
[....]
And I got a job as a chambermaid-
But at the same time
I would not go in the café
and socialise with the other girls   .
because there was boys in there- um
... I was just a socially nervous wreck.
[....]
I was awful- like a social phobia,

Dorothy also took on work in a supermarket and in the Student's Union Bar. Concerning this, the obvious observations are that her motives were financial and that she risked tiredness through overworking. However, I speculate that she may have felt driven to compensate for the anxieties caused by her 'social phobia'. Also, other symptoms had begun to manifest that suggest 'highs' and 'lows':

I was working the bar and I was-
And I was- I remember doing the tables
and I was <u>knackered</u> and exhausted
and other times I would be full of beans,
absolutely full of beans
but then on the nights I was exhausted
[....]
it... it was a very old building.
And I felt like the trees
were all conspiring against me
and I was absolutely <u>scared</u>
walking home from the bar late on,
on my own back to my room.

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With reference to Dorothy's expressions of fear, I am reluctant to speculate overmuch on these, preferring to view them as understandable given that she was alone late at night. Nevertheless, the demands of her various pursuits were undoubtedly considerable: in the second year of university, the combination of these with those of her course began to cause serious problems. Therefore, I conclude her prologue at this point. Although her personal narrative includes several significant narratives, all appear to focus on unease in social circles. Accordingly, I view this as a negative dominant narrative that displaces the personal narrative. As described above, this fluctuated accordingly to later schooldays and the problems during the first summer at university (above). Like the diagram pertaining to Mr. CBA's personal narrative, it is important to recognize that the phenomena described should be viewed as pertaining to Dorothy's personal identity. Despite any indications or 'warnings' of impending overwhelm, this is *all* that can be safely stated at this stage in her narrative. Notably, other than interpreting her shyness as 'social phobia', *she made no mention of suspecting illness at this stage*. In this context, I regard feelings of 'being different' as a frequent and unfortunate aspect of adolescence.

8.2.3: Mr. K.: no dominant negative narratives

Mr. K. spoke on many subjects in his one interview, giving his views on many aspects of user involvement politics, psychiatrists, the mental health system and so on. However, this was often in a generalized sense, as opposed to specific topics. Indeed, the *only mention* of his life prior to overwhelm was a relatively fleeting reference to his early childhood in the context of racial prejudice. In the interests of uniformity of discussion, I include parts of this extract:

> Let me give you an example-
> as me being an Asian,
> [......]
> Went to school,
> all white friends,
> at the High School-
> all white friends, played with white friends,
> really good, miss them a lot.
> Hopefully I will go on Friends Reunited to catch up.
> Just to say that when I was in *Hospital B*
> there was a nurse called *Nurse A*.

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She was shocked!
"How do you know all that?"
"Because your brother was in the same school as me,
the same High School as me,
same class in primary school as me.
That was a good attitude-
up here you know I didn't feel racism …
Went to Bradford
which has a large Asian,
Black African people and white.
You would think that the Asian …
Walked down the street
and someone called me a racist name, racist abuse.
You say that my attitude changed
if that makes sense.
Because in a way that I didn't know
I'd never experienced that sort of thing in my life.
Shocking.

Ostensibly, this presents a problem with regard to the presentation of the prologue of Mr. K.'s personal narrative. Against this, I posit that it *is the very lack of data that is significant.* Unlike Mr. CBA, who cited a form of loneliness; and Dorothy, who describes difficulties in mixing with other people, Mr. K. seems to have had no significant problems whatsoever. Obviously, I acknowledge that this is speculation. Nevertheless, I suggest that Mr. K.'s early personal narrative was a balanced narrative in which there were no dominant narratives (other than the usual ones of family, friends, school, money and so on). This includes the fact that he reported no significant instances of racial prejudice until his visit to Bradford.

8. 2. 4: Eddie Hooper-Smith: achievement, experimentation and speculation.

The interview with Eddie Hooper-Smith differed markedly from the previous three in that he had prepared a written narrative to accompany the interview. With hindsight, I feel that this influenced the flow of the interview in that he concentrated much on the period of overwhelm and recovery but said little of a prologue. However, like Mr. CBA, he spoke of his university days. Also like Mr.

CBA, he mentioned cannabis, though more directly as a possible cause of mental illness.

Eddie's account of university life was much more positive than those of Mr. CBA or Dorothy:

> I used to enjoy myself, yes.
> I'd enjoy my cider
> and I used to smoke...
> I used to smoke a bit of cannabis as well
> and people say
> 'that's what's made you ill'
> but I don't know if it is so...
> That's one of the things I have to admit to.   *i*
> It might have caused some trouble.

The use of cannabis as a recreational drug is a vexed issue, particularly if, like Eddie, the user is vague concerning the amounts. I include the following exchange because my question led Eddie to mention a number of possible factors.

> **(Ray:) Do you think that the cannabis did anything,**
> **or do you think it's other things, Eddie?**

> Everything adds up, doesn't it?
> It might have caused some trouble.
> Um.... It's a combination of things.
> Pushing yourself.
> Drinking.
> Probably....
> How you initially, you know, your initial make-up;
> the actual make up of your head.
> Might leave you predisposed to illness.

On balance, I believe that Eddie is describing what many persons would believe to be a 'normal' student lifestyle involving use of drugs and alcohol, occasionally to excess. Therefore, I am reluctant to speculate on the long-term effects of these. Instead, I close his prologue by noting that, later, in the context of overwhelm he explains that he obtained employment after leaving university and that his girlfriend was supportive. Similarly he notes that his parents had had 'high expectations' for him and were supportive throughout his illness.

Thus, although the data concerning the prologue phase of Eddie's narrative are sparse, I feel there is much that can be gauged by induction. The fact that his parents had high expectations for him, and that he attended university, suggests that he enjoyed a successful school career. Thereafter, his description of university life, including the fact that he had a girlfriend, suggests continuing success: despite experimenting with drugs, he was able to complete his degree. This leads me to believe that the prologue of his personal narrative is an evenly balanced narrative across a central axis. Cautiously, I speculate that the entirety of university life was a dominant positive narrative during its duration (I assume that this was three years).

8.2.5: Mr. P.: insulation, suppression and changed expectations

In contrast to the first four respondents, Mr. P. adhered to a chronological narrative in his first interview. Whether or not this was due to the fact that he identified his problems as possibly beginning in early childhood is a matter of conjecture. All that can be stated with confidence is that his self-awareness and recall made this a relatively easy transcript to structure.

> ....although it didn't really appear on the surface
> until I was nearly thirty,
> I actually think it was there in my childhood...............
> I had it in my childhood-
> I think it stemmed
> from being an ill child, physically,
> even the fact
> that I was one of three: *(Note: Mr. P. has two sisters)*
> I was the middle one
> and I was quite protected as a child.
> My mom would stick up for me,
> more so than my dad, but I was still –
> Even my sisters to a certain degree protected me
> in a cocoon if you like,
> from the outside world

Mr. P. explained that this had an effect akin to smothering. In that he suppressed his emotions, his childhood can be compared to Dorothy's with respect to the formation of a negative nested narrative leading to a core belief:

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all the other voices in the household
were more dominant than mine.
I felt as though my voice wasn't heard
So when it came to anything emotional,
I bottled it up.
Bottled it up inside-

When Mr. P. was seven, his father left home to work away. This led to the formation of another negative nested narrative:

although he'd shown a lot of love and affection
before he went away;
suddenly that all stopped.
And I was told that I had to be
the man of the house
and protect my sisters
and look after my mom.

In my *fourth level coding* I noted that:

This sudden change in personal circumstances would have presented Mr. P with a form of paradox whereby he was obliged to behave in an overtly masculine way despite any inclinations to sensitivity (cf. Chadwick, 1997).

Mr. P.'s relationship with his father changed forever:

I never really gained that relationship back
that I lost with him.
[......] We couldn't get emotionally or deeply involved
I couldn't get involved in his emotions
and he couldn't get involved in mine.
Even to the point of-
even when my mom died
We never showed any emotion to each other:
[.......] and that lasted until the day he died.....
And I never really got to show
how much I loved him really

So far, Mr. P. had created the impression of a rather stern, unhappy childhood leading to the formation of negative core beliefs and nested narratives (need to withhold emotion; perceived gulf between father and self). However, obviously aware of this, he was keen to show the other side:

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> ...although I did point out
> the negative side of growing up,
> there was a lot of positives as well.
> I did come from a loving family

The next extracts concern Mr. P.'s schooldays. It is important to note that he has a slight speech problem, which led to bullying.

> I did find it hard mixing at school.
> I've got to admit
> that I only had a couple of friends-
> I didn't have that many.
> the speech problem also put me at a –
> a very disadvantage *[sic]*
> because children can be more cruel
> than adults can
> so you stand out in every way,
> it's a stone in your heart,
> the name-calling and all that
> so I learned very early on
> that I was slightly different to the rest.

Whilst Mr. P.'s self-description is virtually the same as Dorothy's, I posit that the reasons are very different. Whereas Dorothy's problems were broadly centred on adolescence, Mr. P.'s were specific, being derived from his speech problem. Also, his unhappiness will have been exacerbated by the fact that he had learned to withhold emotions (see above). Later, on leaving secondary school, he entered into various employment schemes, then a number of jobs calling for different skill levels. It is relevant to state at this juncture that he is gay and entered into a long-term relationship. However, at this point, his personal narrative shifts focus, gradually descending into overwhelm.

Despite the wealth of data in two interviews, a degree of speculation is necessary concerning Mr. P.'s personal narrative. Perhaps surprisingly, he made no mention of being bullied at secondary school. Since he did not draw any great attention to the early years of his employment (other than sarcastic comments about the Conservative party), it would seem that his life entered a settled period at this point. Accordingly, I feel that this area of his personal narrative is best described as a balanced narrative with – speculatively – a dominant positive narrative concerning his relationship. This is in contrast with

his childhood, which was definitely compromised in his early years by brittle-bone disease then, later, by bullying. Guardedly, I posit that these factors will have been sufficient to displace the balanced narrative. Therefore they are shown as consecutive dominant narratives in a diagram that is more complex than those pertaining to the previous interviewees:

8.2.6: Anita: surviving childhood abuse

Like Mr. P., Anita's interview approximately followed a chronological narrative. Also like Mr. P. her early narrative includes many significant nested narratives, some of which are dominant. These can be summarized as follows:

i)   Childhood abuse by father
ii)   Rejection by mother
iii) Raised by grandmother
iv)   Taken into care when aged ten
v)   Abuse in care home
vi)   Running away from care when aged fifteen
vii) First marriage at sixteen

Associated with these narratives is much data: accordingly, I have selected apposite extracts pertaining to each narrative. First is a stark statement by Anita that sets the tone for subsequent extracts:

> because I was quite... I was a naughty child
> my mom gave me into the care system at ten
> because she couldn't –
> her words, not mine –
> she couldn't cope with me.

The probable reason that Anita was placed into care was abuse by her father and associated rejection by her mother:

> my paternal father abused me......
> So that was my first experience of abuse,
> with my paternal father.
> And that was one of the reasons
> my mother absolutely hated me
> because I told my mom what he was doing....

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but she said I was just absolutely a liar,
and that I was the devil's creation
and that all I was doing….
was procreating evilness in the world……

Prior to being placed into care, Anita was raised by her grandmother. She describes many aspects of her upbringing as repressive at this point:

My nana was very, very puritanical in thought:
you didn't question anything at all.
[….]children should be seen and not heard-
it was very strict.

The same restrictions were applied to dress code:

My nana saw it as the devil's work to be vain.
You know, if you were vain about yourself
it was the devil's work
If you were over-indulgent
it was the devil's work.
She saw that the liking of jewellery
and to make yourself cosmetically attractive
it was the devil's work.

As explained above, Anita was placed into care by her mother. She describes both negative and positive aspects to her new life:

So going into care for me
was a double sided thing
because it was all the rejection and hurt
but it was a bit of freeing-up experience as well
because I could have clothes
and I could have deodorant
and I could brush my hair, you know,
I could feel
I was not going to be the spawn of the devil by-
I was quite pleased… in some respects.

Nevertheless, care was not a 'picnic'. Anita was obliged to learn a survival strategy:

There's a pecking order in care,
[….] so you've got to establish yourself.
[………]
And I learnt to be an extreme bully in care…….

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because that's how you get through the care system.
So nobody touches you.
[....]
And I became a very over-the-top bully.
And with heightened sort of mood anyway –
It made me extremely violent.

In my *fourth level coding*, I speculated upon the above extract:

Anita describing herself as having 'heightened mood': I do not feel this is
sufficient evidence to suggest mental illness; rather it is more likely to describe a
state of awareness or readiness necessary for survival.

At the age of fifteen, Anita ran away from care:

Because the care....
[......]
the two care officers on a night
were both paedophiles.
And we were all being abused.
There was a national scandal leading to a public enquiry.
So I got away.... I got away.
I couldn't handle it
so I just got away.

In my *third level coding*, I speculated as follows:

(Significant others/past trauma) Self-explanatory but query post traumatic stress
disorder?

Anita now lived rough, surviving on food stolen from supermarkets. She cited
this as a learned behaviour that she would repeat in later life when unwell (see
next chapter). However, importantly, she said that she felt no regrets:

It's all made me the person I am today, Ray.
There's no sorrow or joy attached to it:
it's just the way it is
And I'm okay most of the time, you know...
So that's not bad, is it, really?

The next stage of Anita's narrative describes her life following care. Although
some details are missing, it is helpful to note that despite her stealing, she did
not have any lasting involvement with the justice system. She describes

determination in her working life; that she married an older man; and problems associated with the birth of her first child (puerperal psychosis). Therefore, I close the prologue of her narrative at this point.

Thus far, Anita's personal narrative is as follows. Unevenly balanced, it includes two dominant narratives of abuse; the first mainly psychological and the second mainly physical. In connection with the psychological narrative, I include the repressive experiences of her early life. In connection with the experiences of physical abuse, I speculate that these could constitute significant nested narratives which may become manifest as psychological difficulties in later life. It is also incumbent to ask whether or not Anita had begun to form imagoes at this comparatively early stage of her life. Although I am reluctant to speculate overmuch, I suggest that there is a strong possibility that an Anita-as-survivor imago was an active part of her personal narrative.

8.2.7: Anne: positive imagoes and experimentation

Anne's narrative is similar to that of Mr. CBA, Mr. K, and Eddie-Hooper Smith in that she spoke little of her childhood and early adulthood. However, she made sufficient reference to her professional career to build what I believe is an accurate picture. The first extracts are an unequivocal definition of identity. Several imagoes are indicated, namely 'partner'; 'career person'; 'mother'. Note that Anne refers to herself as 'middle class', also her idealistic views:

> A part of identity is
> a middle class identity.
> So it's GCSE's; A levels; degree;
> possibly find your life partner at University;
> First graduate job;
> buy a house;
> start a family [.....]
> I had the best times of my life after University.
> When I was with *B*-----
> *B*----- was my partner,
> [.......]
> Okay, so I've had these privileges-
> financially, emotionally,
> that a lot of people don't get.

Following her first degree, Anne's career flourished as she worked in two university departments and obtained an M.Sc. Thus I posit that her self-esteem will have been high at this juncture, both professionally and socially. However, like Mr. CBA and Eddie Hooper-Smith, she also describes drug use:

> Prior to going *abroad*
> I was smoking a lot of skunk
> which is horrible stuff –
> evil, nasty, dangerous drug...
> [......]
> Yeah- I was part of a recreational drugs sub-culture.

At this stage in her narrative, Anne proceeds to describe an extended holiday in the Far East in terms of 'a reward' for her success in obtaining her M.Sc. Concerning this, the course of the events that followed is somewhat confusing. Whilst it is evident that overwhelm occurred during this holiday, it is not clear if phenomena diagnosed as mental illness had already become manifest. Moreover, given that later data describes her looking for employment, the impression gained is that of a career break as opposed to a holiday. However, these observations must remain speculative. I summarize her prologue as follows: due to her stated success, her personal narrative is positive overall. Included is a dominant narrative within which is nested her schooldays and the early years of her career, including her dissertation. Also present is a second dominant narrative, namely that of an apparently stable and happy relationship with her partner. After some reflection, I believe that drug use should be mentioned on the grounds of Anne's descriptions (see above).

8.2.8: Sandra: shut off and not fitting in

Of all nine interviewees, Sandra was the *only* one to describe other members of her family as suffering from phenomena diagnosed as mental illness:

> Mum suffers from depression;
> Dad suffers with bipolar.
> I just think
> That my Dad abuses my Mum basically.
> I used to query

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whether he raped her and stuff like that,   [.....]
I can get on well with my Dad
and I can get on well with my Mum
but I find it difficult
 to get on with them together
because they're always fighting.

Associated with these observations are extremely strong statements, which
include some confusion:

The thing is that
I've always hated my Dad
and I've always hated their illness, [..........]

> **(Ray) When you say you've always hated his illness,**
> **do you mean for what's it's done to him?**

I don't know if I've I hated his illness:
I've hated, I've hated-
I've always hated him.
Whether that's the illness, I
suppose I don't know.
It's going into my lifetime but er....
I think, I don't think I've hated him.
Like my Dad's always been unstable
for most of his life, really.

A consequence of her father's behaviour was that Sandra spent much of her
time with a friend's family. Associated with this were stressful events that
caused Sandra to experience a crisis. However, since this was short-lived, I do
not cite it as the onset of overwhelm:

Actually I've lived my life
shut off from my family.
I lived my life
shut off from everyone, really.
I think my closest family
was my friend's mum that died,
I tended to live round there a bit. [.......]
I think when I was about fifteen or sixteen
I wanted to kill myself.
I've actually taken acid and then...
My friend from school died
and then I think a year later

> my friend's mum who I was close to died,
> and at that point
> I sort of had a bit of a breakdown.
> Went to see my doctor
> and told him I was crazy:
> he told me to come back in two weeks
> and I never bothered.
> So I like- I just basically went through
> and got through it on my own.

After completing a foundation course, Sandra went to university to study Applied Psychology. Her student days can be compared to those of Mr. CBA's second year and, especially, Dorothy, in that she was isolated. One reason for this is that she continued to live at home (Initially, I found this odd given her earlier accounts of unhappiness but her decision was probably due to a desire for isolation):

> I was living at home;
> I was living with my family still [....]
> I was totally socially anxious and...
> I've never been diagnosed with social anxiety
> but I'd say......
> I have, well,
> very low self-confidence in that end.

Thus, Sandra appears to have suffered from the same 'social phobia' described by Dorothy. However, unlike Dorothy, who undertook multiple tasks, Sandra made a pragmatic choice to cope with her insecurities:

> I just shut off...
> I think that's what I've done
> most of my life,
> I just... I live in my own shell.
> [...] I just cut other people out.
> It's not the easiest way;
> it's not the happiest way of living,
> but it was the way I got through.

Associated with her choice is a self-assessment very similar to that of Dorothy:

> I see myself as individual ....
> as sort of........
> not fitting in,

just someone who's individual:
maybes isolated [*sic*]
but not necessarily lonely,
because I don't know
that I wanted others in.

For clarity, I place Sandra's description of her course and interest in psychology at this point. It is particularly important to appreciate that she acquired this knowledge *before* her experiences of serious mental illness.

I did a degree in Applied Psychology.
So I've always been interested in mental health, whether-
I think because of suffering from depression myself
it's like self-help.
I do psychology
and I can explore things,
I can help myself.

Despite Sandra's insight and various coping strategies, she experienced overwhelm shortly after graduation. Thus the prologue of her narrative can be drawn as follows: Negative overall, it includes the following dominant narratives:

i) Her father's bipolar disorder, also mother's depression

ii) A complex narrative in which are feelings of 'not fitting in', and her self-enforced isolation.

8.2.9: Mr. Gwent: happily married; successful career

This interview was unlike all others in that it focussed almost exclusively on the process and aftermath of overwhelm. Whether this is because Mr. Gwent differed from the other eight respondents in that his first (and only) experience of overwhelm occurred relatively late in life must remain speculative. As a result, the data pertaining to the prologue is extremely sparse. Nevertheless, like my appraisal of Eddie Hooper-Smith and Mr. K., I believe that it reasonable to apply the *absence* of experiences in the induction of a viable prologue diagram. Firstly, I note that Mr. Gwent implied in one casual sentence that he was a vigorous rugby player. Secondly, I include the following extract to provide some insight:

I used to sing in a male voice choir:
Love it, love singing.
We entered into a national competition
and we came second in the national competition;
[....]
So we were singing in this auditorium
and I was aware of the crowd around us and everything...
and as we reached the final part of the song
I burst into tears

Lastly, and probably most importantly, although Mr. Gwent did not go into detail concerning his professional career, it was sufficient to note that he had attained a respected and responsible position in his chosen profession. Also, he has been happily married for many years. Accordingly, it is possible to construct a simple prologue diagram that is similar to Anne's in that it cites career and relationship as dominant narratives. However, the adulthood stage is proportionately much longer: moreover, I have not speculated on the degree to which Mr. Gwent viewed his employment. Therefore, his narrative is evenly balanced across the central axis:

Mr. Gwent's narrative is the last to be explored in this section. The following section, *Overwhelm,* deals with the onset and subsequent experience of phenomena diagnosed as mental illness.

8.3. Summary and conclusions

8.3.1: The wisdom of hindsight

Caution is required in drawing any conclusions from the narratives in this chapter. This is because of the prejudice of the narratives by the declared purpose of the interview, so introducing the wisdom of hindsight. How this might be avoided is imponderable. Although one method – indeed, the *only* method – would be to interview a person without giving any indication of purpose, it is highly likely that the end-product would be artificial. This is because research is an artifice: if I, the researcher, invite you, a narrator, to tell me of your personal narrative in a research setting, then it cannot be otherwise. You, the narrator will surmise that I will be particularly interested in given areas and concentrate upon

these. Moreover, in the context of social transaction (Novitz, 2001), it is probable that you will wish, in the least, to portray yourself as an interesting, morally upright person. If focussed by the lens of a discrete research topic, then it is inevitable that these tendencies will be both magnified and directed upon specific areas.

Similarly, my role as an audience is unavoidably influenced by that of researcher. In this, the problem is truly unavoidable by virtue of my knowing the purpose of the research. Therefore, the only way in which hindsight can be moderated is to make a deliberate attempt to perceive the narrator as well as the narrative. In this, I, as interviewer have a distinct advantage over those who may read these transcripts. That is, when I read and re-read the narratives, my interpretations and speculations are embellished by my memories of the demeanour of the narrator: the way they spoke, the tone used, their body language, and so on. In addition, I have ready access to the original transcripts plus many and varied notes on same. Accordingly, I wish to stress that the extracts in this chapter have represented gleanings from the full transcripts. In the context of the full narrative, they were often part of or linked to a nested narrative of mental illness. Taken in isolation, it is reasonable to view them as indicators of character, social interactions, and so on as appropriate.

8.3.2: Before mental illness

The aim of the prologues is an introduction *to the respondents as persons* as opposed to a prequel to later events. Thus the narratives should, initially, be viewed in terms of, "This is who I am," and, "These are some of the things that I did." Despite this, as stressed above, there is the problem of hindsight. Probably the best example of this is in the opening statement by Mr. P.:

> I actually think it was there in my childhood...............
> I had it in my childhood-

This example enables a sharp distinction to be drawn between the narratives. Like Mr. P, *Dorothy; Sandra; and Anita* all began their narrative with childhood

reminiscences, so indicating the possibility that mental illness would be connected with the experiences described. In contrast, *Mr. CBA; Mr. K.; Eddie Hooper Smith; Anne; and Mr. Gwent* began by talking about their illness itself or events immediately prior to same.

The outcome of this contrast was somewhat paradoxical in that the first group, by describing narrative strands that began in childhood, inevitably spoke about subjects other than mental illness. Therefore, in this way, I felt I was able to gain a reasonably accurate picture of their lives. *Dorothy* and *Sandra* both described feelings of social isolation, though undoubtedly for different reasons. Whereas Dorothy could be described as shy and disliking change, Sandra experienced significant stressors, including her father's own illness. The question of family relations should also be raised with respect to *Mr. P,* who obviously felt the weight of his father's expectations. Finally, *Anita* differed from the other three respondents in that she experienced severe stressors, including sexual abuse and being placed into care.

However, at this juncture, it is essential to recognize that the aetiology of mental illness remains an inexact science. Probably the most difficult question associated with stress vulnerability models is why a person *does not* develop mental illness. For example, Boisen (1936/71) cites a case of two brothers being introduced to 'vulgarities and obscenities' (p143) by an older boy with the result that one became disturbed, whilst the other embraced his new knowledge with enthusiasm. Concerning depression, the seminal work on women by Brown and Harris (1979) demonstrated statistically that symptoms were often associated with adverse events. Nevertheless, not all women succumbed to illness. Lastly, the disturbing implication of Zubin and Spring's (1977) approach to psychotic illness is that all persons possess a degree of susceptibility, no matter how small. As a result, a combination of factors (including genetic complement) may combine to cause psychosis.

Given this uncertainty, I wish to remain wary concerning the significance of nested narratives in these prologues. In particular, it should not be assumed that the events described indicate an unstoppable collision course with mental

illness. Thus far, although *Anita* has described several significant stressors, including the enforced assumption of negative imagoes ('jezebel'; bully), she has also indicated highly developed survival techniques. Similarly, *Mr. P.,* whilst describing negative events, was at pains to stress positive narratives in his life. More problematical are the narratives of *Sandra* and *Dorothy.* Both, particularly Sandra, described social withdrawal as a coping mechanism: this is in keeping with *self-protective withdrawal* as described by Watkins (1996) with reference to Strauss (1989) and Ruocchio (1991), However, Dorothy also sought company and stimulation through overwork, so raising the possibility of over-compensation for shyness.

I close this section by noting some of the narrative prologues in the second group were so brief as to necessitate some speculation. All five respondents appeared to have had relatively untroubled childhoods, following which age should be viewed as a factor in their narratives. Thus *Mr. K's* prologue concludes whilst he is in his late teens, whilst those of *Mr. CBA, Eddie Hooper-Smith* and *Anne* conclude when they are in their early twenties. As stated in their narratives, all were successful at university, although Mr. CBA describes loneliness. Finally, by virtue of having pursued a professional career for many years, it is reasonable to speculate that *Mr. Gwent* had prospered since training.

Finally, I stress that since no detail of mental illness has been discussed in this section, it would be presumptuous to speculate how the findings might be applied. Nevertheless, in combination, they can be used to emphasize a fundamental aspect of mental illness. That is, until it is acknowledged as a possibility by at least one person, (See Chapter Four), no intervention is possible. Whilst the value of such actions as anti-bullying counselling should not be under-estimated, they remain reliant upon the fact that *someone, somewhere* has identified a potential problem. Ultimately, psycho-social intervention before the onset of mental illness may forever depend upon being in the right place at the right time. The following chapter describes the onset and duration of overwhelm; that part of the personal narrative where mental illness was diagnosed and the mental health narrative became dominant.

Chapter Nine: Overwhelm: Phenomena diagnosed as mental illness become a dominant narrative:

9.1. Introduction: the boundaries of overwhelm

For the purposes of this analysis, overwhelm is represented as a continuous period of the personal narrative between *prologue* and *recovery*. Thus the end of prologue marks the *onset* of overwhelm; similarly, the beginnings of recovery are marked by the *closure* of overwhelm. Despite the obvious artificiality of these points, it is possible to refine suitable definitions for them. To achieve these, overwhelm should be equated with *crisis,* as discussed by Roberts (2005). Using several sources, he opines that there is ' a general consensus among social workers and psychologists' concerning factors that are characteristic of a person in crisis. These include fear, tension, a high level of subjective discomfort and a state of disequilibrium. Thus, *onset of overwhelm* is the point at *which phenomena diagnosed as mental illness are acknowledged to exist;* a point common to all nine narratives despite the initial failure of two respondents (Dorothy; Anne) to recognize same. Similarly, *closure of overwhelm* should be regarded as the point at which the person regains sufficient psychological equilibrium to begin reclaiming autonomy. Whilst this construct may appear unwieldy, it accurately describes the situation in which one's mental health needs are *supported by* but not *managed or controlled by* third parties. In particular, it stresses that *closure of overwhelm should not be regarded as synonymous with regaining of one's former level of mental health.*

Some of the respondents' personal narratives (e.g. Dorothy, Anita, Sandra), are greatly complicated by the fact that there are *several distinct periods* of overwhelm. Pertaining to these, each was followed by a degree of recovery, in turn followed by decline in a new prologue. Drawing on my own experience of multiple overwhelm (I was hospitalized six times in two years), I have decided to

represent these narratives as one continuous period of overwhelm in which the mental health narrative will show peaks and troughs.

Examples of narrative diagrams depicting overwhelm are included in Appendix II. Concerning these, it is imperative to recognize that they are intended as *summaries* or *representations* of an extremely complex process. Integral to this overview is that the mental health narrative is itself composed of nested narratives. In keeping with the schemas of significance and dominance, it follows that *any* given nested narrative may become significant or dominant. Later in the course of the mental health narrative, this nested narrative may become subordinate to another nested narrative or narratives. Thus significance and dominance are not single, consistent phenomena but a nexus of the interacting phenomena that comprise the mental health narrative. In particular, a possible complication of overwhelm is that the mental health narrative may affect other nested narratives such as relationships, career, and so on. Rather than describe the narratives in order of interview, as in the prologue, I have grouped these according to similarities in content. To introduce these, a summary of the experiences of the nine respondents is shown in Table 9.1.

Table 9.1: Summary of Overwhelm

Name	Detail of overwhelm	Diagnosis	Time in hospital	Medical treatment	Duration of overwhelm
Mr. Gwent	'unstoppable crying'; Inertia Hopelessness Suicidal ideation	depression	none	Medication offered but declined	Unspecified
Mr. P.	Numbness; 'like a zombie' Overdose	depression	4 weeks	Medication withdrawn due to overdose. Sheltered accommodation, day centre	Unspecified: Gradual recovery
Mr. K.	Hearing voices; violent towards brother	schizophrenia	4 separate occasions; longest 4 months	Medication	Unspecified: overwhelm mediated by medication
Sandra	Paranoia; religious delusions	Bipolar disorder	2 separate occasions: length not specified	Medication	Unspecified: overwhelm mediated by medication
Eddie Hooper-Smith	Hearing voices, bizarre delusions, violent	schizophrenia	2 separate occasions: i) 6months ii) 1 year+	Medication Input from CPN and support worker	Gradual recovery; some phenomena persisted but controlled
Mr. CBA.	Panic attacks; feelings of losing control	schizophrenia	4 weeks	Medication; input from statutory services	Gradual recovery but some phenomena persisted
Dorothy	Panic attacks, Paranoia, Anger, sometimes violent	Bipolar disorder; Borderline personality disorder	4 separate occasions: Length not specified	Medication; input from CPN and social worker. support worker	Gradual recovery but some phenomena persisted
Anne	Hearing Voices, delusions 2 overdoses	schizophrenia	2 separate occasions: length not specified	Medication	Some recovery but relationship problem
Anita	Extreme disinhibited 'manic' behaviour, delusions violent suicide attempts	i) Bipolar disorder, ii) Personality disorder (?) iii) depression iv) puerperal psychosis	At least 2 separate occasions: length not specified	Medication; Counselling	Some recovery facilitated by medication

9.2.1: Mr. Gwent: And I started to cry....

For Mr. Gwent, the first indication of a possible problem was two years earlier:

> I did have- I did have a warning, funnily enough,
> two years before....
> Um.... A particularly bad, difficult year at work [....]
> I developed this terrible headache.   [....]
> They did various tests
> and after a week
> they released me and said,
> "Go back and see the specialist in November."
> And he said.... "You know what it is?"
> And I said, "No"
> He said, "Stress at work. Change your working habits."

Since Mr. Gwent ended this nested narrative at this point, it is unknown whether or not he made suitable alterations to his working habits. The next indication of illness in his narrative is a comment concerning his demeanour made to his wife by friends. Following this, his wife telephoned his workplace to warn them that he might be ill. On the same day, overwhelm occurred:

> So I walk into the main office
> and I thought, 'I can't do this.' [....]
> And I started to cry:
> I burst into tears.
> And, *Ian* you know, kind of looked;
> [...] *Jane* came round and put her arm round me.
> All I can remember is *Ian* saying,
> "Gwent, you're our rock, you're our rock."
> And er........ That was it.

In my *fourth level coding* I observed that:

> Although the above detail is self-explanatory, it is instructive in that it describes how a slow and unsuspected decline suddenly becomes overwhelm. Something, somewhere, at some time tips the balance. Illness is now evident to the sufferer.

The following extract summarizes the helplessness Mr. Gwent experienced during overwhelm:

> <u>Yes</u> *(Said with feeling)*
> Very frightened. [....]
> Very frightened that my whole life
> had just been blown apart and....
> And.... Failure.
> That's the main thing: I was a failure.

With reference to the above statement, I noted in my *second level coding* that Mr. Gwent's description of overwhelm is similar to Boisen's (1971) concept of 'an eruption of the subconscious'. Mr. Gwent described specific events within the immediacy of overwhelm:

> [.....] And some of the incidents
> I can clearly remember is...
> My daughter phoned
> and I was speaking into the phone:
> I was trying to be so brave:
> I just burst into tears [.....]
> Oh, it was awful.....
> When I heard her cry at me crying.... [....]
> And I just wondered
> if I would ever stop crying.......

Following his 'breakdown' at work, Mr. Gwent saw his doctor and was given a fortnight's sick leave. Although he was offered medication, he declined this due to fear of addiction. Thus his only defence against overwhelm was the support of his wife:

> I basically cried for six months.
> [.....]
> You know, I would cry;
> my wife would go off
> to work in the morning,
> and I wouldn't answer the phone
> or anything like that.
> When she came back at night-time
> I was virtually the same way

At the same time as diagnosis, Mr. Gwent's doctor suggested that he consider early retirement. The following details are important in that they show how overwhelm compromised self-determination:

> My doctor....
> Was really very supportive about...

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Straightaway he put down 'Stress at Work'......'
Depression. Stress at Work.'
And.....Really on discussion
that I would go for invalidity....
It's strange: that you kind of get carried on....
'He's the expert, he knows....'
And therefore follow that route,
but I didn't want it to finish that way
because it takes a lot of choices away from you...

At this point, Mr. Gwent describes a contrasting experience, namely consultation with a psychiatrist whom he condemns as unsympathetic. As such, it outlines disempowerment; however, of greater importance are two concurrent events. The first is continuing overwhelm as detailed above. The second is the judgement of the psychiatrist that he could not be certain whether or not Mr. Gwent would still suffer illness in later years. Paradoxically, despite Mr. Gwent's anger at this, the exchange was ultimately positive in that he decided that retirement was not inevitable; that he might recover. However, his illness was undoubtedly serious. The following extract describes the initiation of a suicide attempt:

Well up in [....] there's a viaduct, a big viaduct,
And this particular night
I actually thought,
'That's it: I've had enough'.   [.....]
And I set off to find it....
and I couldn't actually find it.
And if I'd realised, another-
The [.....] is a famous viaduct, *(another bridge, named)* [.....]
If I'd just driven down there
and I knew exactly where that was.
I would have found it –
it would have done the biz.
And, you know, eventually I gave up looking for it
and I just sat in the car........
and I thought, 'Don't want to die.'
I thought of my wife, the children,
and the family.

Although Mr. Gwent's suicide attempt can be described as 'botched', its significance should not be underestimated. For a short time the mental health narrative became *wholly dominant,* sufficiently powerful to suppress any

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consideration of loved ones (wife, daughter) or hopes for the future. Following this event, it is not clear how long overwhelm persisted: it appears most likely that its intensity lessened gradually following the exchange with his psychiatrist and his decision to try to return to work. Accordingly, I summarize overwhelm in Mr. Gwent's case thus: following extremely sudden onset, phenomena persisted but gradually eased. Concerning his suicidal ideation, this was not necessarily the low point of overwhelm; notably, he summoned sufficient motivation to put his ideas into action. However, at what juncture this occurred after onset was not stated.

9.2.2: Mr. P.: a walking zombie: this is not who I am

Mr. P. was employed in a number of unskilled jobs (including community work) until becoming ill with depression when about thirty. Unlike Mr. Gwent, this was associated with several known antecedent events:

i)   Death of father
ii) 'Coming out' (as noted in his prologue, Mr. P. is gay)
iii) Ending of long-term relationship due to partner disagreeing with above action
iv) Loss of job

Following the loss of his job, Mr. P. consulted his G.P., who gave him antidepressants. However, these did not help: the following extract eloquently describes the depersonalising effect of overwhelm:

> But the problem for me
> was that I didn't even know
> it took time to kick in. [*sic*]
> Once it did kick in
> I was like a walking zombie
> but all the emotions
> were there deep within me-
> I felt that I couldn't bring it out at all.
> I couldn't even feel any emotion
> whether it was happy, sad whatever.
> I couldn't feel anything:
> I was walking round like a zombie

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and I was still tired.
And I thought,
'This is not me, this is not who I am.'

Similarly to Mr. Gwent, Mr. P. experienced a brief period in which the mental health narrative was entirely dominant:

> And then I did a fatal thing
> of deciding not to take them,............ [....]
> which sent me down even more
> .....and I tried to take my own life, basically.
>   *(Note: Mr. P. took an overdose of his medication)*
> And from there I was given the option
> of either going into hospital voluntarily
> or going in on a section;
> and I took the voluntary option........
> Which was really the start
> of the secondary mental health services.

Whilst suffering from depression Mr. P. neglected to pay his rent, which led to the loss of his flat (An example of an associated narrative complicating overwhelm). On discharge from hospital he was housed in a rehabilitation unit, where he lived for two years. He also attended a day centre, where he received counselling:

> I was only in there *(hospital)* a short time: [.......]
> my social worker I was assigned to
> actually got me into *(Name)* resource centre
> which was a rehabilitation unit
> to get me back in the community.
> So I was in there for two years. [....]
> Not just going there on a daily basis
> but also getting involved
> in representing other service users
> and having my own counselling while I was there.

Whilst Mr. P.'s diagnosis was similar to that of Mr. Gwent, their narratives differ considerably. Whereas Mr. Gwent is married and had the support of his wife at home, Mr. P. had broken up with his partner and had become homeless, necessitating location in a rehabilitation unit. Concerning their brief suicidal ideation, there is an important difference concerning timing, that is, Mr. Gwent's

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attempt occurred some time after diagnosis of his illness, whereas Mr. P.'s marked the onset of overwhelm. Moreover, Mr. P. actuated his intent; however, I feel that this was facilitated by the fact that he had ready access to his chosen method (overdose).

Thereafter, as will be shown in the next chapter, their narratives follow similar trajectory in that rehabilitation in the voluntary sector is an important factor in their recovery.

9.2.3: Mr. K.: I was quite violent by that time

Although he did not describe associated phenomena, Mr. K. stated that his illness began whilst he was abroad, in Pakistan. In accordance with his native culture, he consulted a spiritual healer:

> And he did help.
> I mean he gave me some prayers to read
> and he gave me some water
> and he gave some beads-
> a necklace, kind of thing

However, on returning to England, Mr. K.'s symptoms worsened (Note: he gave no reason for this). This was the onset of overwhelm, necessitating hospitalization:

> As soon as I arrived in Britain [.....]
> My parents-
> they didn't know what to do.
> They were like O.K. but that's fine
> I mean what happened was that
> I had a fight
> with my brother.
> The police came.
> Told the police I was hearing voices.
> Took me to the police station-
> I was quite violent by that time.
> The doctor came-
> he assessed me
> and the next morning,
> well, that same night
> I went to hospital.

Mr. K. was hospitalized on four occasions:

The first time I went
                    was probably about two or three days.
                    The second time was probably about a month.   *Hospital A*
                    The third was a couple of days
                    and the last time was four months.   *Hospital B*

When comparing hospitals A and B, Mr. K. complained at length about the strict regime in the latter, opining that the treatment afforded patients was stigmatizing and his mental health actually worsened there. Whilst noting that his likening this hospital to Guantanamo Bay must be considered hyperbole, I noted in my *third level coding* that:

> The above text is important in that it details hospitalization as an adjunct to mental illness, an integral part of the illness experience. As such, the regime at Hospital B had a considerable impact on Mr. K.'s identity in that he found it oppressive. It is reasonable to speculate that he felt dehumanised: a subject to be observed and dealt with according to procedure.

In connection with these remarks I made two contrasting observations. The first was speculation that the strict regime at Hospital B may well have been founded on sound reasoning connected with good practice. The second referred to Mr. K.'s use of the term 'stigma', so indicating a feeling that he was judged according to his diagnosed illness. In this, his experiences are similar to those of Eddie Hooper-Smith (see later), who reported that he often felt unable to express himself lest he was misunderstood. In the following passages, Mr. K. describes his affinity with his psychiatrist yet complains concerning the vagueness of his diagnosis:

                    My psychiatrist was fantastic –
                    he talked to my parents, he understood,
                    he was really understanding.
                    But like any other psychiatrist,
                    if anyone asked questions- [.....]
                    it was only in 2003
                    that I found out
                    what my mental health problem was called
                    which was paranoid schizophrenia
                    or now the term is paranoid psychosis.
                    Why did the psychiatrist not tell me
                    the year before that?

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Mr. K. explained that a name was important despite not knowing what psychosis was. In the following extract he elaborates upon this:

> You've got psychosis, bang, full-stop. [....]
> I mean I was on when I was on quetiapine, clozaril,
> the nurses helped me more than Dr. *A.B.*
> Dr. E.M. explained the medication,
> the bloods, the side-effects, things like that;
> the nurses said what effect it has,
> how it will help you,
> all from the experience side........
> monitoring, things like that.

Like Dorothy (see later), Mr. K. wanted to know as much about the cause and nature of his illness. Like Eddie Hooper-Smith, he did not want to be patronised or stigmatised because of his symptoms. Unlike either of them, he responded well to his medication. Accordingly, the period of overwhelm is much shorter despite including four separate instances of hospitalization. The following chapter describes a similar course to those of Mr. Gwent and Mr. P. in that Mr. K. became involved in voluntary activities.

9.2.4: Sandra: in a bit of a daze and seeking religious links

As noted in their prologues, there are some similarities between Sandra's and Dorothy's personal narratives. In particular, they both report a troubled university career: however, their responses were very different. Whereas Dorothy tried to cope by overworking and involvement in outside pursuits, Sandra was withdrawn, living at home throughout her course. Thereafter, the necessity to find employment appears to have initiated overwhelm in the form of paranoia and bizarre delusions. As described below, her father encouraged her to go into hospital:

> The first time I was properly ill
> and I was sectioned was....
> Just after my exams... in University.   [.....]
> I was in a bit of a daze situation:
> I thought people were coming to get me;
> I thought there was some sort of threat. [.......]

So anyway, I went home one night
and told my mum and dad [......]
then later on that day he said,
"I think it's good that you go into hospital."
And I thought if I went into hospital
I thought I was keeping everyone safe.

In the context of her illness, Sandra described bizarre delusions, some of which centre on religious ideas and beliefs. Although interesting as examples of psychosis, I feel that the precise details of these are ultimately irrelevant to this study. However, by virtue of a stated link with her father's illness, they should not be ignored entirely:

The second time I was ill....
It was last year, round about March [.....]
Both time I've been ill I been in *(Hospital A)*
and gone onto *(Hospital B)*
because it's been on an emergency admission, basically.
Both times I've been sectioned. [.....]
Second time I got involved
with the Alpha Course...
You know the Alpha Course?
[...] ....every time I've been ill
I've had religious links.
I know when my Dad is ill-
I mean he is a very religious man-
when he is ill,
all these delusions
about religion and that.
So whether it's my illness
that makes me go after that,
or whether it's that that makes me become ill-
I don't know which way round it is yet.

In connection with these extracts, I noted in my *first level coding* notes the following:

GUARDEDLY- these lines indicate philosophical searching. However it is ESSENTIAL to examine these data at face value then stress that associated ideas are speculation. On this basis, it is fact that Sandra identifies a link concerning her illness and religious ideas but does not know the nature of that linkage. It is possible that the incidence of mental illness causes her to ask religious/philosophical questions. Thereafter, the two issues may interact with one another. If so, this suggests that her mental illness may be associated with (as opposed to engendering) examination of personal identity.

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As we talked in the first interview, it became evident that Sandra has a precise view of mental illness. This is instructive in describing her overwhelm as a gradual process, a continuum:

> Who knows when I became ill?
> It's like…
> Defining illness, isn't it?
> The only way I can say…
> 'Cos it's my illness:
> bipolar with psychotic symptoms-
> because when I'm psychotic
> I can clearly see I'm unwell.
> With depression or with mania
> they're just symptoms of ordinary living
> just to an increased thingy…
> So at what point is the cut-off point?

We reappraised this issue in the second interview. Notably, whilst Sandra accepts that she has 'a mental health problem', she expresses doubts concerning classification:

> I agree that there's different levels of psychosis
> but I do believe in psychosis.
> And I do believe that
> although some people may think
> I'm not psychotic at times
> I certainly believe that I am.
> And I can get there
> either through drugs,
> or through my mental health deteriorating.
> Rather than saying, a mental health problem.
> Which I'm sure
> I do have a mental health problem:
> whether it's manic depression
> or schizophrenia. [.....]
> I don't like to say,
> 'Oh, it's because I've got manic depression'
> Because I doubt-
> That's just my doubt of classification more so

Sandra embellished her narrative with much detail of her behaviour in hospital. Whilst I consider that any surmise concerning effect on identity would be highly speculative, I draw attention to her above statement concerning drug-induced psychosis. Cautiously, I interpret this to be an expression of confidence, that

she now feels able to control potential overwhelm. Therefore I close this section of Sandra's narrative by noting on both occasions that her illness was mediated by medication.

9.2.5: Eddie Hooper-Smith: it's a year out of your life

Following university, Eddie's narrative is similar to that of Mr. CBA in that he obtained professional employment. Unlike Mr. CBA, he expressed no discontent with his circumstances prior to this period (see prologue). Concerning his illness, he describes a brief period of bizarre delusions, a temporary recovery, then the return of voices and delusions leading to overwhelm. This led to prolonged hospitalization:

> I was in *Hospital B* for a few months,
> six months or something like that.
> That was the first time
> I was in hospital.
> [.....]
> I've been through
> quite a lot of very strong illness.
> I've been in hospital a number of times.

On a subsequent occasion, Eddie was detained under Section III of the Mental Health Act:

> I wouldn't go in
> because I thought
> it was depriving me of life,
> going into hospital, *(Hospital A)*
> taking years out of my life-
> And it was, but that's why I was sectioned.
> I'm happy now
> but for a long time-
> you know- it's a year out of your life.

In my *fourth stage coding*, I draw on my own experiences of detention under Section III of the Mental Health Act to speculate upon the reasons for Eddie's reluctance to go into hospital.

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My reaction to my own detainment under Section III was that it was a form of imprisonment. It had been stated that I was not fit to participate unattended in society; I viewed this as 'compromising my integrity'. Much later, following recovery I was able to dismiss the overall experience as merely another chapter in a serious illness narrative. Therefore, I suggest that the words 'I'm happy now' means that, like myself, he has now assimilated the experience.

Due to the severity of his illness, Eddie was hospitalized in Hospital A for one year. During this time, an important factor was the perceived attitude of staff: noting that he stated in his written narrative that he felt unable to confide in them, I asked him why:

> I found it difficult to talk about things
> because if I said something
> then they would say,
> 'Oh, that's a terrible symptom'
> and I thought I would be in there
> for a longer period.

> **(Ray:) So if you said something innocently** (yes)...
> **they'd misinterpret it.**

> Yes. Most of the time.
> That's what I believed anyway.

In my *third level coding* I note that this interaction is, potentially, extremely disempowering. Essentially, Eddie is implying that some hospital staff expected patients to behave within specific parameters. Any deviation from these, no matter how 'ordinary', was perceived as a *symptom*. In comparison, with reference to my own illness when coding, I recalled that:

> ....laughing was perceived as 'high'; any grumbling was perceived as 'aggressive' etc.

I continue Eddie's narrative by noting that although his parents remained supportive throughout, he feels that he has disappointed them by not living up to their hopes or expectations. This belief is, probably, an inevitable consequence of his illness; thereafter, I feel further speculation is unhelpful. Of far more importance is that his parents welcomed him back into the family home on his discharge from hospital:

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They were very worried about it
and they've been very supportive
I think it's been a great strain on them really [....]
I think they had
quite high expectations for me
and I ended up, you know,
sitting around hospitals
and things like that.

Unable to live alone, Eddie lived with his parents for many years. Gradually, with their support and input from statutory services, he learned to cope with continuing phenomena. In this context, the following chapter describes the continuing significance of the mental health narrative despite the fact that overwhelm has ended.

9.2.6: Mr. CBA: feeling I was losing control

Associated with significant nested narratives described in the prologue, Mr. CBA laboured under a feeling of world-weariness that eventually culminated in overwhelm seven years after leaving university. His description of this is 'classical' in that it details baseless fears and the feeling of losing control:

I don't see it as a pivotal, a pivotal event,
I think it was a gradual drifting into it [....]
 You know, in some ways
I think it was… going to happen. [......]
.............I'm losing control.
I wasn't- I was beginning
to have trouble controlling myself. [......]
Feeling I was losing control.
Someone would come into the office
and I would almost collapse
 with them coming in.
Things like that and…

(Ray:) To use layman's language,
you just cracked up under the strain?

Yes.
I mean in the hospital
they said I was no problem
but I can tell you I
wasn't terribly good inside (laughs)

Mr. CBA did not describe the precise circumstances that led to hospital. Instead, he stated that he spent four weeks in hospital and that the eventual diagnosis applied to his symptoms was schizophrenia. A direct consequence of overwhelm was long-term absence from his employment and the eventual loss of same: however, financial pressures were alleviated by a work pension. Also, whilst his father was supportive, there was a degree of disapproval from his mother. In the months following discharge from hospital, Mr. CBA's narrative followed a course similar to that of Eddie Hooper-Smith in that a gradual improvement was facilitated by medication and input from statutory services. Also like Eddie, he continued to experience phenomena diagnosed as mental illness despite closure of overwhelm. Thus, this period of their personal narratives is virtually identical apart from duration and associated length of hospitalisation.

9.2.7: Dorothy: my thoughts were too much in my head... my mind was trying to kill me

Dorothy's narrative includes several periods of overwhelm. The first occurred early in the second year of her university course. Following the events of her first year at university and the subsequent summer (see prologue), she describes a build-up of internal pressures:

> I think it was like...
> my thoughts were......
> Like not my own,
> I hadn't got proper control of them,
> [......]
> Yeah, but like my thoughts were...
> too much in my head........
> And I couldn't get it out of my head,
> I think I was having
> too many thoughts in my head....
> And I couldn't filter them
> or I couldn't um....

Dorothy's behaviour led to the intervention of her personal tutor, who recommended that she consult a G.P. and a counsellor:

.......and I was telling her my mind
was trying to kill me at this point
and I went to the G.P.
telling him my mind
was trying to kill me
which is what it felt like-

Accompanied by her mother, Dorothy was interviewed by a psychiatrist. Unlike the previous respondents, she believed that she was not ill:

I haven't got a clue
what he said to me apart from,
"You're very ill,
you have to go home today."
And I was thinking,
'I'm not very ill'
I mean, on one hand
I'm telling you that my mind was trying to kill me
so why I could think that on one hand
and that I wasn't very ill?

Dorothy was diagnosed as suffering with bipolar disorder and taken home by her mother, where she was interviewed by another psychiatrist. After discussion and negotiation, it was agreed that she could attend hospital as a day-patient. During this time she received counselling and therapy orientated towards supporting her self-esteem:

.......and I just remember this A4 sheet of my rights- [.....]
I have the right to say 'No';
I have the right to change my mind;
I have the right to say- [...]
I have the right to say how things are
from my point of view
and be respected for my views.

Adjudged to have recovered sufficiently, Dorothy returned to university. However, despite feelings of optimism, she also harboured doubts:

I felt like I'd come through the hardest ....
the hardest journey of my life.
What had I learned?
I think- I thought I'd learned at that point in time
that I was an O.K. person................
I felt like I'd come through hell.
Felt like I'd been to hell and back...

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And the fact that I was back
in the real world, at university
- far too early in my opinion.....
was scary as anything.

For a while, Dorothy prospered at university: in particular she is proud of her participation in a successful student project. However, during her final year at university, she became ill again, necessitating hospitalization. Concerning this episode, she was violent, leading social workers to warn her that she would be detained under Section III of the Mental Health Act if she refused voluntary admission. Whilst she eventually acquiesced to this, it was conditional on her being allowed to tear up the Section form, which she has kept to this day. Part of this reads:

......she is devoid of insight and does not wish – [.....]
 – for admission to hospital.
She is in a manic condition
and with paranoid features
and has a history of paranoid schizophrenic breakdown.

Despite the trauma of this experience, Dorothy stated that there was a positive aspect in that it reified her illness. I view this as an important aspect of her identity in that she was pleased to be reassured that her aberrant behaviour was due to illness as opposed to some hitherto unsuspected character flaw:

I would probably hate to be sectioned,
but at the same time I'm glad
they were going to section me
because it's almost like recognition of the fact that....
I was that poorly
and I have been that poorly
and it's not my imagination,

The severity of Dorothy's illness necessitated her taking her exams in hospital: her pride at passing these should be noted:

I got my results
while I was in hospital
So I got it in my own right
without having to have allowances made.

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After completing her university course, Dorothy was transferred to another hospital. Although her transcript contains many anecdotes describing her brushes with authority during this period, these are probably illustrative of bipolar 'highs' as opposed to expressions of innate personal identity. However, in making this assertion, I cannot ignore the possibility that some of her 'misdemeanours' were an exaggeration of her personality. On discharge from hospital, her personal narrative echoes that pertaining to early university life in that she gradually took on an imposing workload:

i)   Voluntary work at MIND
ii) RSA counselling course
iii) Running sports group at the hospital she attended whilst ill
iv) Involvement with Samaritans

In Dorothy's eyes this caused her to become high again:

> ....and then I was going higher and higher and higher
> because I was doing all these projects
> and they didn't really notice   (*i.e. co-workers*)
> and they just thought
> I was getting my confidence up
> and doing really well.

In my *third level coding* I query her understanding:

> Which comes first here? Becoming high due to the projects or taking on the projects because you are high? Dorothy states that it was the latter but this is not necessarily true.

In the late 1990's Dorothy was hospitalized again. Her psychiatrist diagnosed her as suffering from a personality disorder as opposed to her previous diagnoses of bipolar disorder:

> Dr. *B's* defence of thinking
> that I had personality disorder
> when she changed my diagnosis in '97 [.....]
> ....her theory was that I was over-medicated
> in my first episodes
> and she hadn't witnessed any major episodes

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Dorothy strongly objects to this, at one point stating that she finds it 'insulting' (see below). With reference to this, my belief is that whereas the diagnosis on the Section III form provided certainty, the new diagnosis served to compromise her sense of identity. Associated with this, she felt that her symptoms as experienced by herself and observed by her family were being ignored. This led to a feeling of disempowerment, as she describes below:

> It was like having your power
> or any opinion you had
> totally taken away, disregarded, [......]
> Mum and *my sister*
> were seeing a lot of symptoms
> that were not even being acknowledged;
> at one point during a CPA meeting...... um
> Dr *B--* said to my family,
> "It sounds like you want Dorothy
> to be manic depressive.
> Why do you want her to be?
> This diagnosis is not as bad as one of bipolar."
> And she wasn't listening to the fact
> that they were saying...
> "She's worse than what you see her as.
> She has- things happen..." [......]
> But she said-
> and I just found it insulting really-
> what she described as 'my tortured life'.
> And she encompassed it by saying,
> 'You have difficulty making decisions,
> you have low self-esteem'

In connection with this part of Dorothy's narrative, I speculated in my *fourth level coding* that Doctor B may have been sympathising with Dorothy with reference to 'her tortured life'. Less clear is whether the observations concerning low self-esteem and difficulty making decisions are connected to Dorothy's identity or to the effects of her illness. Nevertheless, the indisputable outcome of the above consultation was Dorothy felt belittled. In connection with this, an important aspect of the interviews is that throughout both Dorothy describes her extensive researches into her diagnoses. Whilst I did not ascertain when she began these, I suspect that it was about the time she was threatened with detention under Section III of the Mental Health Act. Thus, it is highly probable that she interpreted the diagnosis of personality disorder as an affront, a challenge to her previous conclusions.

After 1997 Dorothy's improvement was sufficient to constitute closure of overwhelm despite the persistence of some phenomena. In this, her narrative is similar to those of Eddie Hooper-Smith and Mr. CBA. The following chapter describes her continuing efforts to learn more about the significant mental health narrative.

9.2.8: Anne: my rationality is gone.... I had no control over my action

Anne's narrative differs from the other narratives in that she cites a specific event, namely her trip to the Far East, as initiating overwhelm. However, it is pertinent that, as reported in her prologue, she was smoking skunk. In the same portion of text, she describes 'schizophrenic' symptoms prior to going abroad:

> It could it have been innate-
> it could have been there anyway; [......]
> I remember feeling schizophrenic voices
> without taking any drugs

In the interview, Anne summarizes her experiences abroad as 'going wild' and mentions that she was unfaithful to her partner. Whilst my view of this is non-judgemental, her expression of regret is pertinent to later events discussed in this interview:

> I did go wild.
> Obviously: it was my holiday
> but I had this partnership back home
> and I had these friends back home-

> (Ray)This is with *(former partner)*?

> Yeah, yeah. I was unfaithful to him....
> He found out...
> which could have contributed....
> Um..... It was very irresponsible.

During the interview, Anne tended to make disconnected statements suggestive of events as opposed to definite descriptions of same. Fortunately, her written narrative is unequivocal in explaining that various events and factors associated with her trip to the Far East contributed to overwhelm. For clarity, I have divided this and other extracts into idea units:

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I believe the stress
of my [......] job prior to leaving, (*n.b. details of job given*)
coupled with drinking
too much Thai whiskey,
smoking a funny cigarette,
being spiked
or mixing with wrong crowd,
being a vulnerable woman abroad,
mixing with the wrong sort of men
evoked negative feelings in me
which spiralled into schizophrenia.

However, a crucial aspect of Anne's experiences is that she did not recognize the significance of her state of mind:

In January 2002,
although I did not recognise it myself,
I became ill.

Accordingly, although seriously compromised by phenomena suggestive of *but not diagnosed as mental illness,* Anne managed to remain active in society as detailed in the following extract from her written narrative:

I heard voices inside my head
for an entire year;
I was hallucinating,
suffering from panic attacks   *(Note: Anne had not yet been diagnosed*
with acute depressive anxiety.   *as suffering from mental illness)*
[.....]
I went to work every day
out of my head
and clearly very unwell
to fulfil my commitments
as a partner and (*named work*).
In this state, I kept applying
for jobs up and down the country
knowing that
I would be short listed
because of my CV.

In connection with the above text, the interview provided additional data but no further insight. To all intents and purposes, Anne was overwhelmed by her phenomena:

And I'll go back to the Thailand thing:
hearing the voices
and all that kind of stuff-
I got short-listed
for nine top academic posts:
one for the.......
Um.....working for the local government,
which was a good job.
I was ill at that point.....
Er, irrational, really. Um........

(Ray) Why do you use the word 'irrational' please?

Because my rationality is gone. *[sic]*
I.... I got offered an interview
in my old department
and they didn't want me back.
It was only a holiday.
They didn't want me back, you know.... Um..... Er.....
I messed the interview up
I was all over the place...
because I was ill.

At an unspecified juncture in Anne's written narrative, she describes
intervention by her sister. Overwhelm was now acknowledged:

[.........] My sister took me to my doctor [.....]
who diagnosed me with acute depressive anxiety.
My partner could not cope
and sent me back
to my childhood home with my mum,
when she came to visit
having been told by my sister
that I was ill.
I was in an hour of need.
I had no control over my actions.

At this point, I draw attention to Anne's relationship with her partner. Whether
or not it was compromised by her actions in Thailand (see above) is a matter of
speculation. However, stated in both her written narrative and the interview is
the fact that he could not cope with the consequences of her illness. Probably
the most significant of these was a suicide attempt:

I took an overdose of ninety paracetamols,
and ended up in hospital for two weeks.
My family were supportive
but my partner could not cope

After Christmas he wanted to separate.
The Anne he knew
was not there anymore.
I just wished he could have held a little longer
until I got better
but he wanted an easy life
and did not understand.

Concerning Anne's break-up with her partner, it became evident that this event constituted a *second* dominant narrative. As the interview progressed, Anne referred to him with increasing frequency; for example, she summarized her suicide attempt as 'selfish', continuing:

I don't blame him for leaving me
but I needed him so much (*voice breaks briefly*).
I need him so much-
I shouldn't have taken an overdose:
it was a stupid, stupid, stupid thing to do.
I was ill at the time,
it was part of the schizophrenia-

Although not specified, it is evident that Anne's first overdose led to hospitalization which, like that of Mr. CBA and Mr. P., was probably comparatively brief. Following this, she received support from a HIT team and attended a Drop-In Centre. However, separation from her partner led to a second overdose:

I was still very ill,
and it took a couple of months for myself
and those around me
to recognise that I was extremely ill.
I took a second overdose
after I said goodbye
to my partner in January
and kept stealing paracetamols from shops.

Continuing suicidal ideation led to Anne being hospitalized again:

My immediate family were very supportive; [........]
My sister fought for me
to go into *named psychiatric hospital.* [.......]
I was still very ill in there
and remained for three months,
where they treated me
and experimented with different sorts of medication.

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Following stabilization of her medical regime, Anne was eventually discharged from hospital. Although she did not specify the course of events, she recovered sufficiently to live alone and unhappy in a bed-sit. At the same time, she continued to receive support from and participate in the activities of voluntary services. Accordingly, I close this section of her narrative by observing that whilst overwhelm has passed, mental illness remains significant.

9.2.9: Anita: and off I went on a mad manic spree

So complicated is the overwhelm stage of Anita's narrative that there is considerable risk that a summary will diminish the detail contained within her experiences. In connection with these, there is the recurring problem of differentiating between impact upon sense of identity *of the phenomena themselves* and the impact of the *consequences* of those phenomena. Therefore, in the following extracts, it is especially important to note Anita's subjective views upon the events within her personal narrative. In particular, it is crucial to recall her prologue, wherein there was an active, possibly dominant, narrative of psychological abuse. The consequences of this continue to permeate her personal narrative, as described in what I regard as a pivotal exchange:

> **(Ray)When they said you were procreating evil...**
> **...as a child, did you believe it?**

> I still do, Ray.
> I still believe it.
> To a certain extent
> I still believe it.

In my *first level coding* I note my feelings that this was an extraordinary moment in the interview: in effect, like Mr. P., Anita acquired a dysfunctional core belief in childhood. Later, in my *third level coding*, I elaborate:

> How does the possibility of psychosis equate with a logical origin? It appears unarguable that Anita's personal identity was affected, even moulded, by the many admonitions during childhood. In connection with this, as reported in Anita's prologue, she experienced abuse by her father and also during care. With reference to these events, Turkington and Kingdon (2000) cite the work of Zubin (1987), which suggests that traumatic experiences such as sexual abuse may frequently lead to psychosis.

I begin the overwhelm section of Anita's narrative with details of complications following the birth of her first child:

> The health visitor said she thought
> I had this puerperal psychosis
> and referred me to *Named Hospital A*,
> which was 1982,
> but I wouldn't go- I just wouldn't go. [......]
> Because I was terrified of being mental, absolutely terrified.
> I'd heard horrendous stories
> about *Named Hospital B*.

At this stage, Anita turned to alcohol as a coping mechanism. Notably, she explains how the birth of her child made her question the past:

> It wasn't because of him
> I started drinking.
> I was because
> I couldn't cope with the baby,
> and.... being a mother and it...
> the birth brought about
> a lot of things in me
> that made me realise
> must have been lacking in my own mother...
> You know, about how the heck
> could she do the things
> that she done to me:
> put me in care etcetera when I was,
> when I was her birth child?

Anita's first marriage ended in divorce. A second relationship followed, as a result of which she had a second child. However, she describes her life at that time as 'death by boredom'. Her reaction was an act of rebellion that she describes as a 'manic spree'. As described below, this was associated with erratic behaviour and delusions: Anita was completely overwhelmed by her mental health narrative:

> And off I went on a mad, manic spree...
> [....] I was missing for eleven months.
> I was reported missing to the police and everything,
> Everywhere and anywhere,
> It was the worst manic I've ever, ever experienced. [sic]
> I'd break into cars
> and sleep in the back of cars;
> I'd sleep in shop doorways;

> I'd meet a fella in a pub
> and go back to his place;
> You name it: just anything you can think of.

Associated with this behaviour were delusions:

> I'd got into really dangerous company because....
> Part of my experience:
> I believed I was
> an undercover detective for the police.
> And I thought that my mission...
> or my role was to-
> was to crack all the major drug rings,
> So I started mixing and getting into-
> mixing with all the big, massive drug dealers.

Initially, I questioned whether these experiences impacted upon Anita's sense of personal identity. Later, in my *fourth level coding*, my conclusions are as follows:

> The impression gained is that of helplessness in an unstoppable current of ideation (A combination of mania and obsessive-compulsive disorder?). As such, mental illness was an integral part of Anita's identity at the time. And, as she looks back, she finds the episode hard to believe.

Anita was kidnapped by a rival drug gang and gang-raped, resulting in pregnancy. Following this, she was rescued by the police and hospitalised due to physical injuries. This effectively ended her uncontrolled mania: however, Anita now entered into another traumatic phase due to:

i) attending court (in connection with her rape)

ii) counselling for same from Women's Aid

iii) birth of child conceived during rapes

Eventually, Anita succumbed to depression: she described this as 'a worse state than she had been, ever':

> And that's when I started experiencing
> the massive, massive lows:
> really, really lows.
> But I mean crippling lows;
> lows where the only movement I made

was involuntary-
you know, like blinking and breathing.
Couldn't even be bothered
to get up and go to the toilet-
lows till I was hospitalized,
because I was dehydrated,
and cathetered:
crippled with depression.

Following partial recovery, Anita had a relationship with another partner, by whom she had her fourth child. This was followed by another episode of puerperal psychosis. Later, associated with problems in the relationship, she entered into another pregnancy, resulting in miscarriage. This caused what Anita describes as 'aggravated depression'. Another pregnancy followed: at thirty-two weeks pregnant, Anita was admitted to hospital due to mental illness (probably symptoms of bipolar disorder). Following this, around the time that her child was born, she was diagnosed with borderline personality disorder. This led to another crisis: associated with this diagnosis and suggested treatment, it was suggested to Anita that her children should be taken into care. Refusing this option, she chose to fight a protracted battle with Social Services, finally winning her case after one year and five months, However, the effort required left her exhausted:

through my turbulence
and my chaos,
my mental health,
I'd lost my professional career,
I'd lost any relationships
I'd tried to establish,
I'd lost my children,
I'd had loads of labels and judgements.
I just felt very, very, very scorned
and a bit of a self-fulfilling prophecy
of what my nana and my mother had called me:
the spawn of the devil.
I felt this evil......
sort of monster, gremlin, devil, demon
rolled into one skin.
I had a terrible, absolutely terrible identity crisis
I didn't know who the hell I was any more.

The identity crises detailed above led to suicide attempts, including throwing herself under a bus (injury caused) and attempting to throw herself off a bridge

(prevented by police). The medical response to this was a further regime of medication: gradually Anita improved to a level at which she could participate in voluntary mental health groups. Accordingly, I close examination of this phase of her narrative at this point.

9.3. Summary and conclusions
9.3.1: The totality of overwhelm

Common to all nine narratives of overwhelm was at least one prolonged episode of complete dominance by the mental health narrative. Within this, four respondents (Mr. Gwent; Mr. P.; Anne; Anita) experienced the extremely powerful nested narrative of suicidal ideation. Yet, whilst a view of this as the 'ultimate' expression of overwhelm would be understandable, it would be a gross over-simplification. Of far greater significance is that all of the respondents described processes wherein their identities were effectively lost: of thoughts and actions beyond their conscious control. Despite this, they were (with the possible exception of Anne in the early stages of her illness) *aware* of the turmoil within, thus they became unwilling observers of their own aberrant mental processes. Thereafter, all are able to remember their trauma, as proven by the fact that they provided the often extraordinary level of detail to provide for these interviews.

Thus, this examination of overwhelm has been to share the uncontrolled currents within phenomena diagnosed as mental illness in their immediacy. It has been to share in the initial consequences of those experiences, of personal narratives interrupted by the domination of an illness narrative. Moreover, it has often revealed the *reactions* of the respondents to overwhelm. Sometimes this was guilt, as described by Mr. Gwent; sometimes it was numbness and hopelessness (Mr. CBA; Mr. P.; Anita); sometimes bewilderment (Eddie Hooper-Smith); resignation (Sandra); anger and dismay (Dorothy) and even initial denial (Anne).

And also desperation. Although this word was never used by any of the respondents, I believe it is the most appropriate to describe the accumulative combination of factors within overwhelm. As weeks, then months pass by, so a

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respondent lived through their symptoms, expressing themselves through the lens of their dominant mental health narrative. Sometimes – as was proper procedure – medical staff were watching and recording their progress. Sometimes, as detailed by Eddie Hooper-Smith and Mr. K., this may have been applied too diligently. Thus every nuance of behaviour became open to scrutiny, thereafter assessed in the light of on-going symptoms. Yet such judgements are not confined to hospitals or medical staff: some of the transcripts (Dorothy, Anne, Anita) tell of family, friends, professionals, and even oneself as perceiving the self as an expression of aberrant thoughts and actions instead of a person in their own right. This is the true weight of overwhelm: the crushing of self-belief.

9.3.2: Overwhelm as crisis

Ostensibly, overwhelm can be viewed as the culmination of gradually worsening phenomena diagnosed as mental illness. In practical terms, it is a crisis: an event that necessitates an immediate response. However, possible aetiological factors mean that this may be a simplification of a process involving several nested narratives. Concerning these, probably the most important issue is the relative importance of genetic complement in comparison to environmental factors. In effect, was mental illness inevitable, or was it as result of adverse experiences? To attempt an answer to this question is far beyond the purpose of this study. Nevertheless, it is highly relevant in that it informs concepts of mental illness as a condition that may require treatment on several levels: medical, cognitive, and social.

Nevertheless, this chapter concludes on an optimistic note. Associated with the experience of crisis was the recognition of a problem by at least one party (see Chapter Three). Thus overwhelm was also a turning point in the mental health narrative from which recovery could begin. The following chapter will explore recovery in terms the degree to which overwhelm has been mediated and the long-term effects (if any) of same.

Chapter Ten: Recovery

10.1: Introduction: The limits of recovery

In this chapter it will be suggested that recovery from overwhelm is conditioned by the dominance of the relevant significant narrative becoming reduced to a level whereby other important narratives within the personal narrative can resume significance. Following this, it is possible that the personal narrative can, ultimately, recover balance. More specifically, it will be suggested that the extent to which any person can recover from a profound experience appears to depend upon four conditions:

i)   The possibility that the experience remains active sufficient to constitute a significant narrative.
ii) Associated with the above, the degree of that activity.
iii) Any lasting consequences deriving from the dominant narrative.
iv) Evaluation and re-evaluation of the whole experience in terms of a significant narrative in the life story (Linde, 1997, 283)

The first and second criteria refer to the possibility that a person continues to experience phenomena diagnosed as mental illness. Whilst it is stressed that the severity of these is not sufficient to constitute continuing overwhelm, it is possible that they remain a significant, even a dominant narrative. Deriving directly from the first two criteria, the third and fourth criteria lie at the heart of this study. This is because all nine respondents have experienced a dominant narrative of mental illness and have recovered sufficiently to be able to reprise same. Thus in the interviews they talked not only of the experiences of illness, but of events before, during and after those experiences, and their reflections upon them.

As explained in the examination of personal identity, all experiences can, potentially, contribute to the memories and understanding of the person. In turn, these will be deployed in the assimilation of new experiences which, in a reciprocal process, may be applied to the evaluation of existing experiences. Thus, concerning any experience, it can be stated with some justification that understanding is never complete. Concerning recovery, this leads to a complex question concerning degree: in effect, can recovery ever be complete? In response, the stages of recovery would seem to depend upon the ability of the person to assimilate the experience. Initially, a dominant narrative severely compromises assimilation by causing overwhelm. Only as the dominance lessens can assimilation proceed. Thereafter, the degree to which it can be achieved seems to be conditioned by the four factors above.

In theory, therefore, it is possible that assimilation, and thereby recovery, can be complete. In practice, however, recovery depends upon the continuing process of re-evaluation. From examining people's narratives about recovery, I shall explore in this chapter whether these have returned to their state at the prologue stage or how else these have evolved.

In keeping with the previous chapters, I begin by summarizing the experiences of the nine respondents (Table 10.1).

Table 10.1: Summary of Recovery

Name	Conditioning Factors				Status of recovery
	Medical treatment	Statutory agencies	Other agencies	Other factors	
Mr. Gwent	None	None	Support from wife and friends	Involvement in voluntary organisation Return to work	Complete: equilibrium regained
Mr. P.	None	Attended day centre	Counselling from volunteer	Involvement in voluntary mental health services: New career direction (mental health)	Complete: Equilibrium improved due to positive insights gained
Mr. K	Medication	Not known	Support from family	Involvement in voluntary mental health services; paid employment	Complete: Equilibrium regained
Sandra	Medication	Not known	Not specified	Involvement in voluntary mental health services. Return to chosen career	Equilibrium improved due to insights gained
Eddie Hooper-Smith	Medication	Support worker	Support from family	Involvement in voluntary services; Able to live alone	Improving but recovery incomplete
Mr. CBA.	Medication CBT	C.P.N. Others but not specified	Private counsellor	Involvement in local church. Private tuition of children	Recovery compromised by persisting phenomena
Dorothy	Medication CBT	Support worker Others but not specified	Support from family	Involvement in various voluntary agencies including mental health	Recovery compromised by persisting phenomena and need to understand same
Anne	Medication	Not specified	Support from non-related persons in same household	Involvement in voluntary mental health services Break-up of relationship	Recovery compromised by persisting phenomena and relationship problem
Anita	medication	Social worker	Not specified but children mentioned	Involvement in voluntary mental health services. Physical illness	Recovery compromised by ineffectiveness of medication

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10.2: THE NARRATIVES

10.2.1: Mr. Gwent: I genuinely think I'm a better person

Mr. Gwent stressed the role of his wife in encouraging him to join her in a voluntary capacity at her place of work. Also important was the input of friends:

> It was my wife who stopped me
> from being curled up in bed
> in a foetal position ....
> 'Why don't you come to work with me?
> Why don't you come
> and keep me company
> in the car going to work?
> Keep me company in the car coming home?'
> And that's how it all started... [....]
> It was part of my rehabilitation
> that I helped at *(Farmer's Organization)*[....]
> Yes. And actually I built up my own self-esteem
> by helping the farmers

The above narrative is somewhat similar to Mr. P.'s (see later) in that it describes the therapeutic effect of involvement in voluntary work. I suggest in my *fourth level coding* that self-esteem can be raised by exercising and/or regaining a position of responsibility. Associated with this is the opportunity to exercise interpersonal bonding, acquisition of skills and so on. This is reinforced by the following extract, in which Mr. Gwent expresses his anger concerning his employer's reaction to his illness:

> For six months
> the *company* didn't contact me in any way at all-
> they just left me to flounder.
> And, of course, that made me think
> that they didn't want me anyway   [......]

In my *fourth level coding*, I speculated that non-contact could be a logical, if misguided, policy. However, I also expressed surprise that it appeared that none of Mr. Gwent's colleagues contacted him informally. Indeed, as shown in the following extract, the opposite occurred:

And er.... *one superior*- [....]
he actually phoned me on Christmas Eve
and gave me a hell of a grilling: said,
"It's not up to you to decide
when you come back to work.
We've got to decide
when you come back to work."
And I said, "Excuse me,
my doctor is the person
who put me on the sick:
he's also the person
who says I'm fit for work.
I'm coming in on the 1st of January."
It was awful- awful...

Whilst this narrative describes a clumsy exercising of protocol, it has a greater significance in that Mr. Gwent's response indicates that his self-confidence had been re-established. After consultation with the occupational health section, he returned to work after about six months illness. Initially, his intention was to retire after three months. However, his recovery was sufficient to encourage him to change his mind: four years later, he will retire next year. After free conversation concerning reminiscences and ancillary details, this prompted the following question:

(Ray :) Do you regard yourself as completely cured?

I don't think I ever will be.
There's some part of me........um..... is scarred
died inside me or whatever.....
That I never will have
the emotional stability
that I had a few years back.
There's a vulnerability-
an emotional vulnerability inside me

The above passage is extremely important. Whilst Mr. Gwent retains his emotional acuity (see prologue) there is now an additional significant nested narrative; a small 'worm of doubt' ready to awaken. However, given the severity of his episode of depression, any caution deriving from this narrative should be regarded as a positive quality. After talking further about the virtues (and disadvantages) of showing emotions in public, I asked Mr. Gwent another direct question:

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> I'm a better person.
> I genuinely think I'm a better person
> because I always feel as though
> a strength in me has been empathy:
> I like people.
> Except Tony Blair:
> well, he doesn't count as people. ....
> And...... I think my empathy is enhanced
> by the experience that I've been through.
> And therefore as an employer, as a boss,
> I actually think that
> I'm a better boss in the way
> I think people should be respected and treated. [....]
> So I count it as a strength-
> And I also think it has had a....
> very positive effect on my wife as well,
> having experienced that,
> having shared that with me......
> Yes, that's positive.
> And I'm recovered- that's another positive:
> I'm through it. I'm here now.

In that Mr. Gwent feels that he has recovered and is the better for his experience, his narrative can be compared to a 'quest narrative' (Frank, 1997). Following this exchange, an obvious question was whether or not there were any negative consequences:

> I didn't like it. *(Said very quietly with feeling)*
> I didn't like it at all.....
> It was an awful experience and.....
> It's funny, if somebody should say
> everybody should experience
> what I've gone through and all that *(inaudible)*
> - no, I wouldn't say that,
> I wouldn't wish it on anybody.

Thus Mr. Gwent's viewpoint can be contrasted with that of Mr. P., (see later) who was adamant that he would not change his experience. The following extract concerns stigma:

**(Ray :) You give me the impression
that you haven't personally encountered stigma.**

Oh God, yes....Oh, absolutely.
Yes... I should have mentioned this. [......]
I don't think I'm paranoid about it- maybe.
But if at any time,
after having a breakdown,
you respond in any kind of emotional way
to something at work
you can see them going,
'Uh-Oh, he's off again.'

Although Mr. Gwent provided other examples of his actions or demeanour being misinterpreted, I feel that there is no need to include these. Instead, I draw attention to the similar experiences of Eddie Hooper-Smith whilst in hospital, also to Sandra's tendency to self-diagnose. Thus stigma impacts upon sense of personal identity in that one is aware that others are suspicious of your mental competence.

This was the final exchange of importance in the interview. In connection with Mr. Gwent's cheerful demeanour, insightful remarks, and self-assessment of recovery, I view his personal narrative to have regained balance. Of the nine respondents, his illness narrative showed the shortest period of dominance; thus complying with Charmaz's (1997) description of illness as *interruption*.

10.2.2: Mr. P.: it has certainly given me a lot of insight into who I am

Apart from Mr. Gwent, Mr. P.'s recovery differs from the other respondents in that he did not take medication. Following discharge from hospital he lived in a residential unit for two years and attended a day centre for nearly three years, where he received counselling. This was the beginnings of his recovery:

I got my own one-hour-a-week counselling through her, [......]
which really helped me a lot
And also for a course of anger management
because I had a lot of anger there as well.
Over my father....
And over myself really
the way I behaved in the whole process.

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Mr. P. explained that in addition to helping him find positives in his experiences, his counsellor enabled him to acknowledge that much of his reactions to his misfortunes were justified. This evaluation and re-evaluation of previously unresolved narratives was important in affirming his identity and sense of worth:

> I concluded that
> I wasn't the weakling
> that everybody made me out to be   [.....]
> That I did have a voice-
> that although I didn't cry out at the time,.....
> I was crying out then, saying,
> "This is what I am;
> this is what I've been through."   .
> And it has been shit, basically.   [.....]
> And I feel, well, from that,
> the positives are
> that I'm an okay person,
> that's it's okay to be like that

A crucial aspect of Mr. P.'s self-realization was that he felt he could now express his emotions without guilt, so successfully challenging the core belief described in his prologue:

> And from that
> it's okay to be sad.[......]
> I was sort of........
> at home, more or less told to bottle it up- [.....]
> I actually did that to myself-
> in the end that's what I was doing.
> I was actually like a.........
> like a....... Lamb to the slaughter.

Perhaps the most important aspect of this significant nested narrative is that Mr. P. is aware that it retains potential and must therefore be alert for its influence:

> I sometimes even now-
> when I know I'm doing it
> I'll kick myself- say.....
> "You didn't say a thing;
> you're blocking your emotions,
> you're not showing how you're feeling,"

As he improved, Mr. P. became involved in voluntary work, both at the day centre and at a nearby hospital. This was important to his recovery in that he made new friends and also found that he could cope with the occasional stresses involved. Later, he became the first chairperson of a drop-in centre and obtained work in mental health with the local authority. Eventually, after two years, he was housed in accommodation provided by a housing association. Unfortunately, however, he suffered a number of setbacks, as précised below. All of the events listed would be considered significant stressors on the Holmes-Rahé scale:

i) Mr. P. had been victimised by 'kids on the estate' because he is gay. This became increasingly serious until his house was vandalised and rendered uninhabitable. He reported that the police were helpful; he also received advice from a gay organisation called 'Mesmac'. However, he said that he 'never really settled' for a long time afterwards despite being rehoused in a council flat.

ii) The break-up of a significant relationship. Six months later, his former partner died from a heart attack.

iii) Uncertainty at work due to the imposition of temporary contracts lasting three months.

iv) The break-up of a further relationship, which Mr. P. attributed to his partner having psychological problems arising from childhood abuse. He found this event particularly stressful due to the fact that he had become engaged to this partner.

v) Associated with the failure of this relationship, Mr. P. felt very lonely, therefore spent much more time on the 'gay scene', during which he freely admitted that he spent too much money.

vi) This led to non-payment of his rent, following which he lost his flat. Thus, at the time of the first interview, he lived in bed and breakfast accommodation.

A consequence of this combination of stressors is that Mr. P. feels that his illness has returned to some extent:

To a certain degree
I think it has come back.
I'm not suicidal........
and I wouldn't say I'm totally depressed
but I've been through a – low period.

Associated with this are existential questions:

I do find myself going back into that.....
scenario of a feeling, you know,
'Why is this happening again?'
And I sometimes think, 'Is it me?'
And even to the point where I say,
'Do I do this to myself because
I don't want it to be good....?'
Is it because it's going so good
That I've somehow got to cock it up? [......]
Or is it just another run of bad luck?'

Given the events involved, Mr. P.'s reaction is hardly surprising. Moreover, he expresses the opinion that he cannot 'offload at work'. In this his views echo those of Eddie-Hooper-Smith (see later) in that he seeks contact and conversation outside mental health:

When I'm out,
I don't want to talk about mental health.
It's more... more what's going on around the world, [....]
(Laughs) Sometimes you don't dwell on crises.
Not just in your own life-
you don't want to dwell on anybody else's.

The first of the final two extracts in this section details Mr. P.'s overview of his personal narrative:

...sometimes I question
why people say I'm over this.
This was a bad time in my life -
and all this is not affecting me now at all.
I'm sorry
but I'm of the belief that
whatever happens is a part of you
and it stays with you
for the rest of your life.

The second is specific to his experience of mental illness:

> I'm glad it happened.
> Although I wouldn't wish it anybody,
> I am glad it happened to me....
> because it has certainly given me
> a lot of insight into who I am.
> This journey that I've been on.
> And it's given me a career
> So from that point of view
> I am happy that I have been through it.
> It has been tough, yes,
> and its-
> very much it's had its moments.
> But I wouldn't change it,
> I wouldn't change it.

Associated with the many events current in Mr. P.'s life, both his work situation and financial status should be considered as slightly negative significant narratives. However, the mental health narrative appears to have been virtually assimilated. Notably, his personal narrative has achieved a greater degree of equilibrium due to the gaining of self-knowledge as detailed above, and all the more so given the considerable challenges and life events he described. In this, it can be compared with Franks' (1997) construct of a 'quest narrative'.

10.2.3: Mr. K.: a lot of people say it's a real achievement for a service user to achieve something

As stressed in the previous chapters, Mr. K. ranged far and wide with regard to all manner of issues when interviewed. As a consequence, there is little chronological detail of his recovery. Instead, it is obvious that, despite his complaints regarding lack of information (see previous chapter), his medication was effective. Thus I begin with his present evaluation of his illness:

> I mean I'm not ashamed
> of me having a mental health problem-
> what I mean by that I didn't ask for it
> like the majority of the people
> but if, err, I feel it was God's will.
> If I was going to get it- no problem.

However, Mr. K. is less comfortable with the term 'user':

> I mean 'user' –
> Are we heroin users, cocaine users?
> That was one of the first things
> that came into my mind
> and that was one of the first......
> 'User'.
> Because the word 'user'-
> they will automatically think,
> strongly think that users will be heroin users
> or drug users or cocaine users
> but not necessarily mental health user you understand?

Whilst noting in my first level coding that 'mental health services user' is somewhat unwieldy, I sympathized with Mr. K.'s viewpoint. On further scrutiny during *third and fourth level coding*, I concluded that his stance represents a strong affirmation of personal identity. Not only does Mr. K. acknowledge the mental health label, he is determined to keep it.

Nevertheless, despite his self-confidence, Mr. K. is aware of stigma in that he remarks upon the different attitude to users shown by mental health professionals in contrast to the general population. At this point, however, the interview became less focused as he embarked upon an indignant condemnation of the apparent lack of interest shown by the health service hierarchy in user activities. For the purposes of this study, this was informative only in that it stressed Mr. K.'s ability and confidence to express his opinions. Therefore I have not included any extracts pertaining to this subject. Instead I note the role of participation in user activities in Mr. K.'s recovery, particularly two and a half years as a user-volunteer-researcher. This has led to a lasting interest in mental health which, in turn, has led to employment: Concerning this, Mr. K. is realistic but proud of his achievements:

(Ray :) What's the job you're going to do, please?

> Support Time Recovery Worker.
> [....]
> Duties include looking after aiding recovery,
> taking them shopping,
> taking then to the town centre,

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writing reports
and making sure that they're O.K. –
it's not a fantastic job   *but this was said casually, without complaint*

(Ray :) It's a difficult job:
it's like the first stage to being a CPN, isn't it?

It's the first stage which is really happy.
I mean, a lot of people say
it's a real achievement
for a service user to achieve something. [.....]
I want to go to university in the future.
Probably get a PhD.
I don't want kind of courses
there are for mental health-
not from the medical side
but from the managerial...
Service Users Policy, things like that.

On this note of optimism, I conclude the narrative of Mr. K.'s recovery. The dominant narrative of mental illness has weakened to become assimilated as he has become stabilized with the help of medication. Cautiously, I posit that his personal narrative has regained the same level of equilibrium as the prologue stage. This is based on the assumption that he would have obtained employment much earlier if he had not experienced illness. However, this raises an awkward question regarding the course of his personal narrative: unlike Mr. Gwent or Mr. P., he did not refer to gains in personal understanding (This is despite his many observations concerning the status of users, mental health services and so on). Rather his assessment of his experience is pragmatic, of events that have come and passed. Nevertheless, through those events he has gained new interests and a different purpose.

10.2.4: Sandra: you can't get on with your life if you're constantly monitoring yourself

Sandra's narrative is similar to Mr. K.'s in that she provided few details of the recovery process. Instead, she spoke at length about her understanding of her illness in terms of the knowledge gained through her degree. As a consequence, she is the only one of the nine respondents to take a rather detached, academic view of phenomena and associated events.

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I think I look at psychosis
as a negative thing
in the fact that
it stops me from working,
stops me from functioning
in an everyday society;
but I look at it in a positive way
if it's short-lived
and that it brings about my creativity.
[.......]
I also think it's a positive thing
because I want to work
with mental health: [........]
So that when I work with others:
I suppose I can empathize with it more slightly,
because I've been there myself.

Sandra also expressed uncertainty concerning her knowledge, explaining that, by virtue of knowing the significance of given responses to questions, she could use it to manipulate the outcome of any consultation with medical personnel. Whilst she felt that she would not do this deliberately, she felt she could do so inadvertently: a possibility that she extended to self-assessment. The following extract can be directly compared to Eddie Hooper-Smith's complaint (see later) that medical staff would misinterpret normal emotions:

I think I do worry.
Like, as you're saying,
there is those symptoms,*[sic]*
so every time I'm happy:
'God, am I getting elated?'   [.......]
You do sort of do that to a degree.
And I think I sometimes
watch for it too much, [......]
you can't get on with life
if you're constantly monitoring yourself.

Given that Sandra's knowledge of psychology permeated both interviews, I asked her a direct question: 'What do you think makes you *you?*' Interestingly, her first recourse was her experience of mental illness. Including this narrative, I identified nine significant nested narratives in my *fourth level coding:*

(i)
I think the fact that I've been diagnosed –
and I always say diagnosed
with a mental illness –   .

(ii)
[.......]
With it having such an effect
on my last few years.
To be honest
I think mental health is too much of my life.

(iii)
My Dad's ill
more or less all of the time,

(iv)
I've had my own couple of episodes;

(v)
I studied it at uni;

(vi)
I'm wanting to work in it

(vii)
and my friends
have mental health problems.

at this point Sandra returns to the second nested narrative...
> **(ii)**
> I have let it take over my life
> but I choose to do that.
> Maybe's it's a bit sad,
> I don't know,
> but just to make sure
> it doesn't get on top of me again, I guess.

Then she adds a little more:
> **(viii)**
> I think my moral, my morals:
> the way I've been brought up
> has a lot of impact on who I am.

Finally:
> **(ix)**
> Well, the fact that now
> I consider myself to be gay or bi-
> I think that's part of it:
> it's all this equal opportunities things.

In Interview 1 a question concerning coping strategies led to reflection upon Sandra's shyness and self-imposed isolation as described in her prologue and overwhelm. Following this, she described the positive effects of her illness:

> Every time I've had an illness it's like,
> 'Right- I'm going to get something out of life: [......]
> it's made me come out
> with a vengeance basically.   [.....]
> and I was aiming just getting through basically.
> And then I had my first breakdown-
> and that's when, well:
> that's when my life started really.

We reappraised this understanding in Interview 2:

> Just in the fact that
> I like less isolation and less...   [......]
> I think I just opened up more.
> Whereas before I was just more closeted or whatever.

Associated with these observations was a passage in which Sandra saw both benefits and disadvantages in her illness:

> I wish to work in mental health
> so I think it being-
> I think the episodes are beneficial.   [....]
> I see it as having one episode every couple of years.
> I like those aspects.
> Although they might not seem
> good at the time,
> I'm glad I have them.
> But yeah, if affects me continuously,
> and I'm unaware of that,
> then I'd rather not have it.

Associated with this was a positive observation:

> Are you not sort of glad
> because it makes you
> appreciate the rest of your life?

Yet Sandra then contradicted herself:

> I've glad I've had them
> but I'm not saying
> I'd want to have one again.

Amid general conversation about symptoms, relationships, hospital, and psychology, Sandra reaffirmed that she felt stronger and was going out more. When I pursued this, her response was very similar to that of Mr. P. concerning the importance of diagnosis: the following extract eloquently summarizes the internal conflict of doubts and emotions amid reasoned assessment. For many years, Sandra saw her unhappiness in terms of personal weakness (c.f. Mr. P.) Later, following her illness, she was able to accept a new interpretation wherein she was not to blame:

> ....it's like I've always questioned
> why I'm unwell.
> It's like I feel like shit,
> I feel like this,
> but there's nothing wrong with me;
> no-one will think there's anything wrong with me.
> That's what I've always queried;
> and this is like when I going into hospital
> and I was pretending to be unwell
> because I'm just pitying myself.

The second part of this extract can be compared with 'epiphany' (Frank, 1993):

> And the fact that
> I've been given a label–
> it's like 'Shit, there is something wrong with me.'
> It's not me.
> It's like, I– you know,
> I've got a diagnosis
> I've got a reason that I feel I have done.

After explaining that she is perfectly happy to take medication, Sandra moved to the question of genetic inheritance. In doing so, she raised the possibility of a situation similar to Anita's experiences concerning her capability to look after her children (see overwhelm):

But I don't know
whether I'll ever have kids
And one of the reasons for this
Is because I've been diagnosed with bipolar-
and if I was to have kids then
Unless I was in a settled relationship etcetera
[inaudible] could take them away from me
Just things like relationships
I don't know if --
I wouldn't want to put them through the episodes

This led to an extraordinary confession.........

The thing is that
I've always hated my Dad
and I've always hated their illness,
then when I see him myself,
I think, 'God...' I don't...
It's a bit terrifying really

.........followed by an expression of nascent understanding:

He tries to manipulate people,
I always seen him
as the powerful one-
but he's the one who's vulnerable:
he's been in hospital for the last year.
It's like starting
to change my views and that a bit. [.......]
he was talking about his mum   [.......]
it was certain that she had it.
And he said
how he hated his mum
for most of his life,
and I said,
"Well to be honest Dad,
I've hated you for most of my life,
only like now I understand that behaviour
because it's like the same."

I close this examination by reaffirming that the 'epiphany' theme (Frank, 1993), whereby new understanding can be described in terms of illumination, is a strong element in Sandra's personal narrative. Similarly to that of Mr. Gwent, her narrative can also be likened to one of Frank's later models (1997), that is, a 'quest' narrative whereby learning is the outcome of a personal journey. The consequences of this are, like the narrative of Mr. P., that the insights gained

have enabled an equilibrium absent in her prologue. Associated with the introspection arising from her knowledge of psychology and intention to work in that field, the mental health narrative can be viewed as remaining dominant in Sandra's recovery. Arguably, owing to Sandra's positive self-view, this can be deemed a slight positive.

10.2.5: Eddie Hooper-Smith: it's just something I live with now

Following his first experience of overwhelm, Eddie explained that it was ten years before he became stable through treatment with Clozaril. Associated with this is considerable anger concerning medication and its side-effects: indeed, he expressed the opinion that 'doctors should be made to try it themselves'. The first stage in his recovery was living with his parents and learning to control his voices:

> They were pretty unpleasant voices.
> But as- over the years
> I've got used to dealing with them
> and I do actually find them quite reassuring now,
> because I have a girl
> who I talk to now. [......]
> and I actually find it reassuring.
> It's like when you're a child
> and you have a secret friend.

In association with assimilation, Eddie said that his psychiatrist explained a possible explanation for voices, the essence of which can be described as a function of auditory memory. In my *fourth stage coding*, I note that now he has learned to manage his voices, Eddie does not seem unduly distressed or even bothered by them. Thus it is possible to speculate that this represents reclamation of his identity in terms of self-determination.

Later, as he improved, he left his parents' home and obtained a flat: this has greatly increased his level of personal control:

> For the last couple of years
> I've had my flat
> and it's been very good for me really........

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Because I have my own space
and then I can do
what I like to do and...
It's no problem.
I don't drink any more-
I'll have a glass of wine
or a Malibu and Coke or something.
And then- I was smoking a lot as well;   *i.e. tobacco, not cannabis*
I was up to eighty a day at one stage
but I'm not smoking either.

During the overwhelm stage of his illness, Eddie was unable to read a book or watch television because they would trigger delusions akin to paranoia. Gradually, this has eased off over the years to the extent that he is now able to re-engage with his former hobbies. Associated with this stage of recovery, he is assisted by a support worker:

Yes, I feel more confident in myself.
I've actually got
a support worker at the moment
and he's slowly introducing me
to doing things
like going shopping
and things like that
which I wouldn't have done before.

Noting the various elements of the above extract in my *first level coding*, I noted Eddie's tone and demeanour: he was entirely matter-of-fact about his situation, implying that he did not feel compromised or diminished thereby:

**(Ray :) So this is once again where...
there's rebuilding is going on, yes?
How do you find that?**

Um... Very good. Very happy with it.

When we talked about Eddie's social life, he explained that he goes out to the pub once a week with a group of friends who have had similar experiences to his own. *Notably, they do not talk about mental illness:*

We don't like actually doing it
because if someone hears you saying,
'Oh I'm hearing a voice,'
or something like that,

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they might think,
'Oh, I'm not going to talk to them', you know.
We project ourselves
as if we're quite confident

As in Mr. P.'s interview, this passage is important in that it underlines an intention to be included in society as persons rather than users. Concerning the question, 'Has mental illness impacted on sense of personal identity?' I apply two viewpoints:

i) **YES...** Eddie and his friends are aware of their problems and are trying to overcome them.

ii) **NO....** The illness may be on-going but Eddie and his friends are trying to assert themselves as persons. In other words, there is life after and beyond the illness.

We talked about the future in the light of the present: as a part of his rehabilitation, Eddie has become involved in the same user-research group as Mr. K. In more general terms, he is aware that his recovery is not complete:

Well, I'm a lot better
I'm a lot happier but
I've still got to try
and make something of my life.   [......]
I 'm looking at trying to....
Trying to get a relationship,
get a girlfriend, proper girlfriend,
get a relationship,
get a job, you know.

I conclude discussion of Eddie's recovery by noting that he describes his continuing illness as, "It's just something I live with now, you know." Thus, in terms of a dominant narrative, its influence is gradually waning.

10.2.6: Mr. CBA: there's room for optimism...other times I feel.... I've gone nowhere. I switch from one to the other

Mr. CBA has not worked since he was discharged from hospital in 1987. Early in the first interview, he gave an overview of his recovery that stated clearly the need for time to repair from overwhelm:

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> As the years roll on it gets easier. [.....]
> I find it easier and more natural
> and more philosophical
> rather than hot...
> burning sort of thing....

Recently, Mr. CBA had received cognitive behavioural therapy (CBT) and counselling with a view to addressing a tendency to judge himself in negative terms. Whilst there are similarities between Mr. P. and Sandra, Mr. CBA's problems have persisted for much longer (at least nineteen years):

> ....I think that was to lance old wounds, you know.
> There were other things as well
> but that one sticks...
> really sticks in my mind....
> Yes... I felt *very* bad, failure, sort of thing...

Unfortunately, the therapy was not entirely successful in that Mr. CBA found it 'too prescriptive'. On pursuing discussion, he elaborated on his continuing tendency to ruminate and interpret, explaining that it was a burden when in company:

> When I'm with people for a long time
> I begin to get a bit ragged...
> It takes an effort to keep it at bay
> and I know it's going to get out:
> I feel guilty ... so it's ....
> Um.... I quite often, sometimes just disappear
> because I can feel it
> It's getting too much....

Care must be taken concerning the following extract, in which Mr. CBA further describes the persistence of his ruminations. As opposed to auditory hallucinations such as those resulting from schizophrenia, I suggest that the following describes a constant process of evaluation and re-evaluation:

> It's stuck there and
> It's going round and round
> Yes- it's like a little wheel .....   [......]
> I can't live with---
> You know, it's very compulsive- [......]
> It's in- at the base of the skull,
> it's like a little wheel that turns

- chuntering away to itself...   [......]
It makes me slightly high as well,
it makes me feel
I've got some sort of understanding from it...
If I'm listening to it that is

In my *first level coding*, I suggested that evaluation of the reaction of others
during social contact may be relatively commonplace. However, in my *fourth
level coding*, I speculated that Mr.CBA experiences problems because of the
degree to which his evaluative ruminations occur. Whilst I believed that he was
not describing voices, he was undoubtedly describing powerful intrusive
ideation and conflicting emotions. As explained in the following extract, the
consequences of this are undermining of his self-confidence.

And perhaps if I do this
or perhaps if I do that.....
Um, and watch out
because you're going to do something wrong.   [....]
You shouldn't have said that,
you should have waited until then- ah- yes

(Ray :) Would fear of failure be fair?

Yes. Oh yes....

Mr. CBA's description of constant interpretation and associated self-doubt led to
a direct question:

(Ray :) Do you worry about your symptoms returning?'

I said that to *local GP*, yes.
It can be- I mean,
I make mistakes, slight wobble and I think,
'Oh crumbs, panic stations'

(Ray :) That you could be in for a full-blown........

Yes, yes, or something sufficient
to cause disruption somehow.
Maybe not hospitalization,
I've only been in hospital once
and that was long ago,
but an actual disruption and upset,
I think that's going to happen.

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Aware of the problems of loneliness, and in an effort to re-establish himself, Mr. CBA has recently started to attend church. Also, he has studied a foreign language: this has led to him giving private tuition to young children; a pursuit that requires considerable organizational skills:

> I would never, never,
> you know, never have tried it-
> it would have been,
> 'No, I can't do it.'
> But reality is I had to do something
> and that's been very positive.

Yet, overall, despite these improvements, Mr. CBA remains pessimistic:

> Sometimes, I - sometimes I think,
> you know, things have really moved...
> over the last twenty years
> there's room for optimism......
> other times I feel, you know,
> I- ... I've gone nowhere.
> I switch one to the other.
> Um......... sigh...... It goes with my moods.....

The next extract is extremely evocative of loneliness associated with low self-esteem. Speaking of a friend, Mr. CBA compares himself unfavourably to her with regard to achievement and, possibly, on-going experience of mental illness. Concerning the possibility of a relationship, whereas Eddie Hooper-Smith's overall tone is optimism, Mr. CBA's is sadness and pessimism:

> There's a personal coach working at (*educational centre*)
> who's invited me for coffee...
> That would be very nice.....
> but I don't want to feel you know....
> Being a single guy with no sort of....
> on my own ....
> with someone I like very much.
> It's- There's tension there.... [....]
> Between you, I'd love to go out with her
> but it wouldn't happen ...
> I just don't want to do it.
> To be reminded of that fact... [.....]
> And how I am..... you know........
> It's sort of.......
> I feel constrained in that respect
> and meeting for coffee

> would ram that home
> I mean, she got over depression,
> I've never known anyone so depressed
> and she got over it and out of it
> and I admire her tremendously for doing it.

I close this examination by reporting that on the day following the second interview, Mr. CBA telephoned me to say that I could use the data as I wanted but he didn't want to talk about it. He also said that although June and I can analyse our feelings, he cannot: 'it just leads to me having bad thoughts'. Arguably, his narrative has returned to the level it was at the prologue stage. However, given the duration of the mental illness narrative, the significant narratives associated with the consequences of same, and repeated themes of pessimism, I speculate that a negative imago may be been created. My overriding impression of Mr. CBA is that of a solitary traveller, dogged by memories and a belief that his narrative will remain lonely. Unlike Eddie Hooper-Smith, he sees no likelihood of rebuilding. If so, then the impact of phenomena diagnosed as mental illness may have been massive.

10.2.7: Dorothy: I'm obsessed by the link between what's your personality, what's the symptoms of your mental illness

At the time of interview, Dorothy takes medication and receives assistance from a support worker. Like Mr. CBA, she describes ruminations and interpretations to the point of obsession. Unlike Mr. CBA, her efforts are focussed on the nature of her illness: particularly on the possible aetiology of the phenomena concerned. Essentially, she is asking the question, "Why me?" Moreover, as noted in my first stage coding with reference to the following extract, she is asking, "Which is me, and which is my illness?"

> I'm obsessed between the link
> between what's your personality,
> what's the symptoms of your mental illness,
> what's ..... you being weak,
> what's you being strong,
> what's you- all things like that
> and how inextricably linked they are
> and you can't separate them [......]
> I can't do it, I can't work it out...

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Associated with this is a damning self-assessment in the second interview. This can be directly compared with Mr. CBA's self-view:

> I look back
> To try and find out
> why I'm like this
> and why I'm such a failure.
> You know, it's not very nice
> when your friends
> all have proper good jobs.
> You know?
> And they think all you need to do
> is relax.

Dorothy has received assistance from her occupational therapist in her efforts to resolve her questions and internal conflicts. In a long extract she describes the identification of character traits which, in combination, lead to a constant drive for answers amid achievement. For clarity I list these:

i) Bipolar disorder (diagnosed mental illness)

ii) Hypermobility syndrome (physical impairment)

iii) Perfectionism (personality trait)

iv) Completer-finisher

v) Knowledge-seeking

vi) Analytical personality

Following observation and analysis, the therapist turned to advice concerning Dorothy's way of life regarding sleep, diet, time management, and symptom recognition. However, Dorothy explains that this is not straightforward: in doing so, she evokes comparisons with the overwhelm period of her narrative:

> She said that,
> "If you've got a packed diary
> you take on more and more stuff
> to sort of validate yourself
> you go to these stupid bloody meetings
> to validate your own sense of worth
> you won't cancel them
> if you're feeling unwell.
> You go to – all costs
> and you end up poorly [....]
> But you see I'm-

I don't like stopping.....
I'm not very good if I stop
because my mood drops low

In connection with the above extracts, I noted in my *fourth level coding* that the potent combination of personality traits means that:

'Dorothy is her own ruthlessly exacting judge: if she fails to meet her own high expectations then she condemns herself.'

Additionally, I speculated that any on-going effects of bipolar disorder would both affect her capacity to meet her allotted tasks, thus becoming a source of anger and frustration. Indeed, despite the advice of her therapist and other medical personnel, Dorothy remains tormented by the lack of answers:

I've got to learn to accept it
and I can't do it,
I don't know how to do it.
and that is what my goal is, really.
I think if I could have a better- [.....]
I really can't come to terms
with the fact
that I've got to deal with this
and maybe not function any better
than I do now
for the rest of my life. (*voice strained*)
I can't bloody deal with it
but I have to,
because there's no choice (*Dorothy starts to cry*)

In the second interview, we talked about the possibility that phenomena diagnosed as mental illness have a biochemical or neurophysiological origin. Dorothy's response to this was, "God, I'd be devastated if there wasn't", prompting me to note in my *first level coding* that she:

......needs the reassurance of believing that her condition is due to a bona-fide medical illness.'

This is supported by the fact of her keeping her Section III form (see Chapter Nine, Overwhelm) in the context of her rejection of the diagnosis of personality disorder:

So that is my proof
that I have been poorly (*voice breaks*)
Because I keep thinking I'm imagining it-
No, I do, Ray, it's the truth,
they brainwashed me
that I had personality disorder for four years.

The tension between intellectual understanding of her illness and emotional acceptance of same causes Dorothy to express guilt:

I feel absolutely so guilty-
there's a lot of guilt
in my personality for no reason.
Feel a lot of guilt about
having these emotions and thoughts and behaviours
when I've got a lovely flat-

The above extracts merit direct comparison with the experiences of Mr. P. and Sandra, who both reported emotions akin to liberation by virtue of being able to re-assess previous events as due to illness. However, that avenue is effectively denied to Dorothy by a diagnosis that she interprets as blameworthy. In consequence, doubt and anger form a potent combination that reinforces the dominant mental health narrative. This is demonstrated by her description of CBT, during which she challenged her therapist:

I said to her, [......]
Imagine that you're the patient
and I'm the therapist
and I've come into you and said
"You'll never believe what we've discovered:
the world is flat after all, it's not round,
- you wouldn't believe me, would you?"
And she went 'No'.
I said, "But that is how ridiculous
the extremeness of what you're trying
to tell me
to change my thoughts is.
You're trying to tell me
that I'm not a failure
and I'm trying to tell you
the depth of the meaning
of that is like me saying to you,
'The world is flat.'
You wouldn't believe me:
I'm not believing this...

effing percentage evidence;
It's rubbish because I'll give you
all the evidence in the world
of how I am a failure.
And my evidence is better than your evidence."

Despite her confusion, Dorothy is determined to retain her diagnosis of bipolar disorder. Like Mr. P. and Sandra, the label is a part of her identity: 'Who and what I am':

Now, for me…
I hold on to my label
and I'm not ever letting it go.
Not after how differently
I've been treated in those years
when I had to live
with the diagnosis of personality disorder.

Associated with Dorothy's continuing view of herself is the issue of stigma, particularly the denial of her illness by friends:

Another friend,
who's had a terrible hard time herself [.......]
….when I was very poorly and asked for help
turned round to me and said,
"Why are you asking me to validate your illness?
Because to me
there is no such thing as mental illness
and any form of diagnosis or medication
is abuse as far as I'm concerned
and it is an illness of the spirit'
and I've never got over that. [....]
She will acknowledge that I have difficulties
that mean I can't work
but that's as far as it goes.
and how hurtful that is,
to reconcile that and still be someone's friend.

Thus the interview proved to be a release for Dorothy:

On one hand it's quite therapeutic, [.....]
like a discharge,
and especially with people like yourselves…
who, I've got in my heart
that you believe me.
So it wouldn't be the same-

it would not be the same and I can-
This is something so a hundred percent true
if it was somebody interviewing me who- well-
who I was suspicious of
I've got a very great mistrust of people...
and I've got a great paranoia
that people do not believe me.
I've had it,
I've experienced over and over again in my life.

At this point I close my examination of Dorothy's recovery. Probably the strongest theme throughout both interviews was the feeling of isolation caused by an illness that continues to defy her attempts at understanding. Thus, although she would probably resent the epithet, I saw this aspect of her as 'tormented'. Despite this, she takes pride in her flat and, as implied in an above extract, tries to occupy herself with as many pursuits as possible. Accordingly, I summarize her recovery as partial; similar to that of Mr. CBA in that it has probably recovered to the level it was during prologue. Like Mr. CBA, she remains troubled by a dominant narrative relating to phenomena diagnosed as mental illness. However, additionally, there is a dominant narrative pertaining to the *understanding* of same: in short, Dorothy wants to know *why* she is ill. Until this question is answered to her satisfaction, she will remain plagued by doubt and confusion.

10.2.8: Anne: it's really, really hard for me to come to terms with it because of the time and effort I put into being successful

As the interview with Anne progressed, so it became increasingly complicated. This was due to two factors:

i)   Anne switched rapidly between past and present, interspersed with overviews of both.
ii) Anne would abruptly change subjects, mostly between her own illness and the break-up of her relationship.

I begin review of Anne's recovery narrative by noting that after discharge from hospital, she lived in a bed-sit for two years before moving to a flat in a family house:

Since I've moved
into this household....
my friendship network is changing
for the better
because living in
that small little self-contained prison
for two years,
I was isolated,
I couldn't manage-   [.....]
  manage everything on my own   [.....]
I need to be part of a group,
a group identity

Although she did not provide details, Anne indicated that she has become involved in local user groups. Opining that this enables some social contact, she uses somewhat prejudicial terms when making an oblique reference to her former status. This is important in that it is unequivocally an expression of loss:

I'm starting to.........
to leave the idiots behind,   [......]
I'm starting to mix
with more educated people,
which is great   [......]
I've got to know of...
quite a few people that have had these-
um, been to university
and done their degrees
and they've suffered from the same illness,
which is reassuring
because a lot about my issues
are support networks
Er............. Finding........
I guess the right friends really.

At this point, I interrupt Anne's narrative to provide her own view of her present mental health. With reference to further aspects of her narrative, this is important in that whilst she appears to acknowledge on-going phenomena, she attributes her demeanour to boredom and past events:

I don't, I, I don't ...I don't think ....
No, the landlord would disagree with me [.....]
It's what other people think
rather than yourself sometimes   [....]
another resident thinks
I'm quite ill still.
But it's boredom and lack of stimulation......

> Regrets, Fear:
> I think they're natural things, don't you?
> I don't think it's an illness.

Examination of the above extract suggests that boredom is an inevitable function of her present circumstances. More important is her use of the terms 'regret and fear'. The following extract, which elaborates upon the loss of her former career and associated lifestyle, raises a complex question concerning the nature of imagoes. That is, Anne's words suggest that she still sees herself as a career woman, that the Anne-as-career-woman imago remains active. If so, it persists despite being denied, a reminder of what has been and what should still be:

> ....it's really, really hard for me
> to come to terms with it
> because..... of..... the amount of time and effort
> that I put in to being successful   .
> or having money
> and having that lifestyle, okay?
> Some people never had it
> and go on to do these things.
> What I find difficult is that I know
> what that life's like

Whilst noting in my *first* and *fourth level coding* Anne's insistence that she is to blame for her present situation (compare Mr. P.'s self-questioning), I draw attention to a measure of uncertainty:

> It's like with the acts that I did.
> Was I just being lazy?
> I don't know.
> Did I give up on my working life
> because I was lazy?
> Or did I do it
> because I was too ill?

In connection with the above, I draw attention to the fact that Anne left her employment immediately prior to her holiday (see overwhelm). Accordingly, there is a question as to whether or not this choice was influenced by nascent phenomena diagnosable as mental illness. Associated with the loss of Anne's employment and social status is the break-up of her relationship, for which she

continually castigated herself throughout the interview. The following detail describes a dominant unresolved narrative that has resulted from this event:

> Yes, when he left me,
> with no closure, with no discussion,
> with no support, nothing.
> And every fucking waking day
> and every fucking waking hour
> I think about him.
> And I need to see him
> and I need closure
> but he's not willing to give me that.

In connection with the above extract, my *first level coding* noted that the interview became increasingly concerned with Anne's partner from this point. As will be explored later, this narrative is relevant to Anne's recovery despite its subject matter not being the focus of this study. In tandem with this, she often returned to the theme of loss of her former life, as is summarized evocatively in the following brief extract, which describes her loss of independence. This is in direct contrast to the narrative of Eddie Hooper-Smith, who welcomes the input of his support worker:

> I'm on benefits in *[named town]*
> Um… Now I have to have an advocate
> to go an Orange shop
> to sort my bills out.
> That's sad- got my Master's degree
> with a distinction
> and I can't sort my bills out.

The theme of loss of former identity is reiterated with reference to Anne's relationship with her family:

> I feel that my family position's changed,
> which is really frightening.
> My relationship with my mother as well:
> it's a big-
> I really hurt her.   [......]
> Just my mom wants Anne back.
> And if anything in the big wide world
> I wish I hadn't done it to my mum...... [.....]
> And this is a family position thing-
> I want to go and stay
> with some relations there................

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But I'm really-
I'm not the person that they knew either.

In more general terms, Anne describes her attempts to mediate her isolation. The following extract describes an attitude to her illness that is in stark contrast to those of Eddie and Mr. P. On one level, I find her behaviour extraordinary. However, in my *first level coding* I speculate that she is trying to normalize her illness by seeking an unconcerned response:

> But I live and breathe mental health
> because I don't have a boyfriend,
> I don't have.... That... That thing.
> And I know it's up to me
> to make friends,
> I know friends aren't going to come to me-
> I've got to go to them.   [.......]
> Because I'll meet somebody in a pub
> and they're really nice.
> "Hi............. Hi, I'm schizophrenic.
> Nice to meet you."   [......]
> But that's another identity issue.
> Labelling theory.
> Because I'm not making any friends doing that-
> and it's such a small town.

The final extract from Anne's interview is another overview. This is a statement of denial: that all, including her experiences of illness, could have been avoided. By attempting to minimize the seriousness of her problems, she takes on the burden of responsibility for them:

> Honestly, on a ground level ....
> I was a........young woman-
> young professional woman
> who went on holiday
> and did a few drugs
> and that was it:
> it's quite simple really,
> but I had to-
> I had to make it into a problem.   *i.e. personal responsibility for illness*

I consider that Anne's recovery narrative is complicated by two dominant narratives. Whilst on-going phenomena diagnosed as mental illness are undoubtedly active, their consequences are magnified and exacerbated by the

unresolved narrative pertaining to the ending of her relationship with her partner. Indeed, I view this latter narrative as more dominant than the mental health narrative, and fear that she will never regain equilibrium until she obtains closure.

10.2.9: Anita: I'm not bothered about what other people think about me because I'm going to justify and re-create my life

Anita's narrative begins with her response to her suicide attempts and resultant medication. In common with previous events in her narrative, the following extracts emphasize her force of personality in deciding that she would attempt to resurrect her career:

> That's what I decided:
> get back into work;
> live for my family.....
> You know, establish my career again.
> I'm not bothered about
> what other people think about me
> because I'm going to justify
> and re-create my life;
> because the power and control's
> in my hands:
> I'm going to do it.
> I don't give a sod
> about all these stupid records
> and people's interpretation,
> because they just don't understand me.
> I'm going to be my own driver in my own life:
> and I started taking control
> and getting back to work
> and looking after my children.
> And it was hard- I make it sound easy

Unfortunately, Anita's physical health deteriorated:

> but it was then-
> that's when I started getting irregular heartbeats
> and they said it was anxiety
> and then I became really poorly with it
> and I got admitted onto *Ward Number, Hospital A*
> and it was a side effect of the meds.

Also, Anita suffered serious physical illness:

> Anyway, I was so ill one night,
> went to the *Supermarket,*
> collapsed in the *Supermarket ambulance, acronym given.* [....]
> the next thing I remember
> was a morphine drip set up-
> pancreatitis, six weeks.

Following her illness, Anita was taken off medication. About this time she met a user volunteer representative, which she describes as a 'mixed blessing'. To a reader, the following extract will be confusing in that details are implied as opposed to stated. This is due to the fact that the situation Anita describes was already known to us: that is, although the volunteer was supportive in many ways, they did not agree with medication:

> I met *a user volunteer representative.*
> Yes.... And that's been a mixed blessing.
> Because I've been in services
> for that many years
> I've got a pretty service-way
> of thinking about illnesses.
> And she's quite... *[Sigh]*
> The way she is-
> and I find it quite contradictory
> and I get very confused, so...
> I don't know. [.....]
> I don't think there is **THE** answer
> because if there was the answer,
> we'd conduct the world by that theory. [.....]
> I think it's a bit of that, a bit of this,
> but she is so...
> one and I feel so...
> You know when you're unwell
> and she's va-va-va?   (*'va-va-va' said very quickly)*
> And she beats me into submission;
> beats me into submission.

With reference to the above and the following extract, I note in my *first level coding* that Anita is obviously hurt by what she perceives as a lack of sympathy and understanding. Chadwick (1997a) observes that 'paraprofessionals' such as 'volunteers, parents, and students' often try to 'normalize' mental illness. However, he suggests that such advice is often associated with a poor knowledge of the possible aetiology of mental illness and associated medication. Also, he argues that such persons may be motivated by an

antagonism towards psychiatry: in consequence, such persons often claim 'there's nothing medically wrong with you'. The following extract should be compared with Dorothy's feelings of rejection concerning a friend who denies mental illness:

> She keeps on saying to me that,   (*i.e. the volunteer cited above*)
> "All feelings get hard
> when your emotions are involved,"
> and all that.
> And she doesn't think
> I'm having bipolar episodes;
> she thinks my emotions are bouncing
> from one extreme to the other and...
> I don't know.
> And she doesn't think I need meds
> and I feel that sometimes when I need-
> *Doctor C* says I need to go on meds;
> I feel like a failure because she says that....

Concerning these extracts, I feel that by far the most important aspect is the questions of belief and implied judgements. From one point of view, it is reasonable for any person to believe in an 'anti-psychiatry' model of mental illness. Thereafter, it is also reasonable for that person to attempt to persuade someone such as Anita, who is experiencing phenomena diagnosed as mental illness, of the worth of their belief. However, if that persuasion ultimately results in questioning the attitudes and motives of another person, then it is, inevitably destructive. In this, Anita's narrative can be compared strongly with that of Dorothy, who felt challenged by a diagnosis of personality disorder on the grounds that it implied that she was responsible for her own misfortune. Also, her narrative should be compared with others such as Sandra (above) who feels that a label reifies her illness.

Later in the interview, Anita elaborated upon the attitude shown to her by professionals concerning her personal competency. Having experienced this issue to some degree myself, I was surprised that she was the only one of the nine respondents to raise it. In my *third level coding*, I note there are two different aspects to Anita's narrative, both of which are relevant to personal identity:

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i) The challenge posed by persons believing that phenomena diagnosed as mental illness are synonymous with learning difficulties.

ii) A potentially more serious problem of having one's competency to make decisions challenged:

> Some social workers
> and some of the system
> confuse mental health with learning disabled. *[sic]*
> And they were talking to me
> in sentences of one syllable *[laughs]*
> You know, dum – dum – dum – dum and asking me,
> you know, like one barrister said to me,
> "Can you read and write?" [.....]
> And the social workers when they talk to you....   [.....]
> And all of a sudden
> everything that I've ever owned was denied.
> <u>I was a lunatic</u>

At the time of the interview, Anita's overall mental health is beginning to deteriorate. Therefore, she is awaiting hospitalization in an effort to determine suitable medication. In my fourth level coding I note that she is caught in a classic dilemma: if she takes medication then she suffers from side effects; if she does not take medication then she experiences the return of her illness.

> Right, so I'll get back to
> where I am in my mind:
> Um..... I'm not on any meds at the moment
> because of the side-effects... [....]
> At the moment they say
> I'm in a mixed episode.
> And my moods have been
> like really sort of not okay.
> Like suicide;
> four weeks ago I tried it   (*means not specified*)
> and all this, that, and the other.

Despite this, we concluded on a positive note:

> **(Ray :) Is there any chance of regaining *professional qualification.*?**

That's what we're trying to do, Ray.

Thus Anita's personal narrative is one of partial recovery in which suicidal ideation remains active. Moreover, the issue of medication remains unresolved, thus, despite her obvious determination, her personal narrative remains compromised by a dominant mental health narrative despite some improvement since overwhelm.

10.3. Summary and conclusions
10.3.1 Initiating recovery

To ascertain a point at which recovery can be said to have begun in a narrative involves too much conjecture to be of value. Rather, it is better to understand the mental health narrative as passing through a period of transition wherein overwhelm was gradually mediated. Associated with this was the involvement of the following other parties in all nine narratives:

   i) medical personnel
   ii) voluntary organisations
   iii) family and/or friends

When comparing and contrasting the nine narratives, difficulty arises due to the wide range of phenomena described and associated diagnoses. Initially, it can be observed that both Mr. Gwent and Mr. P. were diagnosed with depression, whereas the other seven respondents were diagnosed with psychotic illnesses. However, it would be an error to use this as the sole criterion for severity: notably, Mr. Gwent reported suicidal ideation, whilst Mr. P. took an overdose. Similarly, it should be noted that in some narratives the consequences of the mental health narrative were complicated by other narratives. Thus recovery may be more than the alleviation of phenomena: it may necessitate the restoration of other nested narratives and even the initiation of new narratives.

Concerning medical treatment, all but Mr. Gwent were admitted to hospital, sometimes on several occasions. However, it is notable that he describes himself as virtually helpless ('curled up in a foetal position') before recovery began, and that he had the support of his wife at home. This description raises

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the question of *why* hospital treatment was deemed necessary in response to the other eight mental health narratives, in particular the differing forms of associated helplessness. Like Mr. Gwent, for *Mr. P.* it was akin to mental exhaustion. This resulted in extreme inertia, wherein assistance and encouragement were needed to fulfil the basic demands of daily life. However, unlike Mr. Gwent, Mr. P. had become homeless and lacked close family support: accordingly, he was obliged to live in residential care following a brief period of hospitalization.

Common to the seven narratives describing psychotic illness is a build-up of phenomena resulting in crisis. Thereafter, these narratives include descriptions of multiple admissions (all except Mr. CBA), lengthy in-patient care (especially in the case of Eddie Hooper-Smith) and continuing regimes of medication and/or cognitive therapy. Importantly, some of the respondents, namely Mr. K., Eddie Hooper-Smith, Mr. K, Dorothy, Sandra, and Anne, received strong parental support. From this, it can be surmised that home care was not a suitable option because medical personnel considered that recovery had not progressed sufficiently. This raises a vexed and often emotive subject: by what standards should recovery be judged?

10.3.2: Immersion

In the anthology '*Speaking Our Minds*' (1996), the editors make a stark complaint against psychiatric practice:

> Why is it that a psychiatric in-patient who feels and expresses the full range of human emotions is in danger of having them interpreted as a symptom of their mental illness?
>
> **(Read and Reynolds, 1996, 76)**

Unfortunately, however, this is not supported by the examples cited, namely Laing (ibid); Hart (ibid) and Brunner (ibid). Rather, these narratives describe what these authors interpret as unreasonable demands for conformity. This is a pity, because the consequences of this are to discredit what is possibly a valid argument. In response, it is incumbent to consider the issue from both points of view, namely those of medical staff and of patient. Medical staff are obliged to assess a patient's symptoms on admission and, thereafter, monitor their

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progress. With regard to this, a patient may be highly unpredictable: in addition to their symptoms, they may be emotionally labile, also resentful. For them, admission to hospital is a new significant narrative within an already traumatic dominant mental health narrative. My own reaction to my first admission was that I was entering a new realm of strangeness, a place of madness where I would be forced to confront my own madness.

To describe the days and weeks that follow admission, I use my own experiences and those in some of the nine narratives (particularly Dorothy and Eddie-Hooper-Smith). With respect to the overall experience, Charmaz's model of immersion (1997) is highly appropriate in that it provides an overview of life dominated by hospital routine. My own experiences are of a curious inertia, often boredom, punctuated by occasional tests and minor consultations. My view then, and to this day, is that this was a deliberate policy to reduce stimulation and thereby the potential for emotion to escalate into a psychotic episode. However, this inevitably leads to two problems. The first is essentially unavoidable, namely the fact that one is aware of being watched, no matter how unobtrusively. The second is the aforementioned question of the full range of human emotions: what is a normal reaction to a particular event?

As the first problem is unavoidable, so the second is unanswerable. Firstly, a hospital environment is in itself an on-going dominant narrative of much potency, whether necessitated by physical or mental illness. As stressed above, it is immersion in routine. Accordingly, one is obliged to adapt personal agency, possibly against one's better judgement, possibly against one's will. Is it so surprising, therefore, that emotional affect is difficult to assess and may be misinterpreted? Secondly is the obvious observation that it is unlikely that *medical staff knew the person before admission.* Therefore, they will not know whether a person laughs easily, dislikes television, is given to thinking aloud, and so on. Whilst information can and should be sought from family members, this area may always remain difficult due to its inherent subjectivity.

Thereafter, although this area is undoubtedly important to personal identity, further exploration will not be pursued. It is sufficient to state that the number of

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and links between the nested narratives within a 'hospital care narrative' undergo constant change. For example, in a review of studies of residential alternatives to hospital, Lloyd-Evans et al (2009) state that:

> The potential for emergency residential accommodation outside the hospital setting to improve service user choice and thus the acceptability of services, while relieving bed pressure on acute wards, was identified 10 years ago.
> **(Lloyd-Evans et al, 2009:115)**

However, despite awareness of user dissatisfaction, the authors imply that this should not be the sole momentum for change. Indeed, they suggest that some models described as 'promising' have yet to be widely adopted because '...clinical practice is running ahead of the research evidence base' (ibid).

10.3.3: Reclaiming the personal narrative

Although all of the respondents had recovered sufficiently to tell me their stories, it was evident that for all but Mr. Gwent the personal narrative had undergone massive change. In some cases this was, ultimately, positive (Mr. K.; Mr. P.; Sandra) whilst in others it was negative (Mr. CBA; Dorothy; Eddie Hooper-Smith; Anne; Anita). However, with regard to the latter, whether or not such change can or should be regarded as irrevocable is highly conjectural and subjective. Instead, it is stressed that recovery is an on-going process, a nested narrative within an active personal narrative. As such, reclamation of what was is not a prerequisite; instead recovery should be understood in terms of regaining personal autonomy. Exactly how this might be measured also involves subjectivity, although an appropriate summary could be seen in terms of involvement in the PCS system (see Chapter Three) to one's personal satisfaction. In this way, continuing contact with medical services, including a regime of medication, need not necessarily be seen as a disadvantage. In turn, this invites reappraisal of the respondents' narratives: instead of viewing them in terms of positivity and negativity, they can be understood as stages in recovery, always possessing the potential for significant change. This possibility will be reviewed in the following chapter, which will compare and contrast the nine personal narratives in entirety.

Chapter Eleven: Integration of findings: towards cross-case analysis

11.1: Introduction: reflections and review

This chapter opens by querying if narrative theory is over-prescriptive; in particular if persons perceive and review their memories and concepts according to the many constructs hitherto described. In conjunction with this exercise, it will also critique the methodology of the research: whether or not a given area might have benefitted from a different approach, or if avenues of interest are unexplored. In doing so, it will lay the foundations for integrating the findings with reference to the research questions.

At this juncture, therefore, it is appropriate to make a declaration that will inform this entire discussion. At face value, the Central Research Question is incomplete: it should seek to establish the manner, degree and duration of that impact. Above all, it should recognize that it does not occur in isolation, but is part of the complex, continually evolving construct that is the *personal narrative*. In turn, constant objective and subjective assessments of the personal narrative by the intrinsic self maintain development of the *personal myth,* the uniquely personal view of the personal narrative, within which personal identity is an integral part. Therefore the final part of this chapter will compare and contrast the narratives of the nine respondents. Integral to this exercise is the respondents' own understanding of their mental health narrative; in particular whether it is an aspect of the past or an on-going part of the present. In this way, it will examine the processes of review and introspection and ascertain the impact upon their personal myths, and thereby their personal identity.

11.2: The ubiquity of narrative

As soon as we acquire language, it is inevitable that we employ it to describe events and concepts. However, at a purely personal level, we can exceed the boundaries of words by recourse to memory and/or imagination. Nevertheless, if our thoughts are to make sense, they must be sufficiently coherent to assume

a recognizable form or construct. Therefore, according to these parameters, narrative can justifiably be described as ubiquitous. Concerning personal reflection as detailed above, it is appropriate to recall Barbara Hardy's summary of narrative:

> We dream in narrative, daydream in narrative, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticise, construct, gossip, learn, hate, and love by narrative.
>
> **(Hardy, 1987, 1)**

11.3: The interview as a vehicle of recall

By interviewing an individual, I invited them to review the relevant aspects of their life story, so facilitating reconstruction as described in Chapter Three with reference to Linde (1997):

> The life story is thus comprised exactly of the most significant narratives of a speaker's life, which are told and retold, reinterpreted and reshaped for different situations.
>
> **(Linde, 1997, 283)**

This raises a fundamental question, 'To what extent is interviewing an artifice?' Expressed another way, 'Would a respondent have reflected upon their experience of mental illness to the same degree *if I had not interviewed them?*' Or would their memories be disjointed, a group of fragments? If so, then my constructs of significant and dominant narratives would have little real meaning. Accordingly, it is incumbent to challenge the entire concept of narrative as a coherent construct incorporating beginning, middle, and end.

11.4: Challenges to narrative theory: the 'discontinuity view'

One area of objection to narrative is due to its 'everyday use':

> The concept of narrative does not hold an established theoretical place in sociological school or tradition.
>
> **(Williams, 2001:187) [Original paper 1984]**

Against this, it can be successfully argued that, properly applied, narrative and narrative analysis meet scientific rigour. However, a more substantial challenge has been made by postmodernism, which focuses on the difference between reality and representation. Applying the generalized term *'discontinuity theory'*, Carr (1986) notes that, at best, narrative is viewed by some postmodernists as a product of creativity, and at worst, a deliberate attempt at social manipulation. Instead it is sufficient to meet the postmodern challenge directly. Firstly, William's observation (above) serves only to demonstrate that the application of narrative is not restricted to an academic environment. In truth, it has been an area of research for decades, albeit subject to healthy scrutiny and question appropriate to its setting. Secondly, the fact that narrative is a communicative vehicle in everyday life means it is unavoidably true that it can be crafted to facilitate specific aims. Thirdly, and most importantly, it has already been stressed that narrative is representational of experience and that language is a necessarily artificial means of description. Accordingly, there is a parallel with the philosophical constructs of direct realism or 'naïve' realism, representative realism, and relativism (Horner and Westacott, 2000; Hammersley, 1992).

Also noted by Carr (ibid), proponents of the discontinuity theory challenge the concept of beginning-middle-end by arguing that these distinctions do not exist in real life. His response is to note MacIntyre's (1981) observation that they are 'forgetting death' before mentioning 'birth' and stating that:

> They are forgetting all the other less definitive but still important forms of closure and structure to be found along the path from one to the other.
> **(Carr, 1986:122)**

It must be emphasized that the postmodern objections deserve more than casual dismissal: as a result, MacIntyre's observation can been seen something of a 'cheap shot'. Instead, it is necessary to apply some common sense in support of the beginning-middle-end construct. In simple terms, concerning the question, "What did you do yesterday afternoon?" an answer has to start *somewhere*. Obviously, this is at a point decided by the narrator; thereafter, it must be relevant: it would be nonsensical to reply by talking about events that happened days previously. However, it is crucial to appreciate that this is a

simple illustration of a simple example. With reference to more complex narratives, the postmodernist considerations cited can and should be acknowledged. For example, Rimmon-Kenan (2002) both acknowledges and eschews artifice with reference to illness narratives by averring that:

> Types of narrative are analytic categories. In reality, narratives never belong "purely" to one category or the other; each contains elements of the other and the distinction is based on emphasis and dominance rather than a clear-cut polarity.
>
> **(Rimmon-Kenan, 2002:15)**

Nevertheless, it must be stressed that the author does not reject the application of narrative but moderates it. In effect, she enables the obvious but crucial observation that although a person may think in narrative, as described by Hardy (above) they may make little or no use of named constructs such as plot, genre, or even narrative itself. However, this in no way negates the basic concept of narrative in the life story, as detailed by Linde (above). Thus this discussion concludes by acknowledging that whilst the precise application of narrative remains a matter of debate, it should be considered a viable analytical tool, both in everyday life and academia.

11.5: Narrative and imagoes

As discussed in Chapter Three, imagoes are described by McAdams (1993) in terms of archetypal patterns deriving from idealized concepts of behaviour and achievement. Inevitably, these constructs incorporate a degree of subjectivity; therefore they can be seen as an artifice, an emotive generalization. As such, in keeping with the previous section, their worth in academia can be doubted. Are they no more than an invention, a product of various authors' imaginations? Or are they founded upon observations of real life? In response, it is necessary to explore the linguistic nature of an imago. Whilst some are obviously derived from societal roles ('husband', 'wife', 'carer, friend', others are adjectives (sporty, bookish, arty,), and some are formed by transition from an adjective to a noun: in other words, a *description* can become a *label*. For example, a person can be seen as 'a success'; 'an animal-lover', an 'artist' and so on. With

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reference to this research, by far the most common imago associated with mental illness is *the user.* Also important, but much more contentious, are the iconic forms in named 'illness narratives'.

11.6: Illness narratives

Illness narratives can be divided into two broad categories. The first, being wholly descriptive with respect to narrative trajectory, is, essentially, an objective view. This category includes Gergen and Gergen's (2001) basic narrative models; also Charmaz's (1997) levels of intrusion, interruption, and immersion. The second is both descriptive and nominal in that it accords a narrative trajectory a *name,* so implying the creation of an imago. This category includes; 'phoenix' (May, 1991); 'epiphany' (Frank, 1993); 'restitution', 'chaos', and 'quest' (Frank, 1997). Concerning the latter types, it is undeniable that they can be interpreted as both subjective and prescriptive. Thus, in his text *The Wounded Storyteller,* Frank (1997) feels obliged to refute the enthusiasm of his 1993 approach by concluding his exploration of his three narrative types with a considered and pragmatic assessment of the relationship between them. Perhaps the most telling of his observations is that:

> Ill people need to be regarded by themselves, by their caregivers, and by our culture as heroes of their own stories.
>
> **(Frank, 1997, 135)**

Rapidly, on further reading, it becomes evident that the author is using 'hero' in terms of 'valour' as opposed to 'central character'. Thereafter, he observes that 'quest' stories risk romanticizing illness, and that the 'phoenix' metaphor can become an instrument of condemnation against those who fail to recover from their illness. This shift in stance is noted with satisfaction by Rimmon-Kenan (ibid); nevertheless she continues to express reservations. Possibly this is because of her own illness which informs her paper (ocular myasthenia) and also because of her extensive use of Christina Middlebrook's (1998) memoir *'Seeing the Crab: a Memoir of Dying'.* Rather than a continuous narrative, this harrowing, sometimes disjointed, work is a collection of significant narratives concerning the central theme of the author's breast cancer. Maybe it was

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written as a catharsis, maybe not: whatever Middlebrook's motives, Rimmon-Kenan rightly uses her text to advocate awareness of narratives 'without epiphanies and for writing that does not overcome chaos' (ibid, 24).

Nevertheless, in any plea for balance and pragmatism, there is a real issue concerning societal attitudes to illness. Concerning restitution narratives, Frank (1997) writes:

> Anyone who is sick wants to be healthy again. Moreover, contemporary culture treats health as the normal condition that people ought to have restored. Thus the ill person's own desire for restitution is compounded by the expectation that other people want to hear restitution stories.
>
> **(Frank, 1997:77)**

Probably more than any other, this statement lies at the core of attitudes to health in the western world. Fundamental to its understanding is the fact that a person can be both narrator and audience with respect to their own narrative. Accordingly, within any long-term illness, such as those described by the nine respondents, any understanding based on knowledge and pragmatism may be tempered by the weight of expectation. Unchecked, such a burden may become oppression.

11.7: Unresolved and failed narratives

Throughout this study, I have harboured misgivings concerning the potential importance of 'unresolved' narratives. As explained in Chapter Three, this construct derived from Labov's (1997) construct of a 'failed narrative', namely a narrative that is rejected by its audience. To this construct must be added my own subjectivity in conjunction with the fact that a person can be both narrator and audience. With reference to my own personal narrative, I cannot avoid the stark judgement that it contains many failed narratives. In such cases, my only recourse is to attempt to reassure myself that I have learned something, even if only not to repeat a mistake. Nevertheless, the belief in failure remains strong, resisting such facile logic. Thus, with reference to the transcripts, my viewpoint was ambivalent. As a person, I could appreciate what I believed to be the very real possibility of a respondent deeming a particular event to be a failed narrative. However, as a researcher, taking an *objective* view, I found that I did

not *want* to designate a narrative as failed. Thus, either way, my assessment was, ultimately, compromised by subjectivity. To this dilemma, my recourse is to reprise the nature of dominance; namely that even the most potent of failed narratives may later become subordinate to a new dominant narrative. Thus it may remain, unassimilated but insignificant, an unhappy memory within the multitude that is the personal narrative.

By applying this viewpoint, a narrative can be understood to be unresolved in the sense that it might (and, ideally, should) be subject to review in the light of new experience. In contrast, the term 'failed' would be inappropriate in that to deny such change, and thereby hope, would represent an unacceptable absolute. However, as explained above, it must be acknowledged that this view is largely *objective* and, moreover, *that of a detached observer.* Therefore, to pursue deconstruction to its logical extent, it is incumbent to focus upon *the individual's subjective view of their own experiences.* For example, whilst one can opine that *Anne's* relationship narrative may, one day, be resolved, it is evident that, at present, she is desperate for closure. Also, it is important that despite her relatively active lifestyle, *Dorothy* used the term 'failure' throughout the interview with reference to the personal circumstances. Similarly, *Mr. CBA* reported feelings of failure many years after overwhelm.

The concepts of unresolved and failed negatives lead naturally to the possibility of the formation of negative imagoes. This important subject is discussed in the next section.

11.8: The creation of imagoes in response to experience of phenomena diagnosed as mental illness

Fundamental to this discussion is that an illness can become a label and, thereby, an aspect of identity. Thus, a person suffering from diabetes can be described as 'a diabetic'; a person suffering from schizophrenia can be described as 'a schizophrenic'. As explained above, this also occurs in the event of an adjective becoming a noun. Concerning illness narratives, this is not necessarily the case, as for example, Charmaz's (1997) categories of

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interruption, intrusion, and immersion. However, in complete contrast are those narrative types named by Frank (1993, 1997). To describe an illness narrative as a form of journey implies the existence of an appropriate imago, that is a 'traveller', a 'seeker ', or even, as detailed above, a 'phoenix'. Associated with these, as explained above, are value judgements derived from idealized concepts of illness narrative. The ill person should recover: thus the traveller should reach his goal, the seeker should complete his quest, and the phoenix should be reborn.

It is stressed that this research did not deliberately seek data concerning concepts of imagoes. Instead, any such understanding derives from terms used by the respondents both with reference to their illness and other nested narratives. In most, but not all, of the interviews the 'user' imago was declared or implied. Initially, this term appears value-neutral, a generalized function of experience as opposed to ability or achievement. However, on examination, it appears to have several meanings as opposed to being a single imago, depending upon the course of the mental health narrative. For instance, the narratives of *Mr. K., Mr. P., Sandra,* and *Mr. Gwent* included elements of discovery that could be applied to help other persons. In contrast, the narratives of *Eddie Hooper-Smith* and *Anita* include the role of long-term patient; those of *Dorothy* and *Mr. CBA* failure; and that of *Anne* loss. Thereafter, I am reluctant to make further observations save that focus on imagoes could prove an important adjunct to this research. Accordingly, this issue will be discussed again later in the conclusion to this chapter.

Gradually, this exploration has turned full circle. Undoubtedly the various illness narratives and concept of imagoes are useful constructs for illustrating aspects of the self and personal identity. Yet, with reference to everyday life, are they so well defined? Or are they figments in the imagination of social science researchers? In answer, I believe the issue centres on sensitization. Initially, awareness and conceptualization is at the level cited by Linde (1997) [see above] whereby the life story is comprised of 'significant narratives'. Almost identical, but possibly slightly more refined is Rimmon-Kenan's (ibid) description of narratives in terms of 'emphasis' and 'dominance'. Thereafter, once

established, it is possible that a person may apply an imago to a particular aspect of their life story; if so, it is also possible that this is socially constructed, either by reading or verbal means. This possibility has important implications for this study; accordingly, it will be reprised later.

11.9: The applicability of significant and dominant narratives in analysis of personal narratives

All persons recognize that some events in their lives have been more important than others; similarly all persons recognize that some aspects of their lives are more important – more significant – than others. As explained previously, the personal narrative, and therefore the equilibrium within, is in a state of constant flux due to a combination of internal and external environmental forces. Yet this observation can be turned against itself by positing that, in the absence of events contrary to normal expectations, many people would consider their personal narratives to be stable. This is the basis of the illness narratives described above: that an *abnormal event*, such as illness, causes disequilibrium and may bring *the entire personal narrative* into focus.

Concerning the personal narrative during illness, the description of Rimmon-Kenan (ibid) possesses the beauty of simplicity. By describing the impact of illness in terms of emphasis and dominance, she draws attention to the fact that named illness narratives are an elaboration. Although undoubtedly illuminating, they are *not essential* to the understanding of illness. Instead, it is sufficient to measure the impact of illness in terms of severity of symptoms and the consequences of same. Concerning these, I suggest that her description can be differentiated into areas of importance (emphasis) and degree of effect on same (dominance).

At this point, it is essential that I review my application of significant and dominant narratives in the analysis of the transcripts. Undoubtedly, a valid question is whether I allowed my enthusiasm to invent the concepts I required: that what I believed to be a self-evident truth is non-existent. As noted earlier (Chapter Seven), the term 'significant narratives' is employed by Linde (1993, 283) with reference to the life story. Associated with this, my considered

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response is founded on a combination of observations and questions, including avenues of exploration that were later abandoned due to the need for brevity. First and foremost of these were elaborations upon objective and subjective reactions to stimuli, which, in turn, led to scrutiny of *phobias*. The main characteristic of a phobia is excessive and seemingly irrational fear (McDonough, 2004). As such, it can be described as a supreme example of the domination of an objective response by a subjective reaction.

In conjunction with earlier explorations into the intangibility of the self-construct, study of such interactions between objective and subjective responses led to consideration of the personal narrative. A related but different approach, namely the Hassles-Uplift Index, brought attention to the fact that our attention can alight on many events in a single day. In turn, this enables the obvious but crucial observation that, if required, we can focus our concentration upon a single area. At such times, our thoughts are occupied with but one narrative or a group of related narratives. Meanwhile, it is an undoubted truth that many other narratives continue unaffected within the personal narrative. This is the central tenet of significant and dominant narratives: that our minds can be voluntarily or involuntarily focussed on a single chain of events.

Given the data in the transcripts, I had no quantitative assessments of the importance of given narratives. Instead, my use of significance and dominance was, essentially, an approximation derived from qualitative descriptions in the data. Concerning these, it is an unfortunate aspect of presentation that limits the amount of written detail that can be included. I cannot stress enough that the data resulting from the interviews was not solely a *mental illness narrative, but a personal narrative*. This was by virtue of having talked about many subjects, of which experience of mental illness was but one. Of course this was not true of all respondents: for example, Eddie Hooper-Smith and Mr. K. deviated little, whilst Anne spoke entirely of her illness and her partner. However, others, particularly Dorothy, Mr. P., Sandra, and Anita, précised their entire life stories in the course of exploration. As a consequence, I felt that I gained considerable insight into the experiences relevant to this study.

11.10: Overview of the mental illness narrative

The data indicated that the mental illness narrative impacts upon the personal narrative in two areas, *direct and indirect*. The *direct* area pertains to experience of the constituent phenomena:

- The content of the phenomena
- Emotional, intellectual and behavioural reaction to phenomena
- The form of the phenomena as determined by classification of content
- Medical and/or other treatment (if any)
- Duration of phenomena

The *indirect* area concerns other nested narratives which may be affected by the mental illness narrative. Although the consequences are usually negative, it would be inaccurate to generalize to that effect, particularly with reference to intimate and family relationships. These include, though not necessarily in order of importance:

- Intimate relationships
- Family relationships
- Social and cultural relationships (including personal freedom)
- Employment status; ability to work
- Financial status

In positing the above list, I stress that they are broad categories, of which any one of the nine personal narratives included some, but not necessarily all.

11.11: Assessing the impact of phenomena diagnosed as mental illness upon personal identity

11.11.1: Prologue: so when did it all begin?

Common to all prologues are indications of possible overwhelm, some vague and spanning many years, (e.g. the unhappiness reported by Mr. P.) and some that could be interpreted as 'warning rattles' (e.g. stress, as reported by Mr.

Gwent; social phobia and night fears as reported by Dorothy). However, the question of the degree to which the respondents were aware of incipient phenomena and their potential severity is exceedingly complex. To elaborate, it might be helpful to detail my own experiences of phenomena diagnosed as mental illness. Looking back, I can speculate with confidence on certain core beliefs and trends and I can describe in vivid detail the many phenomena associated with my various diagnoses. Yet, despite my best efforts, I cannot pinpoint exactly when an episode began. With the wisdom of hindsight I can identify warning signs, but I cannot ascertain when unhappiness or insecurity metamorphosed into something more. To explain this to someone who has never experienced mental illness, I use the obvious example of a physical illness. We all recognize when we are succumbing to a common cold...... Or do we? Far more likely is that we recognize the first symptom: a soreness in the throat or nose, a first sneeze. By the time we are aware of the cold, it has long begun: we did not recognize the prologue until overwhelm was imminent.

To this construct I wish to add a further large measure of uncertainty. Concerning a physical illness such as a common cold, we may entertain doubts until the symptoms are unarguable. Similarly, we may entertain doubts about the significance of particular thought processes. However, as detailed in Chapter Four, physical illness can eventually be ascertained by a combination of primary and secondary qualities and, probably, the 'tertiary quality' of pain. In contrast, phenomena diagnosed as mental illness are *felt exclusively in terms of 'fourth degree' qualities, namely thought processes.* Thus, not surprisingly, the nine narratives demonstrated a wide range of response to incipient phenomena.

Mr. Gwent was unlike any other respondent in that he was unaware of any incipient phenomena despite reporting a diagnosis of stress, accompanied by a warning to respond appropriately, by his GP. Subsequently, overwhelm was sudden and unexpected. Similarly, neither *Eddie Hooper-Smith* nor *Anne* appeared to be aware of precursors to sudden overwhelm. However, Anne's narrative describes a prolonged period of strangeness that is probably best described as 'limbo' in that overwhelm was not diagnosed. Therefore, strictly speaking, this should be included in her prologue.

The narratives of *Mr. CBA* and *Mr. P.* share commonalities in that they show a gradual decline of which they appeared to be aware but seemed powerless to arrest. Thus, whilst overwhelm was not inevitable, it was the culmination of the constituent nested narratives. In comparison, the narratives of both *Dorothy* and *Sandra* described an intensifying of unease in social circles and, eventually, overwhelm in the form of mania. Interestingly, by virtue of deliberate isolation, Sandra appears to be able to have controlled her symptoms to a greater degree. *Mr. K.* also describes awareness of phenomena at an early stage but, in contrast, sought aid to control same from a spiritual healer. However, unfortunately, he did not elaborate upon the circumstances that subsequently led to overwhelm. Lastly, the complex narrative provided by *Anita* includes several significant nested narratives, any one of which could have been a precursor to overwhelm. Accordingly, further analysis is withheld pending further examination of her narrative in the following sections.

11.11.2: The experience of overwhelm

Common to all nine narratives of overwhelm was at least one prolonged episode of complete dominance by the mental health narrative. Within this, four respondents (Mr. Gwent; Mr. P.; Anne; Anita) experienced the extremely powerful nested narrative of suicidal ideation. Yet, whilst this 'ultimate' expression of overwhelm would be understandable, it would be a gross over-simplification. Of far greater significance is that all of the respondents described processes wherein their identities were effectively lost; of thoughts and actions beyond their conscious control. Despite this, they were (with the possible exception of Anne in the early stages of her illness) *aware* of the turmoil within, thus they became unwilling observers of their own aberrant mental processes. Thereafter, all are able to remember their trauma, as proven by the fact that they provided the often extraordinary level of detail about their experiences in these interviews.

11.11.3: The intensity and duration of overwhelm

From any point of view, this section must be regarded as highly arbitrary. With reference to the transcripts, onset of overwhelm ranged from a gradual decline (Mr. CBA, Mr. P.) to sudden onset (Mr. Gwent; Eddie Hooper-Smith). Thereafter, however, how should duration of overwhelm be defined? Whilst hospitalization is undoubtedly one parameter, it must be stressed that recovery begins there. Thus duration becomes a question of balance, of an indeterminate point when health begins to attain dominance over illness. By adopting this diffuse construct, the possibility of temporary relapse and/or sudden events can be included. Specifically, it is pertinent to refer to the suicide attempts by Anne and the suicidal ideation of Mr. Gwent, which occurred after the onset of overwhelm. Notably, these had very different origins: whereas Anne reacted to the ending of a relationship, Mr. Gwent suffered a surge in depressive thoughts. However, in narrative terms, both represented dominant narratives of tremendous potency, sufficient to suppress all other considerations.

11.11.4: The aftermath of overwhelm

Undoubtedly, if one views a personal narrative in terms of a journey, then overwhelm could be expressed as crossing a Rubicon. More dramatically, some descriptions in the data could be described as opening Pandora's Box. However, such descriptions imply irrevocable action, whereas the data included narratives whereby overwhelm was partially or entirely mediated. Thus it is sufficient to acknowledge overwhelm as a profound experience arising from dominance of a mental illness narrative. Included in this was a process of recognition, maybe even the beginnings of a new understanding, whereby mental illness is now known to be 'the problem'. As explained in the overview of the mental illness narrative (see above), the aftermath of overwhelm may be direct, in that phenomena continue; and indirect in that other nested narratives within personal narrative may have suffered impact. This leads to a concept of recovery as a reclamation, repair, and possible restructuring of the personal narrative. Within this, in the course of normal interactions within the personal

narrative, evaluation and re-evaluation of relevant memories may take place, including those described in the prologues.

Associated with this is a need for some qualification, particularly with regard to direct effects of phenomena. That is, recovery is a state of being as opposed to something possessing specific boundaries. Therefore, it is possible to recognize varying degrees and/or qualities of recovery without contradiction. Thus, recovery can be said to be complete if phenomena are effectively treated with medication. Similarly, recovery can be partial in that phenomena can continue, even remaining a significant narrative. However, as stressed throughout this study, an objective view is virtually certain to be influenced or even compromised by how it is appraised. Thus, as will be shown in the following review of the recovery narratives, an integral part of recovery is a belief that one is recovering or has recovered. If this is absent, then the aftermath of overwhelm may be experienced as chronic illness, maintained in part by the fact of its existence.

11.11.5: Recovery

Since an overview of the recovery narratives was made at the conclusion to the previous chapter, this section will discuss individual personal narratives in turn, making comparisons with other personal narratives as and when appropriate. At the time of interview, *Mr. K.* enjoyed complete recovery with the aid of medication. His narrative was important *for what he did not say:* even amid his occasional grumbling regarding hospital facilities, there was little mention of the reason he was there. Overall, the impression gained was of ready acceptance followed by eventual assimilation. Notably, his experience of illness led directly to user involvement, first as a volunteer then as a paid worker. However, at no time did he speculate upon other career avenues, therefore whether or not this represented a change of direction must be regarded as a moot point. Accordingly, I feel that Mr. K. views his illness as an unfortunate event that ultimately turned out for the best in that it enabled an interest and a career. In this, the mental health narrative remains active in that his personal identity now includes a positive user imago.

Like Mr. K., *Mr. Gwent* now enjoys almost complete recovery, but without the aid of medication. When reviewing his narrative I am struck forcibly by the totality and suddenness of overwhelm: that transformation from competent professionalism to tearful helplessness was virtually instantaneous. As such, it appears to have constituted what was, for him at the time, a previously unimaginable vulnerability. In connection with this, he made a succinct summary:

> I didn't like it.
> I didn't like it at all.....
> It was an awful experience and.....
> It's funny, if somebody should say
> everybody should experience
> what I've gone through [.....]
> no, I wouldn't say that,
> I wouldn't wish it on anybody.

Nevertheless, he drew attention to a beneficial consequence of his experiences:

> I genuinely think I'm a better person   [......]
> And...... I think my empathy is enhanced
> by the experience that I've been through.

Almost certainly, much of this can be attributed to experience of human kindness in the persons of Mr. Gwent's wife and friends. However, it is noteworthy throughout his interview that he made mention of emotional reaction (specifically, tears) in response to ostensibly joyful occasions, particularly renditions of music. Therefore, there is a possibility that experience of phenomena diagnosed as mental illness somehow intensified this quality. Concerning this, exploration would have been a valuable aspect of a second interview: looking back, I regret that I did not think to ask the appropriate question at the time. Unlike Mr. K., Mr Gwent does not appear to have acquired a user imago; instead, I posit cautiously that his data implies a form of 'survivor' imago. This is by virtue of his description of emotional vulnerability (see previous chapter).

Mr. P.'s narrative is similar to Mr. Gwent's in that both were diagnosed as suffering from depression. However, in virtually all other respects, they are

entirely different. Whereas Mr. Gwent was a successful professional, Mr. P. described a succession of unfulfilling occupations and eventual unemployment. Whereas Mr. Gwent's marriage was stable, Mr. P. was alone and unhappy. As a consequence of his combined circumstances, Mr. P. entered into a period of decline, culminating in overwhelm. Thereafter, again in contrast to Mr. Gwent, his rehabilitation began in sheltered accommodation: at this time he appeared to have had no prospects of a return to employment.

Once the impetus of overwhelm had passed, Mr. P., with the aid of counselling, came to see his illness as an affirmation of the negative nested narratives that had blighted his past:

> I concluded that
> I wasn't the weakling
> that everybody made me out to be   [.....]
> That I did have a voice-
> that although I didn't cry out at the time,.....
> I was crying out then, saying,
> "This is what I am;
> this is what I've been through."   .
> And it has been shit, basically. [.....]

As detailed above, counselling resulted in successful challenge of a negative imago: this important concept will be discussed in the conclusion. Also applicable is Frank's (1993) construct of 'epiphany': Mr. P. became able to see himself as an independent individual with a potential in his personal narrative that exceeded all that had gone before. His rehabilitation was gradual but progressive, approximating to Frank's 'quest narrative' (1997) whereby illness leads to self-discovery. Later, applicable to his narrative is the 'melodrama' genre detailed by Gergen and Gergen (2001) in that it contains many later setbacks amid triumphs. As such, this is an extremely important aspect of Mr. P.'s later narrative: given the details in his transcripts, it is evident that he has acquired a resilience that he did not possess before. Therefore, despite his relationship and financial problems at the time of interview, he remained positive, averring that he was glad he had had his illness:

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I am happy that I have been through it.
It has been tough, yes,
And its-
Very much it's had its moments.
But I wouldn't change it,
I wouldn't change it.

The central theme of the narratives of both *Eddie Hooper-Smith and Anne* is *loss*. Both had professional careers prior to overwhelm; both suffered relatively sudden onset of severe psychotic symptoms; both suffered the break-up of a relationship; both continue to be troubled by phenomena, albeit mediated by medication. Also, stated in both transcripts is the fact that their parents remained supportive, though Anne appears to be living alone at a far earlier stage in her recovery than Eddie. Concerning recovery, there are important differences, some of which may derive from the fact that Eddie's narrative is over a longer time period than Anne's. Throughout his interview, his approach was pragmatic, even when describing florid symptoms and expressing his opinions concerning medication. With regard to the present and the future, his life strategy can be described as 'assisted assimilation', that is, a gradual re-integration into society with the aid of a Support Worker. Notably his voices remain, albeit mediated by selective listening. The impact upon his sense of personal identity seems to be considerable: despite his progress, phenomena diagnosed as mental illness can be viewed as remaining a dominant narrative.

In contrast, Anne has yet to come to terms with the consequences of her illness. Therefore, it remains dominant amongst a complex of unresolved narratives in that schizophrenia is at the core of all that she has lost. Throughout the interview, a recurring theme was a pernicious introspection centred on loss and what might have been. Undoubtedly, her convictions are driven by the unresolved narrative of her relationship, which exacerbates feelings of loneliness and rejection. Nevertheless, mental illness should be viewed as the precipitating factor in what Anne views as a catalogue of catastrophe: if she had not become ill, then no misfortune would have occurred. Associated with this are feelings of guilt: however, on repeated scrutiny, I remain uncertain concerning the precise focus of this. Although she cites smoking skunk, the pivotal event was her trip to the Far East: however, whether this was influenced

by illness phenomena (e.g. grandeur) is not clear. What is certain is that she regards her illness as culpable, something that could have been prevented.

I posit that Anne's feelings of guilt should be regarded as a third significant narrative, aligned with the mental health and relationship narratives, but a distinct narrative in its own right. As such, it serves to exacerbate both of the other narratives, particularly the latter. Of crucial importance is that it is a definitive example of an unresolved narrative: by its very nature, guilt can remain corrosive until mediated by understanding and forgiveness. Thus, like Eddie Hooper-Smith, phenomena diagnosed as mental illness remain dominant in Anne's narrative. However, whilst the impact upon personal identity in both cases is considerable, I suggest that there is a fundamental difference between them. In terms of imagoes, Eddie's schema is that of *user,* whereas Anne's is that of *victim.*

From one viewpoint, the narrative of *Mr. CBA* is similar to that of Eddie Hooper-Smith in embracing hope by virtue of nascent narratives of social involvement. From another, it is pessimistic, containing the same aspects of loss as that of Anne. However, the presentation of the narratives was markedly different, whereas Anne's theme conveyed torment, Mr. CBA's often conveyed a fatalistic weariness. It is incumbent to mention Mr. CBA's adverse reaction to the second interview, namely the fact that he felt unable to cope with the self-analysis involved. The impression gained is that his on-going illness and its consequences continue to weigh heavily upon him in that they constitute a powerful dominant narrative. For Mr.CBA, his efforts at rehabilitation provide but a short respite as opposed to release and hope.

Arising from the above observations, and as speculated in the previous chapter, the impact of phenomena of phenomena diagnosed as mental illness upon Mr. CBA's sense of personal identity may have been massive. To describe this, I submit that the trajectory of his mental health narrative has reached a plateau. Whilst it is evident that he makes efforts to ascend beyond his present boundaries, these are compromised by recriminations, regrets, and on-going experiences. However, associated with this summary, I point out that an

important aspect of Mr. CBA's narrative has been previously explored with reference to failed and unresolved narratives. That is, if the nature of unresolved narratives is rigorously applied, then it may be that future events and/or understandings may mediate the impact of phenomena diagnosed as mental illness upon his personal narrative.

Concerning the narratives of *Dorothy* and *Sandra*, it is evident that there are significant similarities. Both began to experience problems in adolescence, which continued during university. Eventually, in the second year of her course, *Dorothy* experienced the first of a series of severe episodes over a period of many years. On the other hand, *Sandra* made a deliberate decision to live at home during her course, so suppressing, if not alleviating, her problems. This policy was successful until, following her exams, she experienced the first of two psychotic episodes, each of which necessitated detention under Section III of the 1983 Mental Health Act. With reference to the nature of their phenomena, both respondents described uncontrolled episodes of erratic and/or violent behaviour. However, despite these common significant narratives, their personal narratives had, at the time of the interviews, taken very different courses.

Much centres on the degree of understanding of phenomena that each respondent has (or believed they have) achieved. In connection with this, I draw attention to *Sandra's* knowledge of psychology, which she has applied to both her own and her father's illness. In both interviews, my overriding impression was that she had gained an understanding of her narratives to a degree at which she felt satisfied, especially that of her relationship with her father. Although these narratives may remain unresolved in the sense that they are unfinished and may yet become negative once more, they are now resolved with respect to past events. Accordingly, despite my reservations, Frank's (1997) construct of a 'quest narrative' can be properly applied: for Sandra, much that was painful is now known, thus its power is diminished. Associated with this, I suggest that the exchange with her father, as detailed in the previous chapter, was an example of 'epiphany'.

In contrast, *Dorothy* remained tormented by her continuing illness despite her vigorous researches into its nature. Undoubtedly, this was exacerbated by the possible diagnosis of personality disorder, which she saw as a conferring of blame for all that had transpired. On repeated scrutiny of her interviews, this event represents a distillation of her central concern: that the causes of her illness are unknown. It is not enough to constantly trawl the past, looking for clues: always it will be possible to focus upon a significant nested narrative, a possible reason why. However, before that, there will always be another significant narrative, and before that another, until, eventually, events in the personal narrative have occurred too early to remember. Denied certainty as a result, one is forced to resort to speculation, thus the whole process of looking for that elusive pivotal event continues anew, probably never to be fulfilled. As such, the quest for knowledge can become a troublesome and debilitating unresolved narrative.

The data indicate that this has become a potent nested narrative within Dorothy's mental health narrative. Although she often enjoys many social pursuits, some requiring a high degree of commitment, she remains vulnerable to both her on-going illness and the question, "Why?" Permeating virtually all of her self-appraisals, it appears to hinder rather than aid her progress: for instance, her antagonism towards cognitive therapy was, in part, due to her conviction that people were asking the wrong questions. Whether or not Dorothy will, eventually, assimilate her mental health narrative must, at this juncture, remain a moot point. Such is her evident confusion that she undoubtedly sees herself a user and, maybe even a victim of her illness and the mental health system. Nevertheless, she has not succumbed to disenchantment (Chadwick, 1997b, 584)) but strives to maintain a healthy lifestyle. Thus I feel obliged to make comparison with *Eddie Hooper-Smith*, who appears to have accepted the fact of his illness (see above), and speculate that Dorothy may, one day, find sufficient answers to satisfy her unresolved narratives. Until then, the *user* imago in terms of continuing experience of phenomena seems likely to remain strong.

Anita also presented a positive outlook when interviewed. However, to pursue this review, I am obliged to stress my own limitations when speculating upon the possible impact of Anita's experiences. There are many events that I know of but do not understand, also that there are many events that I have believed to have understood, only to learn that I did not. Concerning the events described in her personal narrative, I query whether my own capacities for sympathy and empathy are sufficient to fully appreciate the fullness of some of the significant nested narratives. Thus, in unreservedly focussing on Anita's early childhood as the first instance of significant nested narratives, I stress that I do not intend a form of amateur psychoanalysis. Instead, I wish to emphasize that she suffered two serious stressors before the age of ten:

- Sexual abuse by her father leading to rejection by her mother
- Strict and repressive upbringing by her grandmother

As a child, Anita was vulnerable to social negotiation, including guilt and reciprocity (Gergen and Gergen, 2001). Moreover, the dark statements of her grandmother can be likened to Novitz's (2001) 'politics of narrative identity' wherein a person can deliberately subvert another's sense of self. With reference to the constant admonitions described, it is highly significant that Anita uses those terms to describe the aftermath of overwhelm (see below).Thus, in tandem with her mother's rejection, Anita's personal narrative was, in all probability, severely compromised. However, it should be stressed that she described no instances of mental illness until she spoke of her first pregnancy.

Paradoxically, if being taken into care was an affirmation of rejection, it was also described as liberation. On reflection, I suggest that this was due to the fact that Anita could now exercise her full potential. However, it is also possible that this event represents a severance from the past, so marking a new course for her personal narrative, or even the subjective beginnings of a new personal narrative. Anita's transcript concerns survival strategies to meet institutional bullying and also abuse: on balance, I interpret this as the assumption a necessary 'mask' representing learned reactions to a hostile world.

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There is a risk that any summary of Anita's personal narrative in adulthood will be hopelessly inadequate. In consequence, I retain the concept of a mask with reference to Chadwick's (1997a) autobiographical account of internal conflicts resulting in delusion and attempted suicide. Likewise, Anita's relationship problems followed by involvement with drugs gangs can only be described as unhappiness followed by a prolonged period of delusion and mania. Like Chadwick's account, the data provided describe the construction of an alternative identity: this was so complete as to constitute a wholly dominant narrative. If so, this raises a complex hypothetical question concerning the impact of this experience upon Anita's sense of personal identity. That is, was the construct defined by interaction with her former personal narrative quiescent, in suspension, so allowing the formation of an entirely new identity? Or was it responding at a level unrecognized at the time? Whilst I suspect it is virtually impossible to answer this, I draw attention to the fact that Anita was able to remember many of the events of the delusory narrative. Thus, although the possible impact at the time must remain unknown, the later impact was described in considerable detail.

Following overwhelm, Anita was reduced to a state of mind-numbing exhaustion from which she gradually recovered with the aid of counselling and medication. Unfortunately, however, her personal narrative continued to be dogged by several negative nested narratives:

- Puerperal psychosis after the birth of her fourth child
- Relationship problems: concerning these, she did not specify whether or not the two narratives were linked.
- Another pregnancy was ended by miscarriage and what Anita describes as 'aggravated depression'.
- Another pregnancy and eventual birth proceeded amid narratives of hospital admission due to possible bipolar disorder and later, a diagnosis of borderline personality disorder.
- An extended legal battle concerning Anita's suitability to look after her children.

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At this point, I turn to the expression 'battle fatigue' to describe Anita's state of mind. In the following extract she summarizes the entirety of the negative narratives that have nested or continue to nest in her personal narrative:

> through my turbulence and my chaos,
> my mental health,
> I'd lost my professional career,
> I'd lost any relationships I'd tried to establish,
> I'd lost my children,
> I'd had loads of labels and judgements.
> I just felt very, very, very scorned
> and a bit of a self-fulfilling prophecy
> of what my nana and my mother had called me:
> the spawn of the devil.
> I felt this evil......
> sort of monster, gremlin, devil, demon
> rolled into one skin.
> I had a terrible, absolutely terrible identity crisis
> I didn't know who the hell I was any more.

The failed suicide attempts that followed can be compared with Chadwick's (ibid) autobiographical account in that one of Anita's methods (attempting to throw herself under a bus) was the same. On the other hand, whereas Chadwick was driven by delusion and paranoia, Anita appears to have responded to hopelessness. Crucially, in the above extract, she appears to use 'turbulence and chaos' as descriptive of her mental health. Yet, to explore fully, I believe that these two terms must be taken in the context of 'labels and judgements' and 'a self-fulfilling prophecy'. Through this linkage, another careful comparison can be made with the narrative of Mr. P. That is, he saw the onset of mental illness and gradual recovery as an affirmation of his beliefs; more importantly, that he had had *a right to be ill.* Likewise, Anita saw the succession of crises due to illness as an affirmation. However, in her case, it was not that she had a right to be ill, *but that she was fundamentally flawed.* For Anita, phenomena diagnosed as mental illness represented the inevitable outcome of those character traits – those imagoes – that others had seen in her as a child.

On reviewing the data in conjunction with her demeanour at the time of interview, I feel that Anita had begun to assimilate this overview. Throughout

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her transcript, her resilience is undeniable; therefore it was not surprising that she was, yet again, attempting to rebuild her life. I close this review of Anita's narrative as I began: amid speculation and uncertainty. In particular, I ask, and will continue to ask, "Which came first?" The Central Research Question asks if phenomena diagnosed as mental illness impact on personal identity. Yet, in Anita's case, such is the complexity of her experiences that it might be more appropriate to ask if sense of personal identity impacts upon the mental health narrative.

11.12: Conclusion

The overview of Anita's recovery narrative completes the integration of findings. This chapter began by exploring and challenging the applicability of narrative constructs to the experiences described in the data. Thereafter, the data itself were reviewed with reference to two groups of consequences. These are:

- A *direct* area that pertains to experience of the constituent phenomena in terms of content, duration, emotional and behavioural reaction, and medical treatment including diagnosis.
- An *indirect* area that concerns other nested narratives which may be affected by the mental illness narrative. Examples of these included intimate relationships, family relationships, social and cultural relationships (including personal freedom), and ability to work, which in turn, affected employment status and, possibly, financial status

The following and final chapter in this study reviews the main findings and weighs their importance with reference to the Central Research Question, namely 'How do phenomena diagnosed as mental impact upon sense of personal identity?' Following this, it will explore possible avenues for further research and the possible significance and application of narrative constructs to current mental health practice.

Chapter Twelve: Epilogue: reflections, conclusions and Recommendations

12.1: Introduction: the role of myself as researcher and narrator

Throughout this study, I have emphasized my own role as a user of mental health services and that of my wife, June, as user and carer. Inevitably, this raised questions of reflexivity, particularly in the event of shared experiences such as hospitalization. Also, there is the valid question as to whether knowledge of my experiences encouraged an interviewee to be 'more open' concerning their own.

To a large extent, the first issue was met by the demands of interview technique. As explored in Chapter 5, the fact that I was in 'interview mode' as opposed to 'conversation mode' meant that both my intention and attention were directed towards the purpose of the interview. This experience was, I found, very similar to my former activities as a Samaritan and my present role as an advocate/befriender. In both cases, listening to another person is mediated by their perceived need: accordingly, one is constantly aware not only of what is being said, but of its importance to the on-going situation, and to the other's demeanour. In effect, one is analyzing an unfolding narrative at the same time as participating in it: whilst this may seem somewhat callous, I stress that it does not necessarily impede emotional reaction. Indeed, I often found myself empathizing with respondents.

Thereafter, it is important to question whether or not this discipline was maintained in later analysis. In answer, whilst reflexivity can never be entirely avoided, the practice of successive coding levels served to check on preliminary conclusions. With reference to my own experiences, I found that it was relatively easy to avoid undue comparison by identification. To elaborate, I draw attention to my reflection in Chapter Five, where I ask if only a user can understand another user. Also, in connection with this, I draw attention to the wide range of experiences described by the nine respondents. As explored in Chapters Eight,

Nine, and Ten, it is inevitable that there will be commonalities. However, there are also many examples of highly individual experience. Accordingly, any one narrative, including my own, is sufficiently singular to stand on its own without being inadvertently integrated with another.

The question of whether or not knowledge of my own narrative influenced the readiness of the respondents to speak of their own is extremely difficult to answer, if not imponderable. Intuitively, I felt that all of the respondents *wanted* to tell their story on the grounds that they were contributing to what might be useful research. Obviously, however, this may be wishful thinking on my part. Nevertheless, I suggest that if a researcher is able to convey that they recognize the worth of prospective interviewees as persons, then much can be achieved. To this end, a full and sympathetic information sheet explaining the proposed research, possibly supported by a short talk to a user group as a whole, may be a vital link in the chain of recruitment.

12. 2: Reflections (i): the value of a research accompanier

In Chapter Five I discussed the role of my wife, June, as research assistant. In summary, these were:

i)   As chaperone when interviewing female respondents.
ii) Provision of support should an interviewee become unwell during interview.
iii) Monitoring of my own health in response to interviews.

Rapidly, we found that the interactions of an interview were facilitated by three as opposed to two persons. However, on reflection, it would be remiss to claim that this was the product of a calculated approach. Rather, by virtue of our close relationship, June instinctively recognized that I was content to allow a respondent to dictate the pace and content of an interview. Accordingly, in the main, her interjections were in tandem with my own, often with relation to a medical issue such as diagnosis or medication. Notably, only once did she

inadvertently assume the role of counsellor; namely in response to Anne's pleading for reassurance.

In addition, I must emphasize June's many supporting roles in this study. Initially, also as explained in Chapter Five, she was instrumental in providing several useful references. Thereafter, and throughout the study, she was the sounding-board for many of my musings and speculations concerning background reading and methodology (However, lest I create the impression that this was one-way traffic, she found discussion useful with respect to her own voluntary research activities with the Mental Health Research Network North-East Hub; also, later, in her training as a 'Cruse Bereavement Care' volunteer). Later, as the thesis began to take form, she performed the invaluable role of proof-reader and occasional critic.

Over and above these roles, by far the most important was that of confidante and support. To tread the path of a distance learning student is often lonely, despite the encouragement of one's supervisors. Instead of being able to seek the solace of consultation with a colleague 'down the corridor', one is obliged to glower at an unresponsive computer screen. In this context, it is appropriate to be brutally honest by stating that I am frequently handicapped by obsessive ruminations due to my illness. Similarly, my illness is probably the source of sudden despair leading to destructive gestures. Thus, often – too often – has June been obliged to listen to my mutterings and grumblings to the effect that this study should be cast into a convenient abyss (As explained in Chapter Five, at one point I did burn all my work, including computer records; fortunately, most of this could be retrieved). Indeed, particularly in the later days when doubt constantly gnawed, she assured me that walking away forever is a common desire held by PhD students. Accordingly, I state unequivocally that *all* PhD students should be aware of the need for support and be prepared to seek same. It is as this juncture therefore, that I wish to add my thanks to Julie Repper, Gordon Grant, and, latterly, Mark Doel as supervisors.

12.3: Reflections (ii) limitations of the study
12.3.1: Convenience sample

As explained in Chapter Five, the predominant consideration when inviting persons to participate in the study was that of informed consent. Associated with this, I made an early decision that I would not attempt to interview any person who was undergoing in-patient treatment in a hospital. This policy raises conflicting questions that are important both ethically and with reference to research. By declining to interview an in-patient, am I depriving them of an opportunity to tell their narrative at a time when it might be most important to them? From a pragmatic research viewpoint, it can be argued that valuable data could be obtained by interview. However, this is surely outweighed by the ethical considerations associated with the *fact* of hospitalization. At this time, it is highly probable that an individual's personal narrative is dominated by a complex of nested narratives associated with and deriving from mental illness. Accordingly, the question of informed consent is too compromised: whilst an interview may have benefits, it could also be much too intrusive.

Concerning other possible respondents, my view is that membership of a user group is helpful but should not be mandatory. Undoubtedly, many useful contacts were made through the User and Carer Involvement Co-ordinator at the Tees, Esk and Wear Valleys Trust. However, two of the interviewees (Mr. CBA; Mr. Gwent) were contacted directly. This was for two reasons, firstly distance from the 'main' recruitment group; and secondly, the basic fact that their participation in organized user activities was minimal (Mr. CBA) or nil (Mr. Gwent). Similarly, I know of other persons in my home area who might have been willing to be interviewed. Therefore, I suggest that the main criterion for future participation should be informed consent, including permission to advise the User and Carer Co-ordinator of the relevant N.H.S. Trust should the first contact be made by myself or another researcher (It should be emphasized that this would almost certainly be required by a Research Ethics Committee).

12.3.2: Reflections (iii): the retrospective nature of narrative

Associated with the research question is a straightforward but extremely awkward observation, namely that *I did not interview the respondents before their experiences of mental illness.* Therefore, all of the data from the transcripts is expressed through the lens of recovery. In response, one can resort to pragmatism by stating that it would have been impossible to include the necessary foresight in any research. However, far better is to draw attention to the focus of the research: to ascertain the possible impact of phenomena upon personal identity, it was necessary to obtain the respondents' *own viewpoints of same.* As opposed to a prescriptive lead by me, each respondent decided which nested narratives were significant with reference to the overall experience of mental illness. Thus four respondents (Dorothy, Mr. P., Sandra, and Anita) began their narratives with recall of their childhood, whereas the other five (Mr. CBA, Mr. K., Eddie Hooper-Smith, Anne, and Mr. Gwent) chose to begin their narratives much closer to the onset of phenomena.

12.4: The Central Research Question: How do phenomena diagnosed as mental illness impact upon personal identity?

With reference to the data contained in the respondents' narratives, this section will explore the possible impact of phenomena diagnosed as mental illness upon sense of personal identity. To do so, it must first summarise the many possible aspects of experiencing phenomena diagnosed as mental illness. They may be far more than to know a sometimes uncontrollable maelstrom of conflicting thoughts and emotions. They are to experience the nascence and continuation of an *illness narrative,* a nested narrative that may be but short, or may remain active throughout the continuing personal narrative. Within this narrative, they can be the direct consequences of illness: periods of invalidity, of contact with medical personnel, of treatment. It may be that there are additional consequences: the effect upon personal relationships; the effects upon employment and financial status. They can be to involuntarily focus upon a complex of understandings and beliefs derived from societal and cultural concepts and expectations.

Thereafter, caution is required lest generalizations metamorphose into assumptions. Given the discussion so far, it is permissible to view the personal narrative as including some significant nested narratives that can be designated with identities of their own, namely *imagoes.* Applying this construct, personal identity can be understood in terms of an interaction between imagoes of differing qualities. However, in making this assertion, it is essential to appreciate that this interaction may be of extreme complexity due to the number and potency of imagoes involved. In this context, it is a justifiable criticism that to 'name' every individual imago would be exhaustive and, ultimately, meaningless. Instead it is sufficient to concentrate upon those imagoes of greatest significance: in this way, the concept of dominant narratives enters into consideration. As explained in earlier chapters, a single narrative, *and thereby a single imago,* may dominate the entire personal narrative.

Nevertheless, this event does not, in itself, necessarily impact upon personal identity. Rather, as explained in the opening paragraph, the question centres on the consequences of this event. For, in the same way that experience may lead to the formation of an imago, so experience may lead to the extinction of an imago. Moreover, and of extreme importance, some narratives, for example those of *Mr. P.* and *Sandra,* show that positive imagoes may be generated by the initially negative experience of illness. Thus, maintaining caution, the narrative data suggests that much depends upon the duration and severity of overwhelm. Accordingly, at this point, it is necessary to support the assertions made by direct reference to the respondents' narratives.

Mr. Gwent experienced what can be justifiably described as a brief but massive overwhelm, followed by a comparatively short period of recuperation and rehabilitation enabling return to work. Despite the intensity of the illness narrative, it is now virtually dormant, maintained only by the wariness of some colleagues. Crucially, as described in Chapter Ten, recovery is marked by the formation of a positive 'carer' imago. In *Mr. K.'s* case, recovery was much more gradual, being enabled by medication; this led to first employment, so creating a positive imago associated with this new societal role.

I hesitate to designate *Mr. P.'s* narrative as similar to the above narratives due to his descriptions of extended stressors during childhood and unhappy events in adulthood. Arguably, it can posited that the inevitable creation of negative imagoes ('victim'; 'loner') may have gradually inculcated a vulnerability that culminated in depressive overwhelm. If so, then it is a moot point as to when mental illness phenomena became active. Moreover, I stress that this is conjecture, no matter how plausible. Therefore, it is better to concentrate on the nature of overwhelm which, like that of Mr. Gwent, was sudden and massive. Thereafter, however, his recovery narrative differed in that counselling led him to focus on those negative imagoes, that is, *re-interpreting nested narratives and imagoes formed previous to the onset of mental illness.* Thus, crucially, his recovery to the formation of an 'okay person' imago which valued, as opposed to denigrated, his emotional response to setbacks (it's okay to be sad). In this way, his personal myth was revitalised. Nevertheless, the former negative 'loner' imago occasionally intrudes, causing him to ask questions of himself (is it me?).

Another, far more complex example of the revitalisation of the personal myth is demonstrated by *Sandra* when talking about her 'psychotic' imago. The impression gained is that diagnosis was an act not of creation, but of elucidation: that Sandra was now able to name and perceive in depth an integral part of her identity. Thereafter came emancipation: she describes her new understanding of her father's illness (I always seen him as the powerful one – but he's the one who's vulnerable), plus her intention to apply her self-knowledge to her former career.

Using the terminology employed by Frank (1997) the first two narratives adhere to the *restitution* model whereas the second two are examples of the *quest model.* In turn, both types, particularly the latter, derive from the basic monomyth of Campbell (1993[1949]), which likens the personal narrative to a journey of discovery:

> ....a separation from the world, a penetration to some source of power, and a life-enhancing return.

(Campbell, 1993, 35)

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Whilst it is necessary to guard against enthusiasm in connection with Campbell's religious themes, it is also an easy matter to 'ground' his text in relation to the above narratives. That is, discovery is often synonymous with learning, which, as exemplified by the narratives, may derive from direct experience. Moreover, learning is not restricted to the acquisition of new narratives but can embrace the reinterpretation of existing narrative. Applying this understanding, it becomes evident that the personal identities of the four respondents named were enhanced differently. For Mr. Gwent and Mr. K., there was little or no reinterpretation described, whereas for Mr. P. and Sandra, it was the most important aspect of their narratives. Indeed, Sandra's new interpretation of her father's illness can be viewed as in accord with Frank's (1993) description of 'epiphany'.

In comparison, the data provided by *Eddie Hooper-Smith* can also be described as a restitution narrative, but complicated by the fact that illness phenomena remain significant within the mental health narrative. Alone amongst the respondents, Eddie has been obliged to deliberately create a 'friend' imago, whereby he can achieve a measure of control. On repeated examination of the relevant data, the impression is gained that this has become less significant than might be supposed. In effect, by acknowledging his voices in terms of 'a secret friend' (Chapter Ten) he diminishes them to the same level as imaginative wanderings. However, of greater impact upon his sense of identity are the admittedly limited descriptions of social difficulties caused by prolonged overwhelm. In that the data describes a programme of rehabilitation assisted by a support worker, the 'user' imago must be viewed as active. Nevertheless, in keeping with a restitution narrative, Eddie's outlook remains positive.

The remaining four narratives exhibit varying degrees of contrast to those already discussed. Strictly speaking, all should be designated as restitution narratives in that a degree of recovery has been achieved. However, this is compromised either by continuing phenomena, the consequences of same, or a combination of both. Thus, for all four respondents, the 'user' imago is strong, an integral part of their personal identity. In addition, a sense of loss and/or

failure is pervasive; of positive imagoes that became extinguished. *Dorothy* remains tormented by the nature and aetiology of her phenomena: in this sense, she is engaged in an unfulfilled quest narrative. Moreover, as detailed in Chapter Ten, awareness of her employment status in comparison to her friends has engendered a potent 'failure' imago (I look back to try and found out why I'm like this and why I'm such a failure). Similarly, *Mr. CBA* is also greatly troubled by a 'failure' imago, though the data suggests much appears to derive from on-going phenomena. In his case, his entire personal identity is compromised due to constant evaluations of his actions by the 'wheel chuntering away to itself' (Chapter 10).

In assessing the possible impact of illness phenomena upon *Anita's* personal identity, one is therefore obliged to recognize that the data describes many severe stressors in her personal narrative. This is especially so concerning her childhood, which included several events that probably led to the formation of negative imagoes. Whether these were directly linked with later illness phenomena must remain speculative. Instead, all that can be stated with confidence is that it is not until her adult narrative that she begins detail of illness phenomena. With reference to these, some events are so extreme that, as suggested in the previous chapter, they constituted the formation of an entire 'alternative identity' as opposed to an imago. Thereafter, she entered into a period which I shall compare to Frank's model of a 'chaos' narrative in that her personal narrative was dominated by the day to day flow of on-going crises. It was only when these were resolved that she felt able to 'resume' her life. Yet, as the opportunity for reflection became possible, so the 'user' imago gained importance. At the time of her interview, it was dominant in that her efforts to maintain positivity and progress were being compromised by the failure of her medication regime.

Finally, the combination of consequences of illness means that *Anne's* narrative can be regarded as a 'chaos narrative' or even a 'broken narrative' (Hydén and Brockmeier, 2008; Frank, 2008). This is because her personal narrative is dominated not only by the loss of employment status but by the failure to rebuild her relationship with her former partner. Throughout the interview, coherence

was punctuated by pleading and questions: in effect, her personal myth is lost in recrimination. This observation leads to a summary of the nine narratives to the effect that it must be emphasized that *any* named narrative model or construct is but an approximation, relating to the main trajectory. Thus within a 'quest' narrative there will be instances of 'chaos', within chaos there will be instances of 'restitution' or maybe even 'epiphany', and so on.

The impact of phenomena diagnosed as mental illness upon sense of personal identity can be measured in the same way that the impact of any significant narrative can be measured. That is, in terms of *causation* and *plot*: of what was before, of what happened, and what is now. As exemplified by the narrative data, the personal narrative, and thereby the personal myth, can be wholly dominated by the intensity of overwhelm. Thereafter, often with the assistance of other persons, restitution is possible and the personal myth can be restored, even enhanced. On the other hand, if the illness experience leads to the creation of negative imagoes then the impact of mental illness may be profound. Notably, these imagoes may also exist by virtue of the consequences of mental illness as opposed to the phenomena themselves. They may be generated by the consequences of overwhelm: as, for example, through the loss of employment (e.g. *Mr. CBA*); the ending of a relationship (e.g. *Anne*). They may even be, as Novitz (2001, 151) states, have been '.....actively imposed on us by others': such is the nature of stigma, as experienced by *Dorothy*. Thus the impact of illness phenomena upon sense of personal identity may be bleak indeed, whereby the personal myth, and thereby personal identity, is darkened by recrimination and despair.

This section closes with an important qualification to the above observations. As has been stressed throughout this thesis, the personal narrative is not static but constantly evolving due to the impact of new experiences. Thus recovery should not be regarded as a return to former status, but as an indication of restored narrative equilibrium. Crucially, as demonstrated by Mr. Gwent, Mr. P., Mr. K., and Sandra, recovery involved the acquisition of new understanding. Moreover, as an integral part of the personal narrative, the nature and influence of any one nested narrative may alter. Similarly, the nature and influence of any one imago

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may alter due to the impact of new experience. Accordingly, any impact of phenomena diagnosed as mental illness upon personal identity should not be seen as indelible, but potentially changeable. Whilst experience cannot be unmade, its consequences can be nullified by new experience. Thus, it is possible that a person may again be overwhelmed by a future dominant negative narrative. Likewise, it is possible that a present negative narrative will yield to a burgeoning recovery.

The remainder of this chapter discusses recommendations for further research and the possible additions to present application of narrative theory in NHS practice. As an introduction to this, the following section briefly elaborates upon a construct of despair and how it can be challenged by the active pursuit of hope.

12.5: Hope: the resolution of unresolved narratives?
12.5.1: Personal narrative and personal myth

This section opens by focusing on the crucial distinction between the personal narrative and the personal myth. Despite objective and subjective understanding of memories, the personal narrative is essentially factual, being comprised of experience. In contrast, as defined in Chapter Three, a personal myth is a complex expression of personal identity deriving from the perceived role of the person in those experiences. Thus, in this way, understanding of nested narratives within the *personal narrative* leads to formation of the *personal myth*: concerning this, Novitz's (2001) detail of 'narrative identities' is a useful definition of imagoes. However, through internalized processes of reciprocity, the *personal myth* influences subjective understanding of the *personal narrative.*

Concerning the *personal myth,* it is essential to appreciate that it is an introspective construct as opposed to an idealized construct. Not only does it include notions of *what we would like to be,* it also includes notions of *what we are.* Therefore, it includes awareness and impressions of both positive and negative qualities, possibly in the form of imagoes. As explained above,

concepts of these arise from the perceived role of the person in the experiences that are part of their personal narrative. Thus it follows that a group of related positive experiences may lead to the formation of a positive imago; similarly a group of related negative experiences may lead to the formation of a negative imago. However, once an imago is formed, this relationship becomes much more complex. As explained above and with relation to the data, the personal narrative and the personal myth are reciprocal. Thus an imago not only maintains itself through understanding of past experiences, it may increase in potency through influencing understanding of new experiences (e.g. Sandra's deliberate use of her 'psychotic' imago; the involuntary negative impact of 'failure' cited by Mr. CBA and Dorothy)

In the previous chapter, I reviewed the constructs of unresolved and failed narratives which, by their nature, pertain to negative experiences. From an objective point of view, a narrative cannot be described as failed; instead, it can only be designated as unresolved. However, this distinction is, effectively, irrelevant concerning the possible effect of such a narrative, namely the creation of a *negative imago*. This is the true potential of any significant negative experience: that it will initiate the construction of a self-entity that influences subjective understanding of the personal narrative. In this way, depending upon the strength of the imago, the nature of narrative can become distorted, and unresolved narratives may indeed become to be seen as failed. Associated with this, the dynamics of the entire personal myth may be adversely affected. This is particularly so if a person comes to believe that their personal narrative, and thereby their personal myth, has lost agency. With reference to Butler (1975) and Erikson (1963), McAdams (1993) suggests that:

> During the later years of life, our mythmaking may subside somewhat as we
> begin to review the myth that we have made.
>
> **(McAdams, 1993:278)**

At face value, this construct is straightforward in that many experiences will have long ended. Nevertheless, if it is applied indiscriminately then it can contradict the fundamental principles of narrative theory and, potentially, deny any hope for the future. Should one come to believe that their personal myth is

effectively complete, then the personal narrative will lose its vitality: within new experiences, opportunities for new understanding will be overlooked, for the simple but erroneous reason that the time for change is past. Yet, if the nature of the personal narrative is recognized as constantly evolving then hope may flourish. Always there is the possibility of a new significant narrative being initiated late in life. Secondly, it is possible that the very process that McAdams cites, namely review, will prove to be the vehicle by which major revisions of the personal myth are made. This is because review is not – or should not be – passive recall but an active process of reconstruction in the light of past and new understanding.

12.5.2: Revitalizing the personal myth

In an exploration of recovery, Roberts and Wolfson (2004:38) explain that focus is on two main areas:

i)   A 'familiar' dimension of clinical and social recovery
ii) Personal and existential dimensions of recovery

Given the second of these, which draws on subjective and self-evaluated accounts, there are obvious comparisons with the original data obtaining in this study. Thereafter, the authors (ibid, 39) opine that the 'most widely accepted contemporary definition of recovery' is that by Anthony in 1993. However, on examination of that author's text, it appears to be a description deriving from several sources, as opposed to a definition *per se*:

> Recovery is described 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, 527)**

Thereafter, Roberts and Wolfson (ibid) explore recovery with relation to psychiatric practice, of which some concepts will be briefly explored later. This section, however, is concerned with a potential paradox within the above

recovery construct. That is, if recovery is a way of living a satisfying and hopeful life, it follows that hope must be a significant nested narrative within the personal narrative. Yet, as discussed previously, unresolved narratives may be contrary to this possibility, may be vehicles of despair. Thus, it becomes incumbent to address a hypothetical question. If hope is lost, extinguished by despair, how may it be rekindled so that recovery may be initiated?

A detailed exploration of hope is undertaken by Repper and Perkins (2003). Compassionate but pragmatic, the authors define hope as '....the motivating force that gives life purpose and direction' (ibid, ix). As such, it is self-evident that hope is, therefore, the foundation of recovery. However, fundamental to the author's construct is the initial fragility of hope; in effect, the potentially ephemeral nature of a nascent narrative. To be sustained, hope must be allied with opportunity, so realising the potential to exercise personal agency. Later in their text (ibid, 52) the authors revisit their discussion by noting a distinction between hope and optimism by Deegan (1996). Again, emphasis is on pragmatism as opposed to romanticism: optimism is transitory, whereas hope necessitates self-belief, a willingness to acknowledge occasional hardships. Thus, in summary:

> Hope is not like a bolt of lightening [sic]. Rather it begins as a 'small and fragile flame' that can be either fanned or snuffed out'
> **(Repper and Perkins, 2003, 52)**

Focusing on revitalization of the personal myth as a fundamental aim in recovery, the remainder of this chapter makes recommendations for further research into narrative constructs and their application in mental health practice.

12.6. Recommendations
12.6.1: The role of narrative in empowerment

As detailed in Chapter Ten, medical treatment of phenomena diagnosed as mental illness is sometimes viewed by users as akin to a form of imprisonment in that every nuance of behaviour is closely monitored. However, an exhaustive discussion of this topic is outside the remit of this study. Accordingly, I draw attention to relevant extracts in the respondents' narratives, plus discussion in

Chapter Ten. Thereafter, I feel it is sufficient to note that this is an area of sometimes extreme controversy, centring on patient autonomy in connection with the suitability of medical care. In doing so, however, I wish to emphasize that it is a complex narrative comprised of many nested narratives, each of which could provide sufficient material for an entire series of studies. In consequence, it is necessary to make cautious recourse to generalisations in suggesting possible avenues for future research, also application in mental health practice.

Quoting O'Hagan (2001) plus Repper and Perkins (2003), Roberts and Wolfson (ibid) suggest that:

> '....a change in the role of the psychiatrist is required, from someone who is perceived as a remote expert or authority to someone who behaves more like a coach or personal trainer.......'
>
> **(Roberts and Wolfson, 2004:42)**

Essentially, therefore, the authors are espousing empowerment of the user or patient in the process of their own recovery. In an ideal world, this would be fully potentiated: an individual would be free to choose the most effective and compassionate form of treatment leading to an eventual cure. Unfortunately, however, this is not the case. Whilst resources are undoubtedly one issue, another, and far more fundamental issue, is that medicine is an on-going narrative. In simple terms, as shown by the experiences of some of the respondents (e.g. Dorothy, Anita), the most that can be achieved is containment: a permanent cure is not yet possible. Thus the mental health narrative remains nested within the personal narrative; itself a complex narrative containing its own nested narratives. Of these narratives, potentially one of the most important is detailed collaboration between the user of services and medical personnel.

In Chapter Two, I stressed the importance of recognizing the person as an individual. In connection with this, I had earlier drawn attention to authors such as Laing (1990) in explaining that whilst one might know of another person's conscious processes, they cannot directly access them. Ultimately, these

considerations led to my use of the Kanizsa Triangle to emphasize the essential intangibility of the seat of personal identity, namely the subjective sense of self. In turn this inevitably led to discussion of narrative constructs: if an individual's thought processes cannot be experienced by another, then they must be *described*. This is the all-important function of narrative: not only the detail of experience, but the way in which that experience is narrated. Most importantly, narration is not necessarily a one-way process between narrator (the patient, client or respondent) and audience (the practitioner or researcher). Often a narrator can be encouraged by apposite questions or comments, or even a temporary interruption involving the audience's own narrative. In an ideal situation, all facilities are directed towards eliciting a detailed and informative narrative. True empowerment begins with the opportunity to gain as complete an understanding as possible by those parties that matter.

How this might be achieved in current mental health practice is the subject matter of a later section. Firstly, I suggest how future research into means of narration could lead to valuable insights applicable to same.

12.6.2: Future research

Whether or not research into the impact of phenomena diagnosed as mental illness should be exclusively concerned with personal identity is debateable. Rather, in connection with the sentiments of the above section, the principles and constructs described in this study could be better applied to the whole personal narrative. In support of this basic premise is a coda to the interviews, namely an encounter with Dorothy, who is now working part-time for a user-support group. In the course of chatting, she asked about my study, causing me to grumble about the difficulty of drawing narrative trajectory on the computer. On hearing about dominant narratives, she immediately seized on the concept, agreeing with me that it might show how active illness was at a given time. This concurred with what I believe would have been an extremely useful adjunct to the interviews if I had thought about it at the time. That is, a sheet of paper, blank apart from a vertical line dividing it into halves designated 'positive' and 'negative'. Towards the end of an interview, my approach would have been:

'Given the various issues that we have talked about, what do you feel are the most important things that are going on in your life at the moment? If we put them as positive or negative lines on this piece of paper.....? Great. Anything else you can think of?'

The aim of such an exercise would be to support, possibly confirm, impressions gained during the interview. Additionally, and more importantly, the temporary shift in focus might cause a respondent to name an issue not previously stressed (For example, in his first interview, Mr. P. did not cite low self-esteem or financial difficulties after losing his job despite both being highly probable). However, concerning this, I feel it is necessary to exercise caution lest one encourages categories that would not otherwise be named. Therefore, I suggest that any interventions should be limited to reminding a person of an issue already mentioned. The end product of the exercise would be two-fold. Firstly, it would inform first and subsequent levels of analysis. Secondly, it would inform the iterative processes of a second interview. Against this, it is possible that this technique could be deployed *at the start* of an interview. The main advantage of this would be to facilitate conversation with a respondent, particularly if the person is known to have 'flattened affect' due to illness, medication, or both. Another possible approach that could utilize this basic narrative format is a questionnaire. Fundamental to this would be a yes or no question, 'Have you ever been treated for experience of phenomena diagnosed as mental illness?'

Thereafter, only one question would be necessary, namely requesting a considered self-assessment of issues important to a person. This device could be extremely useful in that it could facilitate a comparison between those who had experienced or are experiencing phenomena, and those who have had no experience. Another possible advantage of this approach is that respondents could remain anonymous if desired. However, anonymity should not be a prerequisite. A possible development of questionnaires is that of organizing focus groups to explore the research question. Against this, the potential emotional vulnerability of respondents might render such an exercise inadvisable. In this context, it should be stressed that in the course of this study

some respondents were obviously distressed at times during interview. Therefore, the possibility of adverse reaction to any form of questions should always be included in the methodology of future research.

Finally, it is also possible that the diagrammatic representation of significant and dominant narratives could be refined and developed into a useful research tool. This could be particularly so concerning the trajectory, and therefore the improvement or worsening, of any chosen factor within the personal narrative (for example, mental health in Dorothy's narrative; family relationships in Sandra's narrative). However, whether or not this could, or should, be extended to include quantitative assessment is a moot point. My own view is that such devices are sometimes an unnecessary embellishment: to state that one is better or worse can often be enough.

I close this section by noting two mental health assessment tools which could be deployed in a research setting as well as in mental health practice. These are the Camberwell Assessment of Need, developed by Phelan et al in 1995, and the WRAP (Wellness Recovery Action Plan) developed by Mary Ellen Copeland in 1997. Although Slade et al (2005) suggest that the former can be used as a self-assessment tool, the detail of some of its categories (e.g. psychotic symptoms, safety to others) appear more orientated towards professional use. In contrast, the WRAP is much more orientated towards self-assessment in that it aims to identify helpful strategies for recovery, including the identification of 'early warning signs'. Notably, it suggests that many persons may benefit from a supporter, who could be a family member, friend, or health profession (WRAP Workbook, 2004, 15).

In effect, this vehicle of self-assessment is, in itself, a means of empowerment: maintenance of a WRAP workbook (2004) enables awareness of and agency within the personal narrative. As such, it might prove extremely in a research setting as a daily record of the currents within a respondent's personal narrative. However, with respect to both a mental health and a research setting there is a pertinent question as to whether or not the necessary introspection is invariably beneficial. Inevitably, WRAP encourages focus on both positive and

negative significant narratives. In consequence, it focuses on both positive and negative imagoes. Unavoidably, therefore, it is possible that this may exacerbate a problem instead of alleviating it: for example, Mr. CBA's narrative concluded with his expressing his aversion to self-analysis (Chapter 10).

12.6.3: Application of findings to mental health practice

Since the mid-1990's, mental health practice in this country has been driven by a series of major initiatives:

- In 1999, the Department of Health's laid out a strategy for the mental well-being of adults of working age. Entitled 'the National Service Framework for Mental Health', it set out standards of care which were intended to cover a 10-year period. The strategy included a commitment to research or evidence-based interventions and distinguished between the needs of people with 'common' mental illness such as depression and anxiety, and those with severe mental illness such as psychosis. The strategy began a process by which the National Institute for Clinical Excellence (NICE) would lay down treatment protocols for each illness area.

- In January 2005, the economist Lord Layard presented a report that identified mental health as a major social and economic problem. Notably, it stated that the majority of mental health resources were allocated to treatment of psychotic problem; in contrast, spending on 'common' mental illness was insufficient. The report advocated greater spending on psychological treatments for depression and anxiety disorders (pp 16 – 17).

- In late 2009, a policy document entitled 'New Horizons' replaced the National Service Framework. The Department of Health currently places great faith in talking treatments for common mental health problems and advocates that these should also be available for people with psychosis. In tandem with this, a programme which trains and increases the

availability of cognitive therapy called IAPT (Increasing Access to Psychological Therapies) has offered much greater access to treatment for people with common mental health problems.

Essentially, these are based on a desire to find adjuncts and/or alternatives to medication for phenomena diagnosed as mental illness. As such, it copies the practice termed psycho-social intervention (PSI), which was developed in the mid-1990's, having its root in the family education and support programmes in the 1990's (Brooker et al, 1994). Sin and Scully (2008) define PSI, with reference to Brooker and Brabban 2004, also NIHME 2005, as follows:

> .... a term used to describe collaborative work with service users which integrates a range of medical, social and psychological interventions delivered within the recovery perspective.
>
> **(Sin and Scully, 2008, 162)**

Crucially, therefore, PSI combines many possible responses to mental illness, including medication, structured family intervention, and cognitive behavioural therapy (CBT). Notably, PSI is designed to empower users of mental health services when engaging with practitioners, as emphasized by O'Neill et al (2008):

> Practitioners viewed clients not as people with mental health problems or illness, but as people experiencing illness in the context of their daily lives.
>
> **(O'Neill, Moore, and Ryan, 2008, 584)**

However, in recent years, mental health policy appears to have entered a state of uneasy flux. Brooker and Brabban (2008) suggest that national strategy appears to favour CBT, as advocated in the Layard Report (above). If so, it should be noted that this approach is but part of the multi-disciplinary construct that is PSI. Accordingly, the authors opine that any significant trend towards CBT could, ultimately, lead to 'decommissioning' of PSI. Unfortunately, part of the problem may lie in that the essentially simple concept of PSI has become unwieldy by virtue of over-inclusion. Earlier in their review, the authors note with concern that progress in this field has been mixed, also that:

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> ....the teaching curriculum can appear to be a *'complex matrix of theoretical concepts, philosophies, competencies and frameworks.*
>
> **(Brooker and Brabban, 2008) [italics in original text]**

Yet, on examination, the comparison with the narrative constructs described in this study is self-evident. PSI concentrates upon the entire personal narrative, of which mental health is a nested narrative. Associated with this is a statement by a practitioner that coincides with identification of dominant narratives as proposed above:

> Clients identify areas that are the most problematic, and I think that at that level you are going to get a lot more co-operation because you are working at something they want to look at, and that's what makes it a collaborative process.
>
> **(O, Neill, Moore, and Ryan, ibid)**

It should be recognized that the first contact with medical services by a person almost certainly means that phenomena have become active. Thereafter, as explained earlier, the possible formation of a dominant narrative derives from objective and perception of on-going experiences, including activation of existing imagoes. The PSI approach recognizes that medication alone may not be sufficient to meet this combination: whilst it may counteract the direct effects of phenomena, other nested narratives may be impacting upon the person. Thus, a comprehensive response is required whereby the social needs of the person are incorporated: in this way, it may be possible to counter both the direct and indirect effects of phenomena. Of more importance, however, are the mechanisms by which a negative imago might be formed. This research stresses that an imago can be sustained by reciprocity. Accordingly, it is arguably a more powerful entity than a dominant narrative, which can be viewed as deriving from on-going experiences. Therefore, it is evident that much therapeutic advantage can be effected *if the formation of an imago is prevented.*

Consultation with a mental health professional can be likened to an interview in that one party hopes to elicit a viable and relevant narrative from another. Accordingly, the same observations concerning narrative constructs apply to interactions between users of mental health services and medical personnel as to those outlined above in connection with future research. It cannot be stressed

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enough that the purpose of any interaction, research interview or consultation, should be based on achieving a relaxed and mutual understanding. Narrative constructs could be applied equally well to CBT and PSI. Significance, dominance, and imagoes could all be linked with 'core beliefs' as identified in CBT (Beck, 1995). Meanwhile, in keeping with PSI strategy (Sin and Scully, ibid; National Institute for Health and Clinical Excellence National Clinical Guideline Number 82 (Revised 2010) 243 – 327) other psychosocial factors could be explored in terms of nested narratives within the personal narrative.

I close this section, and the entire study, with reflection upon the personal narrative of Mr. P. Having listened to what were, at times, descriptions of extremely intimate experience, I feel sure that he will not object to further scrutiny. By virtue of assisted introspection through counselling, he prevailed not only over his depression, but also over an existing negative imago. Thus, ultimately, phenomena diagnosed as mental illness proved beneficial, the beginnings of new narratives and positive imagoes. So what if he had not received counselling? What then?

What then?

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Appendix I

Local Research Ethics Committee Approval

Following a request for further information and revised documentation, the study was given a favourable ethical opinion by the Hartlepool and North Tees Local Research Ethics Committee on 5th May, 2006.

The REC reference number of the research is **06/Q1001/25**

The final list of documents reviewed and approved by the Committee is as follows:

  Application

  Investigator CV

  Protocol

  Covering letters

  Peer Review

  Interview Schedules/Topic Guides

  GP/Consultant Information Sheets

  Participant Information Sheet (Version Two)

  Participant Consent Form (Version Two)

It was a condition of approval that a progress report for the study was submitted 12 months after the date of approval, and then annually thereafter.

Research Governance Approval

This was granted by the Tees, Esk and Wear Valleys NHS Trust on 5th November, 2007.

Appendix II: Participant Information and Consent

This section includes the following documents:

i) Participant Information Sheet: this was given to potential respondents to read at a convenient time. Agreement to participate in the study was notified directly to myself in person or by telephone. (Note: there were no refusals.)

ii) Consent Form: this was provided and explained immediately before the beginnings of the interview proper.

iii) Letter of notification to participants GP or consultant: a reminder that this facility was offered was given in connection with signing the Consent Form. Only one participant (Mr. Gwent) asked me to do so.

UNIVERSITY OF SHEFFIELD HALLAM

Centre for Health and Social Care Research: Faculty of Health and Wellbeing

<div align="right">

Ray Wainwright
Research and Development Team
Tees, Esk and Wear valleys NHS Trust
Teaching and Development Centre
Berwick Hills
Middlesbrough
TS3 7SE
Telephone 01642 516981

</div>

Participant Information Sheet
(Version Two: April 2006)

1. Study Title: How does experience of mental illness affect a person's sense of personal image and identity?

2. Invitation:

I am inviting you to take part in this study by agreeing to take part in a series of personal interviews. Before you decide anything, it is important for you to understand why I am doing this research and what it will involve. Please take time to read the following information carefully. You are welcome to talk about this study to other people if you wish.

Part 1 of this sheet tells you the purpose of my study and what will happen if you agree to take part.

Part 2 gives you more detailed information about the conduct of the study.

You can contact me (Ray Wainwright) via the Research and Development Department of the Tees, Esk and Wear Valleys NHS Trust (i.e. the person who gave you this information sheet) if there is anything not clear or if you would like more information. Please take time to decide whether or not you wish to take part in this study.

3. What is the Purpose of this Study?

This study is a five years part- time post graduate research project for the award of PhD at Sheffield Hallam University.

The purpose of the study is to gain insight into what it feels like to experience mental illness. Another way of expressing this is to investigate how experience of mental illness has affected individuals as persons. To understand this fully I will divide it into three parts:

i)   To investigate the various symptoms (phenomena) involved in individual experiences of mental illness.
ii) To investigate personal reaction to those symptoms in terms of coping with any problems they may have caused and or still cause.
iii) To investigate personal reaction to any treatment if it was required.

4. Why are you being invited to volunteer?

My research requires input from a small number of volunteers (about six). This information sheet is being passed to you by a member of the Research and Development Department of Tees, Esk and Wear Valleys NHS Trust. This person already knows that you have experience of what Medicine describes as mental illness. Unless I already know you personally, it is probable that I know nothing about you at this stage.

5. Do I expect everyone I ask to take part?

No. It is entirely up to you whether or not you take part. If you decide **NOT** to take part, then your decision will be respected. No persuasion to take part will be made now or at any future time. This is true for everyone who is invited to volunteer.

If you **DO DECIDE** to take part I will give you this Information Sheet to keep. I will also ask you to sign two copies of a Consent Form, one which will be yours to keep. However, please note that you will be free to withdraw from the study at any time. If you do decide to withdraw you do not have to give me any reasons for withdrawing and I will not try to persuade you to stay.

A4

6. What will happen to you if you decide to take part?

I will interview you about your experiences of mental illness. I expect that the time needed for the first interview will be about an hour and a half. However, we could finish before then if you wanted to. Please note that more than one interview will be needed. The reason for this is that at least one follow-up interview will be needed to check the results of the first interview. Also, the first interview may raise issues that are worthwhile investigating more deeply. Similarly a second interview may raise issues that can be investigated in a third interview etc.

With your agreement I would be accompanied by an assistant who will tape the interview. Afterwards I will transcribe the details so that I can send you a copy.

You can check this so we can talk about it at the next interview.

Please note that any tapes will be kept in a locked filing cabinet, of which I will have the only key. When my study is complete, all tapes will be destroyed.

I would like to conduct the interviews at a mutually convenient private place where you will feel as relaxed as possible. For this reason, a private office on Trust premises would be a good place. However, if you would prefer somewhere else such as your home, then a suitable venue would be arranged.

Please note that travel expenses will be paid if necessary.

7. Are there any risks or disadvantages if you agree to take part in this study?

It is only fair to warn you that I will be asking questions about your own experiences of mental illness in the context of your life story. Since these are highly personal, you may find these intrusive or distressing no matter how tactful and sympathetic I try to be. Therefore I remind you that you are free to ask me to stop any interviewing immediately if you do not wish to continue.

For the same reasons there will be ample opportunity to chat informally with myself and members of Trust staff after interviewing if you should wish to do so.

A5

IMPORTANT: please note that one of the items (No. 7) on the Consent Form seeks your permission to contact your GP to inform him that you are participating in this research. It is the usual practice to offer this in studies such as mine.

You do not have to agree to this. Instead you can initial item 8 on the Consent Form to indicate that you do not wish me to contact your GP.

Similarly, I offer to seek your permission to contact your GP should you be distressed by the interview. Alternatively, you can provide me with a named contact instead of your GP. Also we can seek advice from the Patient Advice **and Liaison Service (PALS) provided that you agree to this.**

8. What are the benefits of taking part in this study?

Unfortunately I cannot offer you any personal benefits as a result of volunteering to take part. It is possible that you may gain a deeper understanding of mental illness as a result of the interviews, but I cannot guarantee this.

9. What will I do with the data gained from the interviews?

I hope to use the information obtained from the interviews to gain insight into what it feels like to experience mental illness. This information will then be written up in conjunction with existing texts as a PhD thesis.

Please note that I will be subjecting the interview data to a process called **Narrative Analysis.** This means that I will analyse and interpret your story and retell parts of it from my own understanding. Although much of this will be done with your agreement during interviewing and checking of interview data, it is possible that some of my conclusions will differ from your own ideas. If there is a marked difference in our ideas, then your ideas can be recorded in conjunction with mine as part of the study. (This is a research practice recommended by Smythe and Murray (2000)*.

*Smythe, W.E., and Murray, M.J., (2000) Owning the Story: Ethical Considerations in Narrative Research in Narrative research Ethics and Behaviour, 10(4), 311- 336

10. What if there is a problem?

Any complaint about the way you have been treated during the study will be addressed. The detailed information on this is given in Part 2.

11. Will my taking part in this study be kept confidential?

YES. The only time your true name will be used is when you sign the Consent Form. Full information on this is given in Part 2.

12. Contact Point

I can be contacted as follows:

Ray Wainwright

Research and Development Team

Tees, Esk and wear valleys NHS Trust

Teaching and Development Centre

Ormesby Road,

Berwick Hill

Middlesbrough

TS3 7SE

Telephone 01642 516981

This completes Part 1 of the Information Sheet. If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

PART TWO

13. What will happen if you do not want to carry on with the study?

As previously stated, if you do decide to withdraw, you will not have to give me any reasons for withdrawing and I will not try to persuade you to stay. Any records of interviews, both taped and written, will be destroyed immediately. No references to you will be made in the final results of this study.

14. What if there is a problem?

If you have a complaint about the research you should contact:

Jacqui Lovell
Research and Development Manager
Tees, Esk and Wear valleys NHS Trust
Teaching and Development Centre,
Ormesby Road,
Berwick Hills,
Middlesbrough TS3 7SE   Telephone 01642 516983

15. Will your taking part in this research be kept confidential?

Any tapes used in interview will be labelled according to a coded labelling system which will not be available to a third party. They will be kept in a locked filing cabinet until they are no longer required. Then they will be destroyed by fire.
Similarly, transcripts will be identified via a coded labelling system. Records of transcripts on computer files will be available via a user- password which will be known only to me. Please note that these will be kept on a memory stick, not a computer hard drive. Written records of transcripts will be kept in a locked filing cabinet until no longer required, upon which they will be destroyed by fire. Details of transcripts will be used in the final thesis. This detail will include quotations. Anonymity will be preserved via the same coded labelling system that will be used for storing of transcripts.

It should be recognised that the use of pseudonyms will not be enough in itself to ensure anonymity. Other people may recognise you from personal details when they read the final study. **Therefore, as many personal details as possible will be altered by mutual agreement (e.g. Age, home, town etc.).**

A8

NB: Involvement of your family doctor (GP) I would like to remind you that it is usual practice in studies such as mine to offer to notify a volunteer's GP in writing to the effect that he or she is taking part. However, this action will only be taken provided you give your express permission.

16. What will happen to the results of the research study?

After analysis, the results of this study will form part of a PhD thesis. In turn this will help other researchers (including members of the medical profession) to gain a deeper understanding of how mental illness affects patients as persons.

17. Will volunteers be able to obtain a copy of the findings of your study?

Yes. Copies of my thesis will be made available to all volunteers upon completion.

18. Who is organising and funding the research?

The research is being organised by me, Ray Wainwright, following consultations with my University Supervisors and under the jurisdiction of the Research and Development department of the Tees, Esk and Wear Valleys NHS Trust. In order that I may conduct it on Trust premises, I have been awarded an Honorary Contract by the Trust.

I am not receiving any payment for this research.

19. Who has reviewed this study?

This study was given a favourable ethical opinion in the NHS by the North Tees and Hartlepool Local Research Ethics Committee.

Thank you for reading this Information Sheet. If, after consideration, you would like to take part then you can contact me directly or via a member of the Research and Development Department of the Tees, Esk and Wear Valleys NHS Trust. A Specimen Consent Form is attached for your inspection. If you agree to participate in this study then you will be asked to sign two Consent Forms, one of which you will keep and one of which will be kept by me.

Signed   (Ray Wainwright)

A9

Appendix II.2 Specimen Consent Form

<u>Consent Form for Research Interviews</u> (Version Two April 2006)

Title of Project: How does experience of mental illness affect a person's sense of image and identity?

Name of Researcher: Ray Wainwright

<u>**Please initial where indicated:**</u>

1. *I confirm* that I have read and understood the Information Sheet dated............... for the above study and that I have had the opportunity to ask questions... *(initials).*

2. *I agree* to take part in this study......................... *(initials).*

3. *I agree* that my participation is voluntary and that no pressure has been brought to bear on me to participate...............*(initials).*

4. *I understand* that I am free to leave the study at any time and that I do not have to give any reasons for doing so. I also understand that no person will attempt to change my mind if I decide to leave the   study.............*(initials).*

5. *I note* that interviews will be taped provided that I agree otherwise they will be transcribed in not form. The tapes and transcripts will be stored for four years in a locked filing cabinet at the researcher's home address...............*(initials).*

6. *I note* that anonymity and confidentiality will be maintained...........*(initials).*

Please initial EITHER item 7 OR 8

7. **Either:** *I agree* that you can contact my GP by a letter countersigned by myself to advise him or her that I am participating in this research...................*(initials).*

8. **Or:** *I do not agree* that you can contact my GP..........*(initials)*

9. *I agree* that you can seek support from the Patient Advice and Liaison Service and/or a contact named by me on my behalf if needed .... *(initials).*

Please sign this form to indicate your consent to participate in this research

(This section to be countersigned by the researcher)

....
Name of volunteer   *Date*   *Signature*

....
Name of researcher   *Date*   *Signature*

A10

Appendix II.3: Specimen letter to GP

(Address as for Participant Information Sheet)

Dr A. N. Other
Address

Date

Dr. Other,

Re. Mr/ Mrs/ Miss/ Ms Patient

I am researching a PhD on 'Impact of experience of mental illness on sense of personal identity'. This research is monitored by the School of Nursing at Sheffield Hallam University.

Ethical approval for the research has been obtained via the Hartlepool and North Tees Local Research Ethics Committee.

The above person has accepted an invitation from me to participate in a series of interviews regarding their personal experiences of mental illness. After reading an information sheet (copy enclosed) and discussion with me they understand that the personal revelations involved may prove distressing. Accordingly, they have given me permission to notify you so that you are aware that they are participating in this research.

I will be pleased to further any additional information that you may require.

Yours sincerely,

(Signed)..Ray Wainwright

cc. Participant

Appendix III: Coding of interviews

Introduction:

The purpose of this Appendix is to demonstrate my method of coding. Initially, all tapes were transcribed in **prose** form. Coding was pursued in four stages:

i) **FIRST – LEVEL CODING** was observations made by myself *at the time of transcribing.* Including the highlighting of relevant passages, it includes memories of the 'feel' of the interview plus my reflexive observations, particularly to data that reminded me of my own experiences of phenomena diagnosed as mental illness.

ii) **SECOND – LEVEL CODING** was a detailed summary of observations made in first-stage coding plus an early description of the personal narrative. This was written following completion of transcription.

iii) **THIRD – LEVEL CODING** derived from close examination of the transcript to determine any significant narratives that could be identified and/or surmised from the data. Significant narratives may also be termed as codes, categories, sub-dimensions, or themes.

The results of the above coding exercises were all expressed in **prose** form.

iv) **FOURTH – LEVEL CODING** was the reduction of passages of text detailing significant narratives into 'idea-units' (Gee, 1989, as detailed by Reissman, 1993). This device served to support third-stage coding by allowing more detailed examination. Also, individual nested narratives were given brief labels at this point for the purposes of reference and easy comparison with other transcripts.

It is important to appreciate not all of the data was subjected to fourth level coding. Instead, only the passages deemed most relevant by virtue of first, second, and third level coding were thus analyzed. At this point, the personal narrative was arranged in chronological order by manually sorting printed copies of the data. In this way, data from interviews 1 and 2 were intermingled.

A12

For the purposes of demonstration, my coding system will be explored in two stages:

i) A section of 'raw' data subjected to first-level coding. Originally, for ease of reference, I underlined in blue. In connection with this exercise, I stress that the data is in its original state, that is, complete with interjections, word whispers, irrelevances and comments that were not used in later coding.

ii) The same section summarized and expressed as 'idea units'. Interspersed with this data are comments from first, second, and third level coding.

Section 1: The 'raw data'

This section begins with my preliminary notes preceding the first interview with 'Mr. P.'. This practice was carried out for all interviews. As noted above, data deemed to be of importance was underlined in blue.

1.1: Preliminary Notes

Mr. P. has been known to the researcher's wife, June, for six years. In this time he has often worked closely with her on User Involvement projects. Although he has known Ray for approximately the same time, they do not know one another well.

Important Note: This transcript contains a great deal of confidential material that could identify Mr. P. Certainly it would be easy for people who know him reasonably well (co-workers; friends) to identify him from the transcript. Nevertheless, after careful consideration, this detail has been left in on the grounds of continuity and to provide a context for other aspects of the interview. It is also important to note that it is the usual practice to use only short excerpts – as opposed to entire transcripts – in the final write-up of a study such as this one.

On completion, this transcript will be shown to Mr. P. for discussion.

1.2: Notes on transcript

Principal researcher: Ray Wainwright

Assistant researcher and occasional interviewer: June Wainwright.

Ray's questions and comments are written in Arial Font 12 aligned LEFT.

June's questions are in Times New Roman Font 12 aligned LEFT and preceded by her name in brackets. (June).

The respondent (Mr. P's) text is in Arial Font 12 aligned RIGHT.

Interjections are shown in brackets. ( )

Interruptions are indicated by a dash -

Personal details that might compromise confidentiality are italicised and enclosed in brackets. ( )

Pauses are indicated by dots…….….…..

Stressed words or phrases indicated by <u>underlining</u>

Passages deemed to be of particular relevance are <u>underlined in blue.</u>

Occasionally, Mr. P. gives a detailed response that covers more than one important topic. In such instances the response is subdivided by use of Arial Font 16 numbers 1, 2, 3.

1.3: Extract from Interview One

For ease of reference, line numbers were appended to the interviews. However, it should be noted that in this they vary from the original due to the need to conform to the prescribed margin format for this study.

47   What I'd like to do is have a conversation (right) and…. In many ways
48   what you think is most important will be some of the things that you
49   mention. (Right) So…. When do you think your experiences started with
50   respect to…?
51
52   Well- I was actually thinking about this last night really… because I
53   have, as Time's gone on, reflected over the years about when it
54   first started, <u>although it didn't really appear on the surface until I</u>
55   <u>was nearly thirty, I actually think it was there in my childhood. I had</u>

56	it in my childhood- I think it stemmed from being an ill child,
57	physically, even the fact that I was one of three: I was the middle
58	one and I was quite protected as a child. My mom would stick up
59	for me, more so than my dad, but I was still - Even my sisters to a
60	certain degree protected me in a cocoon if you like, from the
61	outside world; in a sense

(See Mr. P's elaboration on his illness below)

FIRST – LEVEL CODING:

There is much detail in this section concerning childhood problems. Review in the light of later data

THIRD – LEVEL CODING:

Family Dynamics (past) This statement is unequivocal:
- i) **Mr. P. states that he believes his problems began in childhood despite not manifesting until he was thirty.**
- ii) **Mr. P. states that he was physically ill.**
- iii) **As a consequence, he was cocooned.**

HOWEVER, in itself this is little more than an opener.

69	You have two sisters?
70	
71	I've got two sisters- I've got an older sister and a younger sister.
72	My older sister's two and a half years older than me. My younger
73	sister's thirteen months. (Mhmm) So that's the difference.
74	
75	How old are you, please?
76	
77	Forty one next month. I'm forty one in May. Before any of us came
78	along, the three of us, my mom had two miscarriages- so I think in
79	some ways that also set the scene before I was born and the
80	problems that my mom had with me initially. I wouldn't – I couldn't
81	take my milk, any form of milk, even powdered: I would just throw
82	it up. So although I was born chubby, quite a big baby at birth, I
83	had lost quite a lot of my weight in the first six months of my life
84	just throwing up. It wasn't until I was six months that they actually
85	found a formula that I could keep down- (right) it was okay for me.
86	I was also born with what we call 'brittle bones'? So by the time I
87	was three and a half I had been in hospital three times with broken
88	femurs.
89	
90	Wow!
91	**(On this basis it is not surprising that Mr. P. was 'cocooned')**
92	(June)Nasty
93	
94	Very nasty and my parents and my grandmother- because all the
95	instances of my breaking them happened at my gran's- didn't
96	happen anywhere else. All brought into question at the time.
97	
98	(June) Oh God- so did they blame your grandmother at the time?

A15

99	
100	Yes. In actual fact it was just me jumping off a pouffé. Twice
101	jumping off a pouffé and once in the kitchen, on a mat: I just
102	slipped on a mat in the kitchen. (Oh dear) And so I was in a
103	hospital for those times, getting mended, you know, legs in the
104	air...*chuckles*. So for the first seven years of my life I was
105	backwards and forwards for one thing or another, with not only an
106	awkward G.P. but also at the Children's Hospital in *place* before
107	*Hospital A* was built. So for the first seven years of my life... And
108	I've still got a phobia of going to that many doctors around me in
109	white coats.

110

111 Not surprised. I'm not surprised. So the brittle bone --- Did that slowly go
112 or- ?

113

114 Yes. It gradually resolved itself. I mean my mom did have to give
115 me certain things when I was younger, to build my calcium up-

116

117 Yes, that's what-
118 -but apart from that it did resolve itself eventually.

119

120 So physically- you haven't got that any more?

121

122 I haven't got that any more. But because of all those physical problems
123 and because I was also born with a speech problem, which will come
124 across on the tape, I do know that! **1.** I was quite protected as a child.
125 And because of that all the other voices in the household were more
126 dominant than mine. I felt as though my voice wasn't heard. Although
127 they protected me, I wasn't heard as a child. So when it came to anything
128 emotional, I bottled it up. Bottled up inside- and I think that's why
129 eventually my mental health came into- came into effect. **2.** And also
130 when I was seven years old my dad – through work – went to work away
131 and suddenly, although he'd shown a lot of love and affection before he
132 went away; suddenly that all stopped. (Mhmm) And I was told that I had
133 to be the man of the house and protect my sisters and look after my
134 mom. And that had quite a large lasting effect on me as well (mmm) and I
135 never really- Although he retired early I never really gained that
136 relationship back that I lost with him. I mean on the surface we looked
137 okay, we could joke about certain things, but we couldn't get emotionally
138 or deeply involved in either of our- : I couldn't get involved in his emotions
139 and he couldn't get involved in mine. **3.** Even to the point of- even when
140 my mom died we never showed any emotion to each other: it all went to
141 my sisters. I'd show my emotion to my sisters; he'd show his to my
142 sisters; it wasn't to each other. It wasn't that affection really there- and
143 that lasted until the day he died..... And I never really got to show how
144 much I loved him really. And so that played a real large part in my
145 depression as well.

146
147

148
149 **FIRST-LEVEL CODING:**
150

    151   1)   Physical protection has metamorphosed into dominance,
152   resulting in reported suppressed emotion.
153   2)   Childhood family relationships would be vastly complicated by
154   the paradox described.
155   3)   The description of regret is obviously important. See later notes
156   (Pages 14; 19) and concluding remarks.
157

158 **SECOND – LEVEL CODING:**
159

160 *(Note: A full summary of my first level coding was written following*
161 *transcription. For purposes of instruction I have placed the relevant section at*
162 *this juncture:*
163 Given that the transcript describes depression in response to unfavourable events,
164 it is reasonable to assume that the diagnosed mental illness was precipitated by
165 those events. Thereafter, the extent to which Mr. P. was affected by the described
166 events in childhood (physical illness; speech impediment) must remain highly
167 conjectural. The events (Death of father; ending of long-term relationship;
168 'coming out'; loss of home) that led to his depression and suicide attempt could
169 be reasonably described as sufficient to severely distress many people.
170

171 **THIRD LEVEL CODING:**
172

173 **Family Dynamics (past) This strays into the nature vs. nurture argument.**
174 **Although Mr. P.'s childhood should not be described as dysfunctional, it**
175 **was troubled in the sense that certain circumstances have made a lasting**
176 **impression**

This data and observations were explored in their own right and as a lead to iterative questioning in Interview 2. In fourth level coding, significant narratives identified in both interviews were further analysed by deconstruction into 'idea units'. This is demonstrated in the next section with reference to the above data. As noted above, it is important to appreciate not all of the data was subjected to fourth level coding. Instead, only the passages deemed most relevant by virtue of first, second, and third level coding were thus analyzed. At this point, the personal narrative was arranged in chronological order by manually sorting printed copies of the data.

Appendix III.2: Example of data subjected to fourth – level coding

In fourth level coding I deemed individual line numbers unnecessary. Instead, for reference purposes, the origins of the data were indicated in terms of interview number (i.e. 1 or 2) and line numbers. As part of my analysis, individual idea units are appended with my observations. In addition, any first, second, or third level coding is detailed at the appropriate juncture. In this way, a personal narrative in chronological order is obtained. Thereafter, comparison and contrast with other narratives is effected using the prologue-overwhelm-recovery construct.

Concerning this presentation, it is important to recognize that it is a faithful reproduction of the data subjected to fourth level coding. From this body of text were selected relevant passages for inclusion in the main body of the thesis. Associated with this exercise, my appended comments were removed.

We began the interview proper by speculating when Mr. P's mental health problems may have begun.....

[1:53 - 59]
.......although it didn't really appear on the surface
until I was nearly thirty,
I actually think it was there in my childhood.   *Childhood problems:*
                    note assisted insight through counselling (see later notes)
I had it in my childhood-
I think it stemmed from being an ill child, physically,
even the fact
that I was one of three:
I was the middle one
and I was quite protected as a child.
My mom would stick up for me,
more so than my dad, but I was still –
Even my sisters to a certain degree protected me
in a cocoon if you like,
from the outside world;   *Evaluation (refer to later notes)*
                              mi: present in childhood?
                              Physical health -ve
                    Significant others (mother/sisters) +ve
        Family dynamics: slight –ve): over-protective; 'cocooned' - 'smothered'?

Mr. P talked about his role in the family:
[1: 119 - 124]

I was quite protected as a child.
And because of that
all the other voices in the household
were more dominant than mine.   *low status within family*
I felt as though my voice wasn't heard   *loneliness*
Although they protected me,
I wasn't heard as a child.
So when it came to anything emotional,
I bottled it up.   *felt unable to express self (Emotions bottled up)*
Bottled up inside-
and I think that's why eventually
my mental health came into-
came into effect.   *(Childhood: Loneliness/ Low self esteem)*
                                                      (Family dynamics: -ve)

Mr. P. described a significant change in his family circumstances when he was seven years old
[1:124 - 128]

when I was seven years old
my dad – through work – went to work away
and suddenly,
although he'd shown a lot of love and affection
before he went away;
suddenly that all stopped   *withdrawal of love and affection*
And I was told that I had to be
the man of the house   *sudden altering of personal status*
 and protect my sisters
 and look after my mom.

                                   Life event: –ve (see later notes)
Possible internal conflict due to enforced self-concept of 'strong man'
                                                      cf. Chadwick 1997

Mr. P's relationship with his father changed forever:
[1:130 - 139]

Although he retired early
 I never really gained that relationship back
 that I lost with him.   *perceived gulf between father and self*
I mean on the surface we looked okay,
 we could joke about certain things,
but we couldn't get emotionally or deeply involved
 I couldn't get involved in his emotions
 and he couldn't get involved in mine.   *withholding of emotions*
Even to the point of-

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even when my mom died
we never showed any emotion to each other:
it all went to my sisters.
I'd show my emotion to my sisters;
he'd show his to my sisters;
it wasn't to each other...................... *Emotions repressed; 'bottled up*
It wasn't that affection really there-
and that lasted until the day he died.....
And I never really got to show
how much I loved him really.................. ***Unresolved narrative: regret***
And so that played
a real large part in my depression   *Significant others: (father –ve)*
                                             Life event: (death of mother)

FIRST-LEVEL CODING:

i) Physical protection by family has metamorphosed into dominance, resulting in reported suppressed emotion.
ii) Childhood family relationships would be vastly complicated by the paradox described.
iii) The description of regret is obviously important. See later notes and concluding remarks.

THIRD-LEVEL CODING:

Family Dynamics (past)
This strays into the nature vs. nurture argument. Although Mr. P.'s childhood should not be described as dysfunctional, it was troubled in the sense that certain circumstances have made a lasting impression.

Appendix III.3: Summary and further observations

The data were stored in the following forms:

i) The 'raw data' subjected to first, second, and third level coding. For the purposes of easy reference, the lines were numbers.
ii) Data deemed important were then subject to fourth level coding.
iii) The data were arranged in chronological order to obtain a personal narrative.
iv) Relevant extracts were used in the main body of the thesis.

When writing the main body of the thesis, it was occasionally necessary to check the context of a section of data. This was done by returning to the original interview as described in section (i).

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## Appendix IV: Diagrams of personal narratives to show trajectory and dominance of nested narratives

As explained in Chapter Seven, the personal narrative is shown as a band spanning an axis of neutral value. Each short line in the banded narrative represents a short-lived nested narrative pertaining to a minor positive or negative event, such as those detailed in the Hassles-Uplift Index developed by Lazarus et al in the 1980's.(Cooper and Dewe, 2004). The first diagram shows a personal narrative containing an even distribution of positive and negative nested narratives.

Figure 1: Personal narrative drawn as a band containing equal positive and negative values: a *Balanced Narrative*
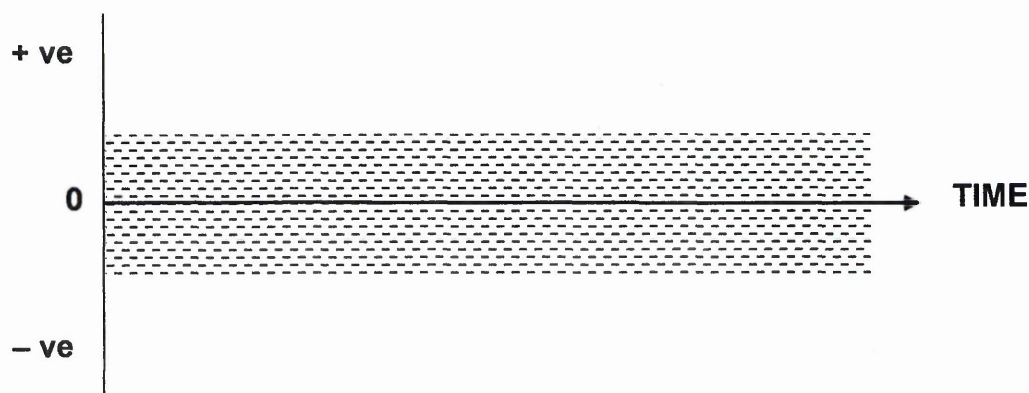

However, in the event of a nested narrative becoming dominant, the equilibrium of the entire personal narrative will be affected to some degree. If the dominant narrative is *positive*, then the personal narrative will become *elevated* (Figure 2). On the other hand, if the dominant narrative is *negative*, then the personal narrative will become *depressed* (Figure 3):

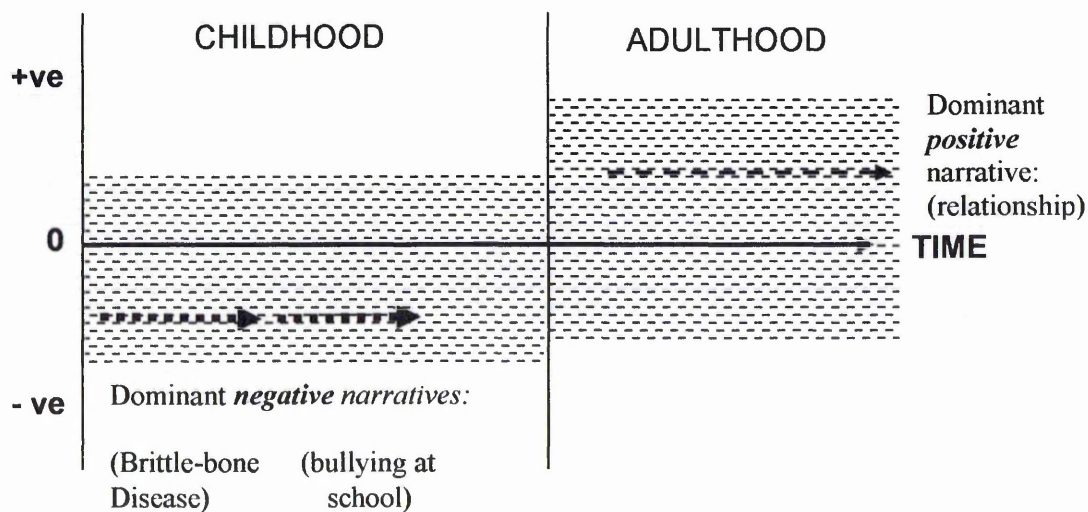**Figure 2: Personal narrative *elevated* due to the influence of a dominant *positive* nested narrative**
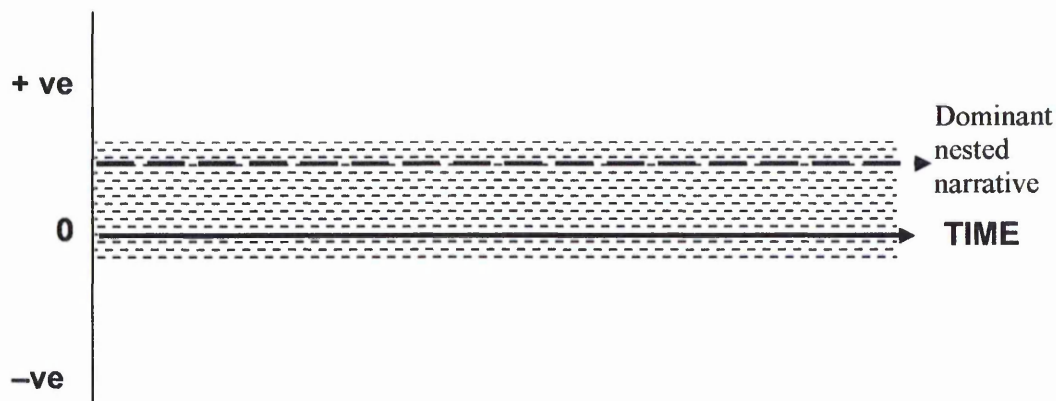
Figure 2: Personal narrative *depressed* due to the influence of a dominant *negative* nested narrative
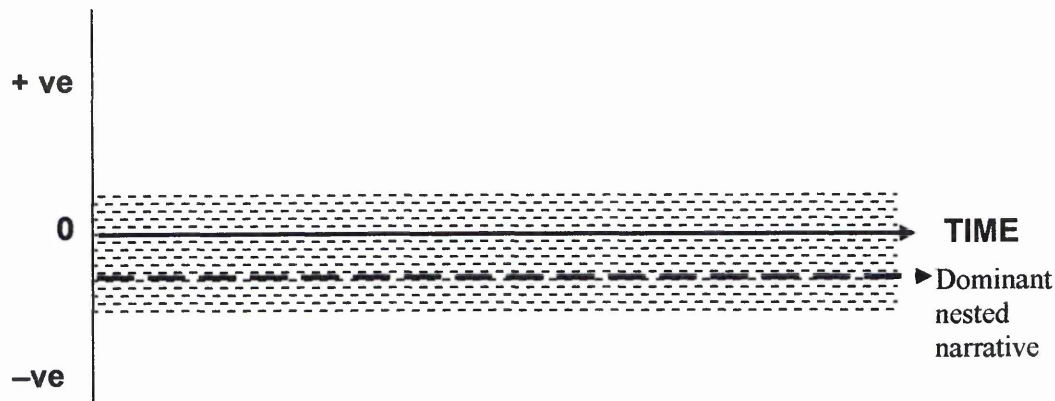
This basic concept can be applied in constructing trajectory diagrams that summarize the relevant periods of a respondent's personal narrative. For purposes of illustration, I compare the personal narratives of two respondents, namely *Mr. P.* and *Anne*. As explained in the main body of the study, personal narratives were divided into three stages, namely *prologue, overwhelm*, and *recovery*. The prologue of *Mr. P's* narrative is depressed during childhood then becomes balanced in adulthood:

Figure 4: Mr. P. Prologue:

Childhood compromised by dominant narratives of ill-health and bullying at primary school
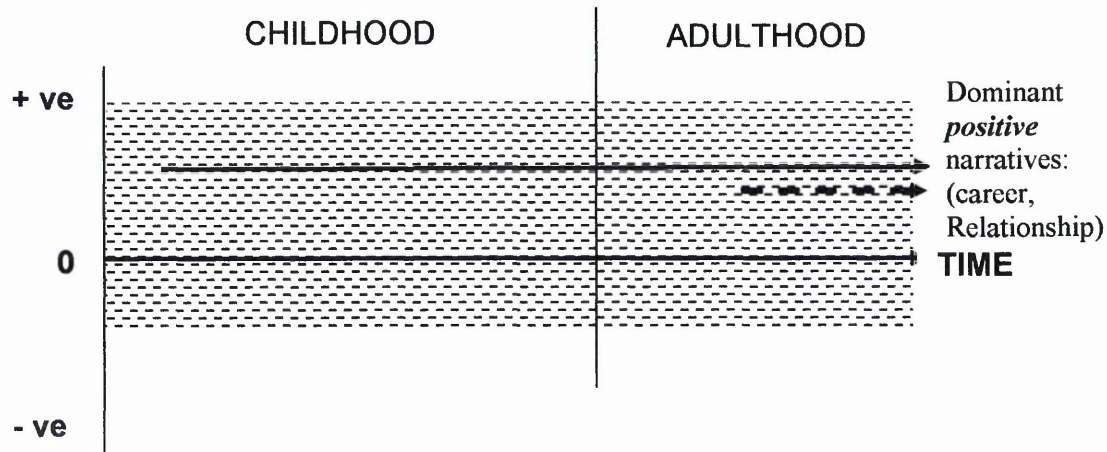

A22

In contrast, the prologue of *Anne's* personal narrative was elevated due to a successful education and career, plus a stable and happy relationship:

Figure 5: Anne: Prologue

Personal narrative elevated due to positive dominant narratives pertaining to career and stable relationship

Following the prologues, the narratives of Mr. P. and Anne serve to underline the arbitrary nature of the *overwhelm* construct. Initially, it is obvious and, as such, unequivocal: it is the point at which the mental health narrative becomes wholly dominant over all other nested narratives. How long it should be viewed as such is questionable, requiring a degree of informed speculation. That is, response to overwhelm almost always involves a period of invalidity, whether at home, at hospital, or both. Essentially, the person has ceased to function due to the dominance of the mental health narrative. Thereafter, recovery is not instantaneous but gradual as other nested narratives become sufficient to lessen to the dominance of the mental health narrative. Thus, I show overwhelm as continuing until recovery becomes evident. However, I emphasize that the exact point at which this occurs is heavily reliant upon subjectivity: for recovery to be viable, the person must believe that it is happening.

For both respondents, overwhelm was associated with the break-up of a relationship. For *Mr. P,* his decline in mental health was a consequence of several factors, namely relationship problems and other emotional difficulties,

A23

plus job loss. Following a suicide attempt and brief hospitalization, overwhelm can be understood as gradually giving way to recovery as Mr. P. regained his self-confidence and agency with the assistance of counselling. In contrast, *Anne's* narrative differs in that the break-up of her relationship was almost certainly due to disinhibited behaviour associated with her mental health narrative. In her case, I interpreted overwhelm as the period during which she was hospitalized several times, including two suicide attempts. Thereafter, her recovery is partial, compromised by continuing mental illness and the unresolved narrative concerning her former partner.

The following figures show the mental health narrative trajectory as the personal narrative enters overwhelm. For clarity, the prologue and overwhelm stages are patterned differently:

Figure 6: Mr. P. Overwhelm
Gradual onset of depression leading to personal neglect and dominant mental illness narrative resulting in suicide attempt.
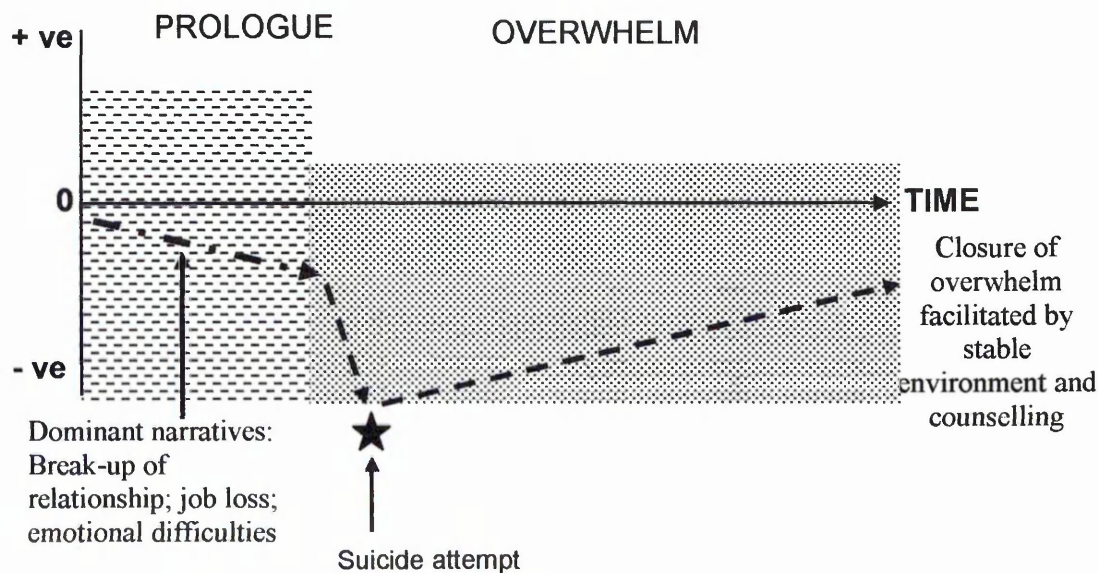

In contrast, Anne's narrative is complicated by another negative dominant narrative pertaining to the break-up of her relationship. As a result, the resultant diagram could become cluttered: this is resolved by regarding the trajectories of

the mental health narrative and the relationship narrative as identical until Anne's first suicide attempt:

Figure 7: Anne: Overwhelm

Overwhelm characterized by disinhibited behaviour during and after trip to Far East. Subsequent effects of mental illness exacerbated by break-up of relationship: this included periods of hospitalization following suicide attempts.
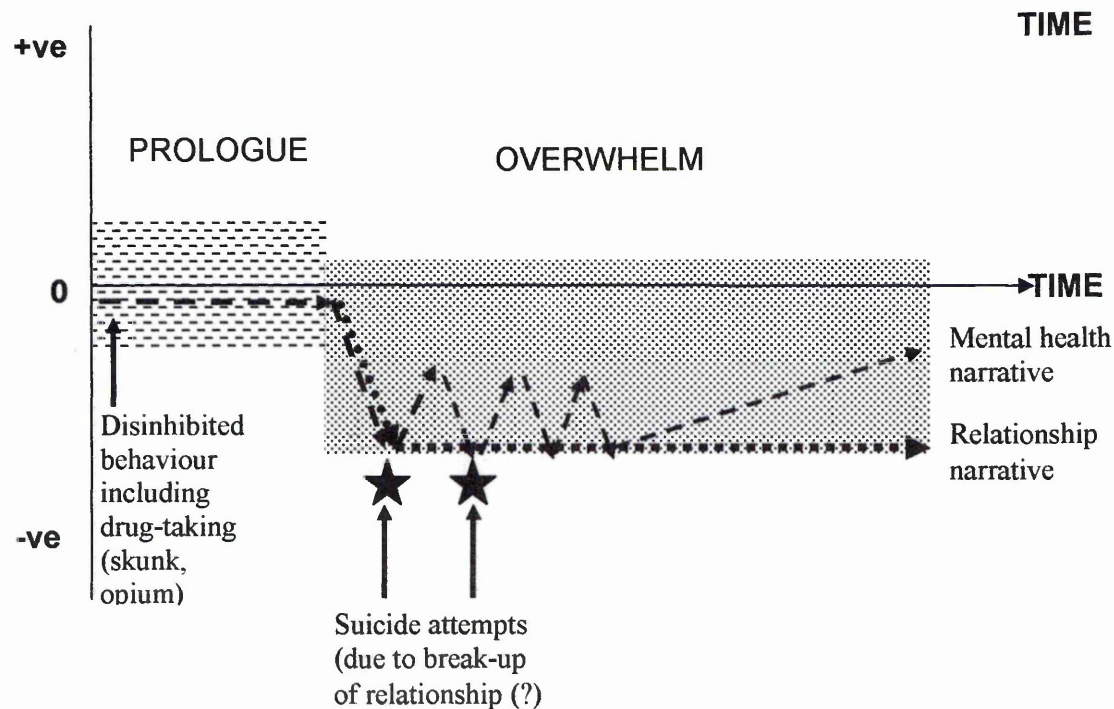

For the purposes of comparison, I felt it was helpful to include a summary of *overwhelm* when showing recovery trajectory. Gradually, the personal narrative of *Mr. P.* achieves an even balance as the mental health narrative is restored. Perhaps surprisingly, although the breaking of his engagement had led to an accumulation of stressors, his demeanour remained positive. Accordingly, although I have indicated these on his narrative diagram, I do not consider them to have influenced his mental health narrative (and thereby his personal narrative):

A25

Figure 8: Mr. P: Recovery

Gradual recovery over a three-year period sufficient to enable return to work. Personal narrative restored to balance despite recent stressors.
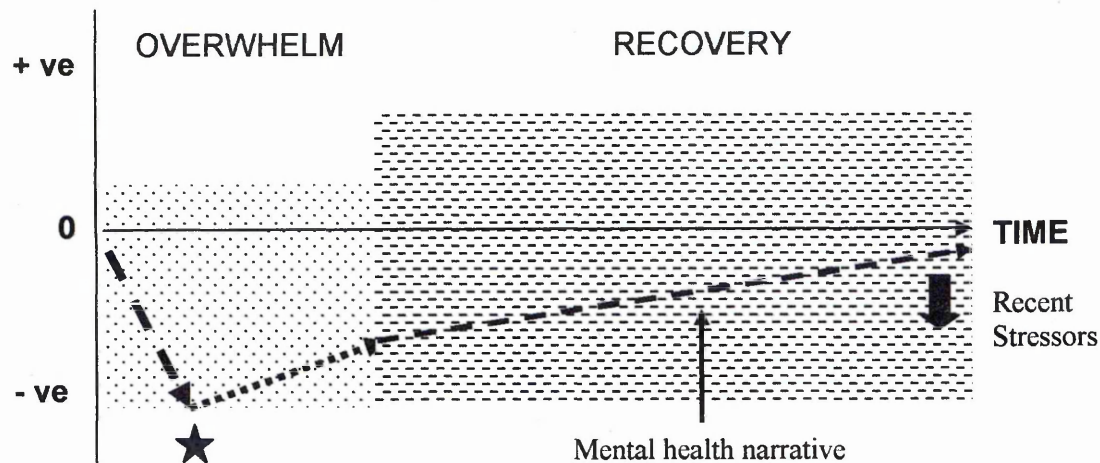
In contrast, *Anne's* personal narrative was dominated by the unresolved relationship narrative. This was inextricably interwoven with her mental health narrative in that she believed her illness had led to her partner leaving. Nevertheless, the mental illness narrative was also dominant in its own right by virtue of the loss of her career and continuing symptoms. Unlike Mr. P, Anne is unequivocally a user of services: in terming herself 'a schizophrenic', she accepts and maintains her label:

Figure 9: Anne: Recovery

Partial recovery but progress compromised by combination of dominant mental health narrative with strong negative dominant relationship narrative

A26
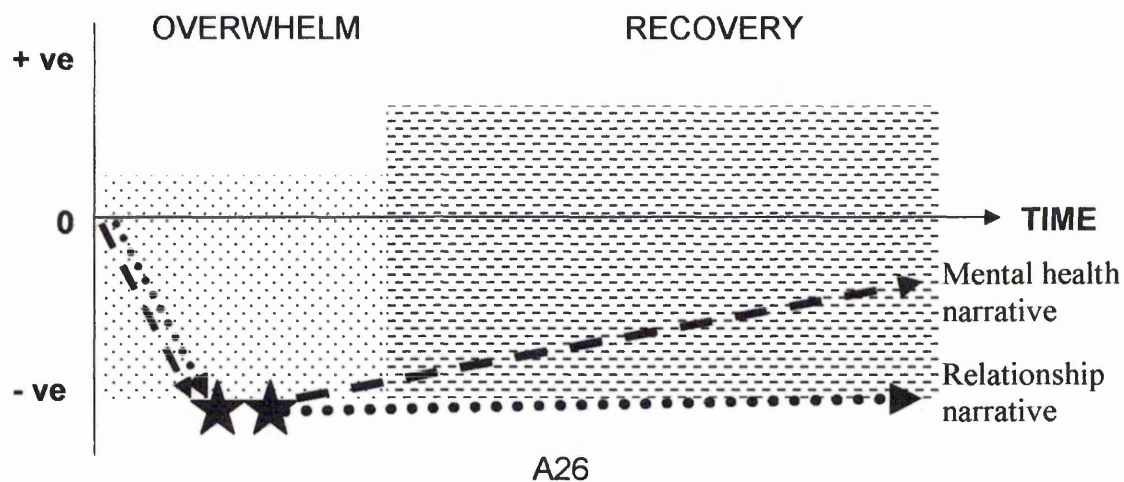
The final stage in the series of diagrams is to combine all three stages. Due to the amount of information contained, I found that a landscape format was more useful. These are shown overleaf.
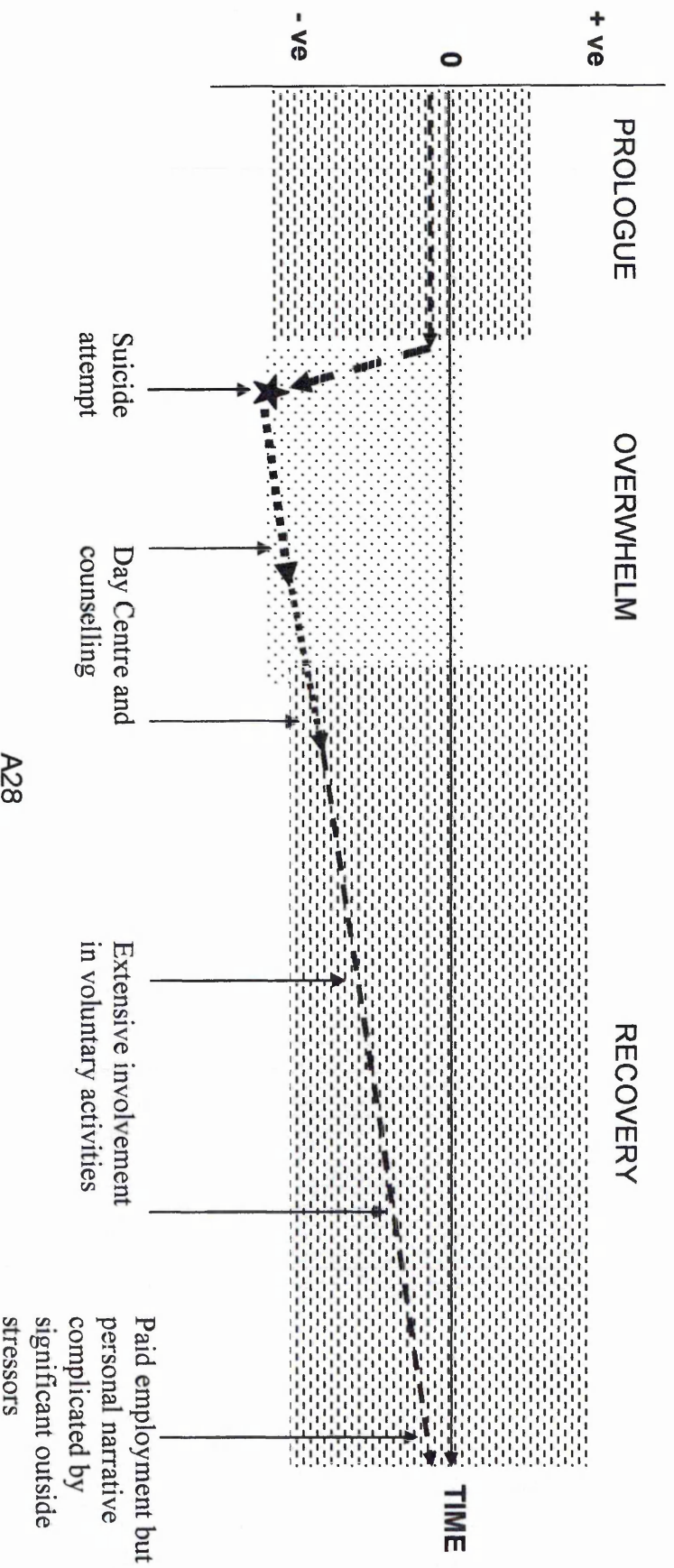
At this point it is pertinent to question my hopes and motives for creating these series of diagrams. Firstly, they provide a visual summary of individual narrative stages and, if desired, the individual personal narrative. Originally, they were included in the main body of the text; however, my supervisors felt that they interrupted the narrative flow of the chapters concerned. Accordingly, it is probably better to stress the ancillary use of the diagrams, that is, as a guide to understanding with reference to further research. This may be particularly so concerning a second or third interview. If so, my strategy would be to use thefirst interview to construct diagrams for the three stages plus the personal narrative diagram. These could then be printed and used in connection with an iterative approach in subsequent interviews. Concerning this, one obvious avenue is that any significant narratives not mentioned in the first interview could be added to a diagram during same. Another would be to add and/or clarify dates so that an accurate time scale can be established.

Thus I close this Appendix by referring to my proposal for the use of narrative diagrams in further research. Initially, a researcher could explain the principle of narrative trajectory by using basic details of their own personal narrative as an example. Thereafter, all that would be needed is a rudimentary construct upon which narrative trajectories could be drawn as an interactive exercise between researcher and respondent.

Figure 10.2: Mr. P: Personal Narrative

*Mental health narrative compromised by stressors in childhood and early adult life, culminating in depression and a suicide attempt. Gradual recovery over a three-year period sufficient to enable return to work. Personal narrative restored to balance despite recent stressors. **This represents an improvement compared to the personal narrative in the prologue stage***

PROLOGUE   OVERWHELM   RECOVERY

+ ve

0

- ve

Suicide attempt

Day Centre and counselling

Extensive involvement in voluntary activities

Paid employment but personal narrative complicated by significant outside stressors

TIME

A28

Figure 10.8: Anne: Personal Narrative

Mental health narrative positive during prologue due to stable relationship with partner and successful career. Overwhelm due to schizophrenia symptoms that may, in part, be related to drug-taking. At the same time, her relationship ended, resulting in two suicide attempts. Partial recovery but progress compromised by combination of dominant mental health narrative with strong negative dominant relationship narrative

PROLOGUE   OVERWHELM   RECOVERY

+ ve

0

- ve

TIME

Stable relationship

2 suicide attempts as consequence of break-up of relationship

Broken relationship persists as a dominant unresolved narrative

Incomplete recovery facilitated by medication and input from Support Worker; also participation in voluntary sector

Mental health narrative

Relationship narrative